

**Whatever Happened to Carl Rogers?
An Examination of the Politics of Clinical Psychology**

A Chapter from the Upcoming Book:

**HUMANISTIC PSYCHOLOGY: A CLINICAL MANIFESTO
A Critique of Clinical Psychology and the Need for Progressive Alternatives**

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To be published by
University of the Rockies Press
Colorado Springs, CO
Louis Hoffman, Editor

Praise from Natalie Rogers: “I read your excellent chapter and found myself saying BRAVO! I agree that the medical model is well-entrenched and resisting Carl’s discoveries. This article is long overdue and I am truly grateful for your careful and important analysis of the situation in academic clinical psychology here in the United States. On each page I found myself saying, “Yes! True! I agree! and thank you!” (See Natalie Rogers’s website at <http://www.nrogers.com/carlrogers.html>)

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HOW TO ORDER THE UPCOMING BOOK: Contact David Elkins at davidnelkins@hotmail.com and ask to be placed on the “no obligation” pre-publication list. You will be notified by e-mail when the book is available and can decide at that point if you wish to purchase it. Other chapters include “The Medical Model in Psychotherapy: Its Limitations and Failures,” “Empirically Supported Treatments: The Deconstruction of a Myth,” and “Why Humanistic Psychology Lost Its Power and Influence in American Psychology.” The book is a hard-hitting critique of contemporary clinical psychology and shows how humanistic psychology can provide alternative perspectives that are in line with contemporary research on what actually heals in psychotherapy. Dr. Elkins is a clinical psychologist and professor emeritus of psychology in the Graduate School of Education and Psychology at Pepperdine

University. He has been active in humanistic psychology for many years and has written numerous articles on humanistic themes, published a book on humanistic spirituality (Beyond Religion, Quest Books, 1998), served as a board member of the Association for Humanistic Psychology (AHP), and was president in 1998-1999 of Division 32, Society of Humanistic Psychology, of the American Psychological Association.

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Chapter One

Whatever Happened to Carl Rogers? An Examination of the Politics of Clinical Psychology

Contemporary clinical psychology doesn't quite know what to do with Carl Rogers. On the one hand, it is widely acknowledged that Rogers changed the landscape of American psychology. Rogers authored 16 books, published more than 200 scholarly articles, gave hundreds of professional presentations, and engaged in public dialogues with some of the most influential thinkers of his era including Martin Buber and Paul Tillich (Kirschenbaum, 1979; Kirschenbaum & Henderson, 1989; N. Rogers, 2008) Rogers's theories have had an impact on education, social work, nursing, counseling, psychotherapy, group therapy, peace efforts, and interpersonal relations. His theories have generated more research than those of any other clinical psychologist in American history (Bozarth, Zimring, & Tausch, 2001; Kirschenbaum, 1979). Rogers and his contributions are recognized internationally and he received awards and honorary degrees from dozens of groups, organizations, and institutions at home and abroad. The American Psychological Association (APA) gave Rogers two of its most prestigious awards – the “Award for Distinguished Scientific Contributions” in 1956 and the “Award for Distinguished Professional Contributions to Psychology” in 1972. He was the first psychologist in history to receive both awards (Cain, 2001a). In a 1982 survey of psychologists conducted by the American Psychologist (see Smith, 1982), Rogers was named as the most influential psychotherapist and 25 years later, in a survey conducted by the Psychotherapy Networker (April/March, 2007), Rogers was again ranked number one. Also, in a study by Haggbloom et al. (2002) that ranked the 100 most eminent psychologists of the twentieth century based on multiple criteria that included professional psychology journal citations, introductory psychology textbook citations, and survey responses from members of the American Psychological Society, Rogers received an overall ranking of six and for clinicians he was second only to Sigmund Freud. In his later years Rogers conducted group workshops in Northern Ireland and South Africa in an effort to promote communication and understanding. For these efforts, he was nominated for the Nobel Peace Prize in 1987 (Cain, 2001a).

It would be difficult to overestimate the significance of Rogers's contributions to clinical psychology. Often called the “father of psychotherapy research,” he was the first to record and analyze the transcripts of actual therapy sessions in an effort to clarify

what makes for effective psychotherapy; he was the first clinician to conduct major studies on psychotherapy using quantitative methods; he was the first to formulate a comprehensive theory of personality and psychotherapy grounded in empirical research; he was the first to develop a theory of psychotherapy that de-emphasized pathology and that focused, instead, on the strengths and potentials of clients (Rogers, 1987; Bozarth, Zimring, & Tausch, 2001; Cain, 2001a). Today, Rogers's ideas are echoed every time psychologists talk about the importance of the therapeutic relationship, raise concerns about the medical model, discuss the significance of the personal qualities of the therapist, or mention the importance of contextual factors in therapeutic outcome (see Wampold, 2000). Even Seligman's "Positive Psychology," a contemporary movement that has attracted hundreds of psychologists, is little more than a reframing of Rogers's original emphasis on the strengths and potentials of clients (see Greening & Bohart, 2001; Resnick, Warmoth, & Serlin, 2001; Seligman & Csikszentmihalyi, 2000; Elkins, in press - b).

The Question Addressed in This Chapter

In light of his many contributions, one would think that a large number of contemporary clinical psychologists would embrace client-centered perspectives and that Rogers and his ideas would be an important part of all training programs in clinical psychology. This, however, is not the case. The truth is, only 10% of clinical psychologists identify themselves as "humanistic" and client-centered therapists are a subset of that group (Cain, 2001b). Further, many training programs in clinical psychology marginalize or ignore Rogers and his contributions (see Cain, 2001b; Elkins, 2007; Wertz, 1998). For example, as a professor in a post-masters doctoral program, I have found that most incoming doctoral students are unfamiliar with the research on client-centered therapy, cannot articulate Rogers's theory of personality, and are not even aware that he had a developmental theory. Even more disturbing, many clinical professors know little about Rogers and often hold stereotypical and misinformed views about his contributions (see Elkins, in press-b). Clearly, something is wrong when one of the most important clinicians in history is ignored in clinical training. Keep in mind that I am not suggesting that Rogers's ideas should dominate clinical training. I am merely suggesting that they should be included and given their proper due. The fact that they are not raises serious questions about the politics of clinical training in America.

Thus, the question addressed in this chapter is: Why do so many contemporary clinical psychologists and training programs in clinical psychology marginalize or ignore Rogers and his ideas? I realize that some would answer this question by saying that Rogers is now out of date or that any substantial contributions he made have already been incorporated into clinical psychology. I would suggest, however, that such answers represent further dismissals of Rogers – the very problem this chapter addresses -- and reveal a serious failure to grasp the nature and extent of his contributions. Thus, in this chapter I will suggest a very different answer as to why Rogers is ignored, one based on an examination of the politics of clinical psychology.

Carl Rogers and the Psychiatric Profession of the 1940s

Before addressing the question directly, I would like to provide some relevant historical information. Carl Rogers (1902-1987) received his Ph.D. in psychology from Columbia University in 1931 and spent his early professional years working in child guidance clinics. Originally, clinical psychologists had been associated primarily with intelligence and personality testing but by the time Rogers came along in the late 1920s and 1930s some had begun to do “counseling” or “guidance.” However, the “more serious” work of psychotherapy was still the domain of psychiatrists. Psychiatrists considered themselves the only ones capable of diagnosing and treating mental pathology because (a) they were physicians and (b) they had been trained in the complex and somewhat mysterious techniques of psychoanalysis. Psychiatrists were at the top of the professional hierarchy and psychologists, social workers, and psychiatric nurses were little more than “handmaidens” to psychiatrists. In short, psychiatrists held the power in the “mental health” field.

They also held the power in psychotherapy. Psychiatrists were the “experts” who “diagnosed” and “administered treatments” to “patients.” In keeping with the medical model, the patient’s job was to provide information and follow the doctor’s orders. The doctor’s job was to analyze the patient’s material and make interpretations so that, in time, patients might gain insight into their own unconscious dynamics. Thus, as physician and trained analyst, the psychiatrist was “in charge” of the therapeutic relationship.

This was the historical stage onto which Carl Rogers walked in the early 1940s with his “non-directive” approach, as his theory was then called. Based on his research and clinical experience, Rogers had come to the conclusion that most clients are capable of arriving at their own insights and solving their own problems. He believed therapy was more successful when the counselor did not analyze, interpret, direct, control, or give advice but, instead, focused on the client’s process and accepted, recognized, and helped clarify the client’s feelings (see Bozarth et.al., 2001; Cain, 2001a; Rogers, 1942). In short, Rogers rejected the therapist-centered model of therapy and articulated a new client-centered approach.

Rogers’s views created an immediate uproar in the professional community, especially among psychiatrists. The idea that patients could solve their own problems without a psychotherapist to direct the therapy and to analyze and interpret the client’s material was considered both naïve and dangerous. Even as late as 1951, at the prestigious Menninger Clinic, Rogers was told that his brand of therapy would create psychopaths (Rogers, 1977).

Rogers was puzzled by the negative reactions and wondered why his ideas were so upsetting. He assumed it was because the ideas were new and had come from a psychologist, not a psychiatrist. However, in the later years of his life Rogers came across a concept that illumined these early experiences. In fact, the concept had such a profound impact on Rogers that it caused him to reassess all of his professional work. The concept was “the politics of interpersonal relationships.” Rogers (1977) described how he was first exposed to this concept:

Three years ago I was asked about the politics of the client-centered approach to psychotherapy. I replied that there was no politics in client-centered therapy, an answer which was greeted with a loud guffaw. When I asked my questioner

to explain, he replied, “I spent three years of graduate school learning to be an expert in clinical psychology. I learned to make accurate diagnostic judgments. I learned the various techniques of altering the subject’s attitude and behavior. I learned subtle modes of manipulation, under the labels of interpretation and guidance. Then I began to read your material, which upset everything I had learned. You were saying that the power rests not in my mind but in his organism. You completely reversed the relationship of power and control which had been built up in me over three years. And then you say there is no politics in the client-centered approach!” (p. 3)

At the time of this exchange, Rogers was unfamiliar with the word “politics” as a term to describe interpersonal relationships. Later, Rogers (1977) wrote,

The use of the word “politics” in such contexts as “the politics of the family,” “the politics of therapy,” “sexual politics,” “the politics of experience” is new. I have not found any dictionary definition that even suggests the way in which the word is currently utilized. . . . 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. (p. 4)

This new concept gave Rogers a way to understand why his ideas had created such furor in the 1940s. Rogers (1977) said,

It has taken me years to recognize that the violent opposition to a client-centered therapy sprang not only from its newness, and the fact that it came from a psychologist rather than a psychiatrist, but primarily because it struck such an outrageous blow to the therapist’s power. It was in its politics that it was most threatening. (pp. 16-17)

A few pages earlier, Rogers (1977) had said,

I see now that I had dealt a double-edged political blow. I had said that most counselors saw themselves as competent to control the lives of their clients. And I had advanced the view that it was preferable simply to free the client to become an independent, self-directing person. I was making it clear that if they agreed with me, it would mean the complete disruption and reversal of their personal control in their counseling relationships. (pp. 6 -7)

Rogers's client-centered views turned the "politics" of psychotherapy upside down. Rogers had said that the client – not the therapist – was the expert on the client's problems. The client – not the therapist – had the ability to solve those problems. The client – not the therapist – held the power. Without fully realizing it at the time, Rogers had asked psychiatrists to give up their role as the "all-knowing doctor" and to focus, instead, on creating a therapeutic relationship characterized by empathy and acceptance that would free clients to grow and thus become capable of solving their own problems. In a sense, Rogers had asked psychiatrists to become "servants" to the client's process.* Clearly, in terms of the "politics of power," Rogers had hit psychiatrists where it hurt.

*(Note from author: It's worth mentioning that, etymologically, the word "therapist" means "attendant" or "servant").

Carl Rogers and Contemporary Clinical Psychology

But what does this history have to do with the question of why Rogers is ignored by contemporary clinical psychology? I would suggest that, in large measure, Rogers is ignored today for the same reasons he was attacked by psychiatrists in the 1940s: his client-centered views represent a threat to contemporary clinical psychology just as they represented a threat to the psychiatric community in the 1940s. To adapt a campaign slogan, "It's the politics, Stupid."

Contemporary clinical psychology is committed to the medical model -- the same model that dominated psychiatry in the 1940s. Most clinical psychologists view themselves as "doctors" who "diagnose" "mental disorders" and "administer treatments" to "patients." Thus, Rogers's view that psychotherapy is not a set of medical-like procedures but, rather, an interpersonal process that frees clients to grow and actualize their potentials is a threat to contemporary clinical psychology just as it was a threat to the psychiatric community 70 years ago. If clinical psychologists adopted Rogers's views, they would have to give up their role as "doctors" and the power this gives them over clients, along with their belief that their medical-like techniques are responsible for therapeutic effectiveness. Further, they would have to focus their therapeutic efforts on creating an empathic, accepting, and open relationship in which their clients could grow, discover their own insights, and find their own directions. For those who view themselves as "doctors" who "administer treatments," this is not easy to do. Even for those who are not invested in power and who are, in fact, drawn to Rogers's ideas, it is difficult to embrace and practice client-centered values. Our profession is so dominated by the medical model that in many clinical settings one's professional competence is judged by one's ability to speak medical jargon and to describe what one does in medical model terms. Also, adherents of the medical model tend to receive the professional and economic rewards (e.g., better jobs, promotions, salaries) that come to those who collaborate with the system. Thus, the politics of clinical psychology, including its medical model ideology and system of professional and economic rewards, makes it difficult for clinical psychologists to embrace Rogers's views even if they are inclined to do so. (For a more detailed critique of the medical model, see Elkins, in press-a).

And what about clinical training? Why do so many programs marginalize or ignore Rogers and his ideas? Again, I would suggest that, in large measure, it's the "politics." Most training programs in clinical psychology, like the rest of the profession, are immersed in the medical model. The academic courses and supervised training are designed to produce "doctors" who can "diagnose" "mental disorders" and "administer treatments" to "patients." Rogers's views simply do not fit in such programs. In fact, if his views were taken seriously, they would undermine the ideology and goals of these programs, not to mention how much they would upset professors who teach courses based on medical model assumptions. Also, imagine what would happen if a significant number of students were drawn to Rogers and his ideas. Suppose they said, "This is what we always thought psychotherapy should be." Clearly, this could create a serious morale problem, leading students to challenge their professors and to question the validity of their training experiences. Thus, in terms of the politics of power, it is in the best interest of most training programs in clinical psychology to ignore Rogers as much as possible.

Insights from the field of critical psychology are relevant here. Critical psychology, which began in Germany in 1970, is now a substantial movement (see Fox and Prilleltensky, 1997; Prilleltensky and Nelson, 2005; Slife, Reber, & Richardson, 2005). Critical psychologists are committed to social justice and examine, among other things, how psychology may collude, wittingly or unwittingly, with social and political forces that are harmful to human beings. For example, critical psychologists have raised concerns about clinical psychology's tendency to focus on individual pathology while ignoring the larger social forces that produce that pathology. Another issue they address -- more directly related to this article -- is how and why psychology sanctions some points of view but ignores or resists others. The term "gate-keepers" has been used to refer to those who exercise power in determining which ideas are "allowed in" and which are not. For example, influential psychology organizations such as the APA and editors of major psychology journals exercise considerable power in determining which ideas receive attention and which do not. Perhaps the most powerful gate-keepers, however, are training programs in clinical psychology. Because everyone who wishes to become a clinical psychologist must pass through their gates, training programs have enormous power to shape students' views of the profession and to indoctrinate them into whatever happens to be the dominant ideology of the profession. Because training programs want to retain their APA accreditation, be viewed positively by the professional community, and ensure that their students are able to function effectively in the "real world" of clinical psychology, they are motivated to provide conventional training so their students can secure conventional internships which will prepare them for conventional jobs in conventional settings. Thus, training programs have political and economic reasons to reflect the dominant ideology of the profession and to marginalize ideas that are not congruent with that ideology. As an example of how outside forces can affect clinical training, consider how quickly some programs reinvented themselves in the 1980s and 1990s to reflect managed care's emphasis on short-term therapies and "empirically supported treatments." The danger in allowing marketplace and other external forces to shape clinical training is that science and good critical thinking may be trumped by political and economic considerations. Indeed, scientific findings have now raised serious questions about the overly zealous claims made by adherents of short-term therapies and so-called "empirically supported treatments" (see Elkins, 2007, 2008;

Hubble, Duncan, & Miller, 1999; Miller, 1994, 1996a, 1996b, 1996c; Seligman, 1995; Wampold, 2001.).

I am not suggesting that those in charge of clinical training programs lie awake at night trying to think of ways to marginalize Carl Rogers. Instead, I am suggesting that training programs are caught in a web of political and economic forces that influence which ideas are considered acceptable and which are resisted. Thus, training programs can become centers of orthodoxy, dedicated to reflecting the status quo, instead of centers of creative and critical thinking that welcome alternative and innovative ideas. This political perspective makes it easier to understand why Rogers, one of the most important clinicians in history, is ignored. He is ignored because his ideas are inconsistent with, and represent a serious threat to, the medical model ideology that dominates contemporary clinical training and practice.

Rogers's Contributions and Their Political Implications

After his controversial debut in the 1940s, Rogers went on to become a leading figure in American psychology. Research on client-centered therapy and the studies it inspired literally dominated psychotherapy research for more than 20 years – from the early 1940s through the early 1960s (Bozarth, Zimring, & Tausch, 2001). Eventually, hundreds of students, psychologists, counselors, social workers, family therapists, group therapists, and even a few psychiatrists embraced client-centered values. They were drawn to Rogers's view that clients have an innate ability to actualize their potentials and that certain therapeutic conditions release this actualizing tendency. While it is not the purpose of this article to discuss all of Rogers's contributions, it does seem important to highlight those that have political implications and are thus in line with the focus of this article. Three overlapping contributions and their political implications are discussed below.

Contextual Factors as the Effective Ingredients in Psychotherapy

During his tenure at the University of Chicago in the late 1940s and 1950s, Rogers came to believe that the "conditions" he had discovered in client-centered therapy (i.e., empathy, unconditional positive regard, and congruence) were the healing factors in all therapeutic systems (Rogers, 1957, 1959). Thus, the research moved beyond an exclusive focus on client-centered therapy and turned to the study of these conditions in other therapeutic approaches. Although we now know that "contextual factors" include more than Rogers's three conditions, contemporary research on contextual factors (e.g., Wampold, 2001) makes it clear that Rogers was on the right track to reject the medical model with its emphasis on techniques and to focus, instead, on other factors in the therapeutic situation as the effective ingredients in psychotherapy. This contribution of Rogers has political implications because, like the recent research on contextual factors, it represents a frontal attack on the medical model and its focus on techniques as the determinants of therapeutic outcome.

Rogers's Theory of Interpersonal Relationships

During the 1950s Rogers and his associates broadened the focus of their research beyond psychotherapy to include other interpersonal relationships such as parent-child, teacher-student, and employer-employee (see Gordon, 1970; Montuori & Purser, 2001; Thomas, 2001). As research findings came in, it became increasingly clear that Rogers had discovered a simple formula with revolutionary potential to transform human relationships: if those in positions of authority are willing to relinquish their power over others and create an interpersonal milieu characterized by empathy, respect, and congruence, amazing things are likely to happen. When individuals realize that they are free to exercise their own power and develop their own potentials, they tend to come alive and to grow in unpredictable but deeply meaningful ways. This new theory had powerful political implications because it challenged authoritarian and paternalistic models of human relationships and supported the power of children, students, employees, women, ethnic minorities, and others whom society has often consigned to subordinate positions in terms of power.

A New Theory of Power

Early on, Rogers's research and clinical experience caused him to reject therapist-centered approaches that focused on guiding, advising, suggesting, and persuading clients. His subsequent research confirmed that clients tend to move in positive therapeutic directions when therapists relinquish their control and support the power of the client. From a historical perspective, Rogers was challenging the authoritarian and paternalistic view of the therapeutic relationship that had originated with Freud in the Victorian Age. This is the same view of human relationships that once led our society to believe that husbands should have power over wives, that whites should dominate blacks, that missionaries should "Christianize" traditional cultures, and that the U.S. government should "civilize" Native Americans. It does not matter that there may have been some good husbands, whites, missionaries, and government agents. It is also irrelevant that some of the oppressed may have liked, loved, befriended, or collaborated with their oppressors. What made these systems inherently flawed and irredeemably immoral was their "politics" – the authoritarian and paternalistic assumption that certain groups know what is best for others and therefore have a right to exercise power over them. Such systems not only violate basic human rights but they also limit or destroy the unique potentials of those who are oppressed. Authoritarian and paternalistic systems – including therapy administered by experts who think they know what is best for others -- are far more dangerous than we have been led to believe.

Psychotherapy is highly political in the sense that it wields enormous power in clients' lives. In therapy, clients make decisions that change their lives forever; they set sail on existential journeys of no return. Thus, how we as therapists deal with the power inherent in psychotherapy is vitally important. As Rogers recognized, there are two basic choices: we can assume the role of "expert" and tell clients how to solve their problems and live their lives or we can adopt an emancipatory approach that supports clients' power and frees them to make their own decisions, solve their own problems, find their own directions, and become more fully who they are. As Rogers (1942) put it,

Therapy is not a matter of doing something to the individual or of inducing him to do something about himself. It is instead a matter of freeing him for normal growth and development, of removing obstacles so that he can again move forward. (pp. 28-29)

Referring to Gertrude Stein's famous statement about the city of Paris, "It is not what Paris gives you but what she does not take away," Rogers (1977) said, "This can be paraphrased to become a definition of the person-centered approach.... 'It is not that this approach gives power to the person; it never takes it away'" (p. xii).

This contribution has political implications because it challenges therapists to abandon paternalistic approaches that disempower and to embrace emancipatory approaches that set clients free. It is difficult to imagine how one can truly respect the power of clients while relating to them as a "doctor" who "diagnoses" their "pathology" and "administers treatments" to "cure" their "mental disorders." We have become so accustomed to such medical model language that we often fail to see just how patronizing and disempowering it is. In contrast, Rogers's approach to therapy, along with other emancipatory approaches, supports the client's power and adamantly refuses to take it away. (For an excellent discussion of emancipatory therapy, see O'Hara, 2001).

Concluding Thoughts: Where We Are Today

Despite Rogers's research which showed that interpersonal factors – not techniques -- were the effective ingredients in psychotherapy, clinical psychology made a radical turn in the 1970s toward investigations of "specificity," i.e., specific treatments for specific disorders (see Bozarth, et al., 2001; Bergin, 1997). Why this change occurred is not clear but it certainly was not based on previous research findings. Most likely, it represented a resurgence of the medical model in the vacuum created when Rogers and his associates completed their last major research project in the 1960s (see Rogers, Gendlin, Kieseler, & Truax, 1967). Also, many researchers and clinicians, perhaps because of their "hard science" training, have difficulty believing that something as "soft" as relational factors can be responsible for therapeutic effectiveness, even though the research has confirmed this again and again. Whatever the reasons, the research tradition that Rogers had originated and that had dominated clinical research for more than two decades went into eclipse in the United States in the 1970s, and for the next 25 years (from the mid-1970s to the late 1990s) specificity research took center stage, bolstered in the 1980s and 1990s by the rise of managed care with its medical model assumptions about psychotherapy and its insistence that clinical psychologists demonstrate the scientific validity of their techniques (see Bozarth et al., 2001, Elkins, 2007).

Today, however, something new is happening. After 25 years of specificity research that involved hundreds of efficacy studies and millions of research dollars, clinical researchers have failed to demonstrate that any particular technique is any more effective than any other technique (Ahn & Wampold, 2001; Elkins, 2007; Messer & Wampold, 2000; Wampold, 1997, 2001, 2005). Equally dramatic, recent analyses and meta-analyses of thousands of research studies conducted over several decades have made it clear that contextual factors – not techniques – are the primary determinants of therapeutic outcome (see Asay &

Lambert, 1999; Hubble, Duncan, & Miller, 1999; Elkins, 2008; Wampold, Mondin., Moody, et al., 1997; Wampold, 2001, 2005, 2007). The term “contextual factors” refers to such factors as the alliance, the relationship, the personal qualities and interpersonal skills of the therapist, client agency, patient expectations, extra-therapeutic factors, and so on. These findings, which are a devastating blow to the medical model with its focus on techniques, are slowly forcing clinical psychology to revisit the idea that certain factors common to all therapeutic systems are the effective ingredients in psychotherapy. This is a powerful vindication of Rogers’s work and shows that he was correct to reject the medical model with its emphasis on techniques and to focus on personal and interpersonal factors as the more powerful determinants of therapeutic outcome. Thus, the eclipse that placed Rogers and his research findings in semi-darkness for more than 25 years is now over and it’s time for clinical psychology to revisit Rogers in the context of contemporary research on contextual factors. The only thing that could prevent us from doing this is our irrational dedication to the medical model and the recalcitrant politics of our profession.

“Whatever happened to Carl Rogers?” Perhaps the best answer is this: he was about 50 years ahead of his time and has been waiting for us to catch up.

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Whatever Happened to Carl Rogers? An Examination of the Politics of Clinical Psychology is a chapter from the upcoming book HUMANISTIC PSYCHOLOGY: A CLINICAL MANIFESTO: A CRITIQUE OF CLINICAL PSYCHOLOGY AND THE NEED FOR PROGRESSIVE ALTERNATIVES by David N. Elkins, Ph.D., and published by University of the Rockies Press, Louis Hoffman, Editor. If you would like to be notified when the book is published, please send an e-mail to davidnelkins@hotmail.com