Rethinking human suffering

Stephen Joseph argues that person-centred theory provides a robust framework for understanding and working with severe mental distress

Over recent decades, the person-centred approach has become a major force in the world of counselling and psychotherapy. Yet the person-centred approach to understanding distress and dysfunction has commonly been overlooked in mainstream mental health services. This is, perhaps, due to the mistaken belief among many psychologists and psychiatrists that person-centred therapy is a good idea for the 'worried well', but that serious mental health problems should be left to the 'proper professionals'. This becomes, of course, a self-fulfilling prophecy. As the person-centred approach becomes marginalised in the NHS because of these beliefs, training courses find it hard to provide placements and supervision for trainees to work with clients with more severe forms of mental distress, and so person-centred practitioners emerge from their training ill-equipped to work with anyone but the worried well, at least in the eyes of these other professionals.

Clash of paradigms

But a deeper look at the theory that underlies person-centred practice shows it does have great potential for helping people who would otherwise be considered to have serious mental health problems. The main problem is communication, as we are essentially dealing with a clash of paradigms: the potentiality model of the person-centred approach on the one hand, and the medical model on the other.

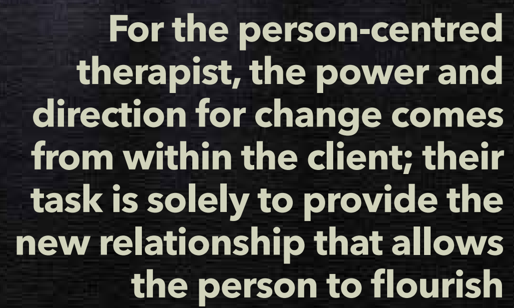
The person-centred approach to helping is based on the assumption that human beings have an inherent tendency towards growth and development: movement towards becoming fully functioning will happen automatically when people encounter an empathic, genuine and unconditional relationship in which they feel valued and understood. However, it is recognised that such relationships are rare; the inherent tendency towards becoming fully functioning is more frequently thwarted and usurped, leading instead to psychological distress and dysfunction.[1] For the person-centred therapist, the power and direction for change comes from within the client; their task is solely to provide the new relationship that allows the person to flourish.

The medical model is based on the assumption that there exist specific disorders requiring specific treatments - an assumption embodied in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, now in its fifth edition.[2] *DSM-5* is a voluminous work, running to many hundreds of pages, which describes the range of psychiatric disorders and the detailed procedure for the diagnosis of each.

Whether or not they adhere strictly to the *DSM*, many mental health professionals take for granted that there is a need for specific treatments for specific conditions; alternative ways of thinking are rarely acknowledged. The person-centred approach emphasises developmental processes and the actualising tendency of the individual; there is no need for diagnosis, because problems in living all have the same essential cause and the approach to therapy is always the same. Person-centred therapy is a relationship in which the client is able to grow and self-right in such a way that they move away from façade, from pleasing others, and towards self-direction, openness to experience, acceptance of others, and trust of their self.[3] As a consequence, the person-centred approach uses different terminology to describe mental health.

Explaining disorder

Rogers wrote that, in his experience, whatever their problem, whether it was to do with distressing feelings or troubling interpersonal relations, all clients are struggling with the same existential question: how to be themselves. ▶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But to what extent can person-centred personality theory account for the range of psychopathology that is described in the *DSM*?

There are three defining features of the medical model:

1. the focus is on the individual – the origins of distress and dysfunction are seen as within the person
2. the practitioner is seen as the expert on what the patient needs, who knows what is best for the patient
3. the emphasis is on distress and dysfunction, and what is weak and defective about people.

Ultimately, the challenge posed by the person-centred approach is to rethink the nature of human suffering. Rogers' person-centred theory offers a meta-theoretical perspective on human nature founded on the assumption that human beings have an inherent tendency toward growth, development and optimal functioning.[1,3,4] Unpacking the implications of this for practice, the person-centred approach is in direct opposition to these three features of the medical model:

1. person-centred therapists are concerned with the social systems of family and community and how external forces act on the person, leading to the development of conditions of worth, which in turn affect their processing style
2. person-centred therapists see the client as the expert on what is best for them and seek to form collaborative relationships in which the client directs the therapeutic process. The therapist is non-directive because the direction comes from the client, hence the term 'client-centred'
3. person-centred therapists are interested in the constructive and healthy potential of people and their movement towards becoming fully functioning, consistent with the aims of positive psychology.

Various individuals and professional groups may seize on one of these three points of opposition to define themselves, but still hold fast to the other features of the medical model. They may perceive themselves as standing against the medical model but, in fact, continue to promote others of its features. Only the person-centred approach offers an alternative to the medical model in all three ways – by looking to health and wellness, seeking to understand the social processes, and taking the stance that people are the best experts on themselves.

At least, that is the theoretical stance of the person-centred approach. In reality, these ideas may not always have been put into practice so well.

The approach has been most successful at promoting the idea that people are their own best experts, but less so in the promotion of health and wellness. In my view, many person-centred therapists have themselves forgotten their theoretical roots, so immersed and besotted have they become with the medical model and its notions of deficit and dysfunction. Person-centred therapists have become so accustomed to using the language and terminology of psychiatry that they have forgotten that theirs is a potentiality model. In looking to the future, we need to ensure that all three aspects of person-centred theory are now given equal attention.

Evidencing the argument

It will seem self-evident to many that the person-centred approach offers a more ethical and effective way of helping, but that is not enough. It must be shown to be so. There is already substantial evidence for the therapeutic role of relationships,[5] but there is a long way to go yet if the person-centred approach is to gain credibility in the current mental health system. If that is ever to happen, we need to take research more seriously and get new evidence that shows the person-centred approach really is an alternative that makes a difference in our understanding of how problems arise and how people can be helped.

Furthermore, we need to do more than convince ourselves. The person-centred approach is not widely represented in our universities, where such research often takes place. Awareness of it among other professionals is minimal. If we want the approach to be taken more seriously, we also need to communicate the research beyond the person-centred community. As I see it, future research developments are needed in a number of areas.

First, we need to see new research that accommodates the ideas of evidence-based practice as they are framed through the lens of the medical model. Such research would develop person-centred conceptualisations of the various diagnostic categories and test the effectiveness of person-centred therapy for specific conditions – not to provide a justification for the medical model, but to show that there are other, more humane ways of thinking about and working with people who have a diagnosis. We need research that meets the standards of professional psychology and psychiatry journals and speaks directly to these audiences in ways that they understand, so that the person-centred approach gets taken more seriously within the wider mental health arena. However, in doing this research, we must be open to testing and discovering the strengths and the limitations of person-centred therapy. Our research may not always show us what we expect or

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In terms of therapy for specific conditions, the most significant development of recent years has been the Counselling for Depression (CfD) programme.[6] Some may see this as compromising the principles of the person-centred approach, insofar as it adopts the language of the medical model. For example, CfD by definition involves the diagnosis of depression. On the other hand, those involved in CfD may see this as a necessary compromise that has meant the person-centred approach is taken seriously in the NHS and by funding bodies.

Second, for those whose stance is to reject any involvement with the medical model, other research and scholarship is needed. Our own understandings of the person-centred approach from its own frame of reference cannot stand still. We need to continue to define our assessment procedures. We need to describe our own use of models of dysfunction. We need an understanding of social and cultural forces. Research that develops person-centred theory in its own right, not as a compromise to other positions, is vital if the approach is to maintain and develop its own distinct stance to mental health. Such research can continue to build in the specialist humanistic and person-centred journals.

Third, rather than remain isolated, person-centred practitioners should also align themselves with other professionals who hold similar views on some of the same theoretical aspects. Such research need not compromise the principles of the person-centred approach, but simply take it to new and influential audiences that will be receptive to its ideas and values. In promoting social justice, we would do well to look to the profession of social work, which shares our concern about the societal causes of distress and dysfunction and their prevention. In terms of health and wellness, recent years have seen much interest in positive psychology.

Towards full potential

It seems self-evident to me that the person-centred approach is a positive psychology.[7] Positive psychologists are concerned with understanding what makes life worth living, which ought to sound familiar to the person-centred psychologist, counsellor or psychotherapist.[8] After all, it was Rogers who introduced the idea of the fully functioning person. But this is not to say that all positive psychology is person-centred. What makes the person-centred approach a unique form of positive psychology is its underlying meta-theoretical stance that human beings are organismically motivated towards developing to their full potential. Research will benefit from a broader positive psychological conceptualisation of measurement that embraces a theoretically consistent approach. We need new research that can show that mental health problems are better understood as expressions of thwarted potential, and that person-centred therapy leads to increases in people becoming more fully functioning, not simply to reductions in distress and dysfunction. Imagine that, instead of diagnostic assessment, we had a new system that was based on these ideas, and that therapists no longer thought about symptom reduction, but about the promotion of a person's potential.

In these three ways – first, by researching person-centred therapy in medical model contexts and using person-centred theory to understand psychiatric concepts; second, by building strong theory and scholarship within the person-centred approach, and, third, by aligning the person-centred approach with contemporary developments such as positive psychology – we can begin to advance new evidence for the person-centred approach to mental health. Ultimately, the challenge posed by the person-centred approach is to rethink the nature of human suffering. ■

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REFERENCES

1. Rogers CR. A theory of therapy, personality, and interpersonal relationships as developed in the client-centred framework. In: S Koch (ed). Psychology: a study of a science. Vol 3: Formulations of the person and the social context. New York: McGraw-Hill; 1959 (pp184–256).
2. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (5th ed). Washington, DC: American Psychiatric Press; 2013.
3. Rogers CR. On becoming a person. Boston, MA: Houghton Mifflin; 1961.
4. Rogers CR. Freedom to learn. Columbus, OH: Merrill; 1969.
5. Cooper M, Joseph S. Psychological foundations for humanistic psychotherapeutic practice. In: Cain DJ, Keenan K, Rubin S (eds). Humanistic psychotherapies: handbook of research and practice (2nd ed). Washington, DC: American Psychological Association; 2016 (pp11–46).
6. Sanders P, Hill A. Counselling for depression. London: Sage; 2014.
7. Joseph S. Positive therapy: building bridges between positive psychology and person-centred psychotherapy. London: Routledge; 2015.
8. Maddux JE, Lopez SJ. Toward a positive clinical psychology: deconstructing the illness ideology and constructing an ideology of human strengths and potential in clinical psychology. In: Joseph S (ed). Positive psychology in practice: promoting human flourishing in work, health, education, and everyday life (2nd ed). New York: John Wiley; 2015 (pp411–427).