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Editorial

Focusing on relationship – is there room for another paradigm in Psychiatric Intensive Care?

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One of the most regularly used terms within policy guidelines, mission statements and healthcare settings in general these days, is 'person-centred'. Disappointingly it is often used as little more than a buzz word or politically correct term. If it is used to convey certain ideas, then these can be anything from concepts of partnership, patient choice, personalised care, to representing humanistic ideas and conveying a holistic approach to care. There is, however, another way in which the term 'person-centred' could be used in healthcare settings. It could convey the values, philosophy and practice of the person-centred approach as formulated by Carl Rogers and his co-workers in the middle of the last century – an approach which is as radical now as it was then; an approach that challenges the dominant biomedical paradigm of modern psychiatric practice; and an approach that, in my view, is desperately needed to counteract the dehumanising effects (for both patients and professionals) of much mental health care within fragmented systems dictated by political and economic agendas.

THE VALUES AND PHILOSOPHY OF THE PERSON-CENTRED APPROACH

The person-centred approach is currently marginalised within contemporary psychiatry. Being widely misunderstood, or understood in the most superficial ways, it is also the victim of damaging caricatures where the helper is, for example, described as having 'a bouncy rubber spring for a neck, and simply sits there nodding and bobbing sagely, interjecting the occasional (but well-timed) 'hm-mm' and 'uh-huh'!' (Vincent, 2005, p. 85). It may be remembered from one's training as having something interesting and helpful to say about listening, especially about empathy and unconditional positive regard, but little else. It is most often regarded as a type of counselling and therapy (sometimes referred to as 'client-centred therapy'), suitable for the 'worried well' but certainly not suitable when working with the tough realities of mental illness and acute disturbance. And perhaps of all the different types of mental health environments, one would least expect to witness the practice of person-centred values and philosophy in psychiatric intensive care or low secure units.

In Freeth (2007) I explored at some length what I see as the key challenges for the person-centred approach if it is to make its presence felt within mental health settings. I highlighted the conflicts and tensions person-centred practitioners may experience when trying to work according to a set of values that is largely at odds with those underpinning modern psychiatric practice. I also pointed out that the approach is not the sole domain of counsellors and therapists but one that, according to Rogers, is 'an approach to life, a way of being, which fits any situation in which *growth* – of a person, a group, or a community – is part of the goal' (1980, p. xvii; original italics). In other words, it is not just relevant to psychological therapy services but to mental health teams of all

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types, both in the community and in hospital, that is, if we are interested in facilitating growth, recovery and well-being.

Of course, these concepts – 'growth', 'recovery', 'well-being', and perhaps we might add 'healing' – struggle to find a legitimate place within the current culture of mental health practice that favours delivering care according to pre-determined outcomes and treatment episodes. Whatever policy might say about, for example, 'recovery' and providing 'recovery-orientated services' (e.g. the Guiding Statement on Recovery by the National Institute for Mental Health in England (2005)), the biomedical paradigm and medical model continue to dominate and dictate practice and service delivery, with its protocols, care pathways and outcome measures. So what do I mean by the biomedical paradigm and the medical model and what is different about the person-centred approach?

The medical model of assessment, diagnosis and treatment, relies on scientific knowledge and the values of reductionism, which in psychiatry translates as arriving at a diagnosis through objective assessment of mental state and treating psychopathology (usually with psychotropic medication) on the basis of there being an underlying disease process usually in the form of a biochemical abnormality in the brain. It is an approach that focuses on pathology and diagnosis and leads to management that prioritises symptom control, or in the very disturbed, containment of behaviour and risk. It may also feed into the 'fix-it' mentality of modern culture that relies on an expert to do the fixing. The person-centred approach is not dismissive of science, our genetic heritage and the fact of a neurobiological substrate of mental state and behaviour. However, it embraces a philosophy and values that lead to radically different aims and priorities. In particular, it proposes a different way of relating to that of the medical model.

It should be pointed out that Rogers also developed a comprehensive and integrated theory of personality and behaviour that considers both healthy personality development as well as what constitutes and contributes to psychological disturbance (Rogers, 1959). This theory, one of the key tenets of which is the 'organism's tendency to actualise', usually underpins the non-directive attitude of person-centred practice. It is more interested in seeing potentials within people rather than deficits. It is neither focused on concepts of illness nor especially interested in psycho-diagnosis. In common with humanistic ideas it values the uniqueness and creativity of individuals. The person-centred approach is also interested in how human beings construe meaning from their experience. Person-centred practitioners would be interested in a person's subjective experience, *as it is for that person*, without trying to define or explain it. Phenomenology, according to the person-centred approach, is concerned with meaning, rather than being a method of investigation of mental experience in order to categorise abnormal psychological events. This is a major difference from the biomedical paradigm that relies on an expert, objective assessment.

One of the most radical aspects of the person-centred approach is its stance on issues concerning power and expertise. In keeping with a desire to facilitate the individual's subjective understanding and experience, the approach seeks not to impose any form of explanation, understanding or authoritarian control and would eschew all forms of paternalistic practice. The theory holds that individuals can be trusted to move in the direction of growth or psychological adjustment, because of their innate tendency to actualise, *as long as* a particular therapeutic or growth promoting environment can be provided. Rogers postulated that this environment is characterised by six conditions for 'constructive personality change' of which three are the more commonly known conditions of 'congruence', 'unconditional positive regard' and 'empathy'. Unfortunately, what is often overlooked is the fact that in order for the three conditions just mentioned to facilitate change, it is necessary for 'psychological contact' to be established (Rogers' first condition). This is certainly not a given within mental health settings when patients may be 'out of contact', being perhaps psychotic, catatonic or dissociated. However, a method of establishing contact has been devised, based on the person-centred approach, albeit one that is currently little known about and practiced within UK mental health settings but which could be extremely valuable, particularly within settings where there is a high level of more severe disturbance (see Freeth, 2007; Prouty et al., 2002) such as intensive care settings.

As well as having a particular attitude to power and expertise based on its theory of personality development and theory of therapy, the person-centred approach also aligns itself with the broad existential values of freedom, having the choice to decide not only who we are but how we behave (the right to self-determination), as well as believing in human beings' potential to take personal responsibility for their choices and behaviour. These issues are particularly relevant for intensive care and low secure units where most patients will be detained under mental health legislation and often treated with medication against their will. As a psychiatrist it is not hard to take the view that there will be some instances when a person's mental state and level of disturbance necessitates the use of 'protective power' (Tew, 2005, p. 79) through legislation and exercise of professional expertise. However, whilst detention and forcible treatment may be necessary, it needs to be kept in mind that there are major, and potentially harmful, consequences to exercising power and authority over individuals. Not only could relationships with mental health professionals be jeopardised and trust compromised, but the exercise of such power may add to the feelings of powerlessness and oppression that might have contributed to the mental disturbance in the first place. Powerlessness in its various forms, ranging from subtle discrimination to overt abuse, is often a predisposing factor or precipitant to mental breakdown. Within locked environments that reduce patients' freedom and right to self-determination, it is therefore imperative that every opportunity is utilised to enable patients to exercise their own 'personal power' as Rogers (1978) refers to it, however contradictory this may seem within the context of control.

CREATING RELATIONSHIP-BASED APPROACHES TO PSYCHIATRIC CARE

If there were one way in which the above values and philosophy of the person-centred approach could be put into practice in mental health settings, it would be through attending to the quality of our relationships and relating to patients. The person-centred approach is fundamentally a relational approach. Rather than mental health settings relying almost exclusively on the medical model type of relationship, I propose developing helping relationships with the following characteristics:

- A belief that persons are of infinite value and therefore worthy of deep respect (this doesn't necessarily mean liking a person or approving their behaviours).
- The desire and attempt to see the person first rather than the psychopathology and resisting the desire to categorise mental experience.
- A commitment to offering relationships and aspiring to a quality of relating that manifests the conditions of congruence, unconditional positive regard and empathy, seeing these as attitudes as having immense healing value rather than simply as techniques or skills.
- A sensitivity to the power dynamics within the relationship, more so in environments where power and control is invested in the system and in professionals, such as secure units. Furthermore, there is a desire to understand power in all its various aspects, and the effect on individuals of power and powerlessness. Mental health professionals would seek not to exert power or control over patients except when absolutely necessary, and for such necessity to be rigorously evaluated.
- A trust in and commitment to a person's tendency to actualise (to adjust, change or grow) given the optimum therapeutic environment, and that this may be as important, or more so, than other treatment methods such as prescribing medication.
- Recognition that in order to provide all of the above much is demanded emotionally and intellectually, making it essential to receive sufficient support and opportunities for thinking and reflection such as training and supervision. The activities of thinking and reflection should include the exploration and questioning of one's assumptions, values and attitudes in all the many different kinds of relationships and situations in which we may find ourselves.

Whilst there is much literature discussing and describing congruence, unconditional positive regard and empathy in the context of counselling and psychotherapy, little has been advanced for (non-therapist) mental health professionals in any great detail or depth and underpinned by the theory and philosophy of the person-centred approach. In

Freeth (2007) I described the value of patients receiving these conditions, and indeed, need for them. Yet, it must be acknowledged that there may be considerable difficulties and challenges when it comes to offering them. For example, how easy is it to empathise with someone's psychotic reality? How can one develop unconditional positive regard for patients whose behaviour is challenging or causes profound suffering to others, or whose habits are offensive? How possible is it to be congruent (transparent) when one is feeling frightened, angry or even on the verge of being totally overwhelmed? These attitudes are demanding and their development is a process which takes considerable commitment. I would suggest that for professionals working in secure settings, where the level of mental disturbance is often profound, their development is especially challenging, and necessary.

Whilst I am not naïve about the barriers to creating genuine relationship-based approaches to mental health care, particularly within a mental health system that is dominated by the biomedical paradigm and quest for economic efficiency, I nevertheless argue that we do need to push against these barriers and make room for another paradigm – one that places relationship and relating centre-stage and which provides the resources for its development. If we don't, then we will not be able to facilitate the recovery and empowerment of individuals that mental health policy so readily talks about.

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