

Why Person-Centred Therapists Must Reject the Medicalisation of Distress

Pete Sanders

What logic determines that to be frightened, overwhelmed or confused is to be 'ill' or have a 'disease'? The place of 'mental illness' in Western culture is not a story of scientific discovery. It is a story of social control, political expediency, and professional imperialism (see, for instance, Parker *et al*, 1995), and associating the treatment of distress with medicine has concealed the element of social control by bestowing on it scientific objectivity and respectability. The illness metaphor for distress has become installed in Western culture to the extent that it is an idea which most people can hardly think *about* — it is an idea which most people can only think *from*. The medicalisation of mental distress has, according to Moncrieff (1997), 'served to obscure the social processes that produce and define deviance by locating problems in individual biology. This obfuscation lends itself to the perpetuation of the established order by side-stepping the challenge that is implicit in deviant behaviour.' This complaint is not new (see for example, Szasz, 1961; Read, Mosher & Bentall, 2004).

The pharmacological revolution of the 1950s and '60s conjured the illusion of administering specific cures for specific so-called 'disorders' such as 'schizophrenia', 'depression' and 'anxiety states', encouraging the view that psychiatry was indeed within the paradigm of physical medicine. Although a growing body of literature continues to discredit the medicalisation of distress, biological psychiatry has been boosted in the 21st century, first by ever more close association with general medical care, and second by the emerging fields of technology-enhanced neuroscience and genetics. Furthermore, despite the fact that these emerging fields have, to date, produced hardly a jot of evidence in support of the biological model of distress, the sheer enthusiasm and levels of funding encourage all but the most sceptical and well-informed to believe that they must valid enterprises.

Distress is not an illness

There is a substantial and growing body of evidence that psychological distress has social causes, not biological causes. Without a biological cause there is no disease, and with no disease there is no illness, and so evidence grows to demonstrate beyond question that there is no such thing as mental illness. Yet the illness metaphor is defended with a series of *non-sequiturs*:

- That severe and enduring mental illness has a biological base.
- That we need a psychopathology and diagnostic system for classifying symptoms and, by association, treatments.
- That psychosis is discontinuous with 'ordinary' mental functioning and so it requires special treatment by experts.
- That psychotherapy and talking cures are ineffective and dangerous as treatments for severe and enduring distress ('psychosis').
- That psychiatry is scientific, deals with the facts of the world, is based on evidence, is rational, and, therefore, is responsible.
- That criticisms of psychiatry are unevicenced, subjective, politically motivated, rhetorical, (and therefore irresponsible) and they appeal to, and hold false hope for, impressionable, vulnerable people.

(I found this list a few years ago and I have amended it many times

over the years, but have lost the original reference. If any reader knows its source please contact me – pete@pccs-books.co.uk – and I will cite it accordingly.)

I want clearly to state that the arguments in this paper are not anti-*psychiatrist*, nor are they anti-*psychiatry*. The paper is against the medical model of mental illness and the medicalisation of distress. I am setting myself against *biological* psychiatry and all of its apparatus. It is – and I am – for the development of a social model. Psychiatrists and psychologists choose their position regarding what we may call the biologisation of experience. A minority of psychologists, psychiatrists and psychotherapists have persistently resisted the medicalisation of distress in our culture. It is a puzzle and a great disappointment that more person-centred therapists are not among them.

This resistance and these arguments are not new. Although paraphrased here, readers are invited to follow the references for fuller expositions.

- Szasz (1961) argued that essentially the logic of the concept of 'mental illness' is flawed and Wing (1978) pointed out that 'disorders' are names for *theories*, not names for things that exist in nature.
- There is large overlap between diagnostic categories in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* both in their description and their application, leaving its

use as an 'instrument' largely invalid and unreliable (see Boyle, 1999).

- There is no link between symptom and distress: people can have many symptoms but little distress, and conversely, few symptoms and great distress (see Romme & Escher, 1993).

- Bentall (2003) collected impressive evidence to demonstrate that so called 'psychotic' experience is not discontinuous with ordinary experience. Nobel Prizewinner and mathematical genius John Nash, and subject of the film *A Beautiful Mind*, diagnosed with paranoid schizophrenia, was asked, during one of his periods of hospitalisation by Harvard professor George Mackey:

How could you, a mathematician, a man devoted to reason and logical proof...how could you believe that extraterrestrials are sending you messages? How could you believe that you are being recruited by aliens from outer space to save the world? How could you...?' 'Because', Nash said, 'the ideas I had about supernatural beings came to me the same way that the mathematical ideas did. So I took them seriously. (Nasar, 1998: 11).

- After millions of dollars have been poured into new technology in the 'decade of the brain', we are no nearer a biological base for the experience of human personhood, let alone human distress. There is no evidence of differences in (a) the distribution or use of

neurotransmitters, (b) brain structures, and (c) activity levels, between the brains of people diagnosed with a psychotic condition and people with no diagnosis, that cannot be equally explained by changes due to childhood experience. For example the brains of traumatised children show structural and functional changes similar to those being associated with psychotic conditions. For various summaries of this and other research see Read, Mosher and Bentall (2004).

- Evidence continues to mount for social and environmental causes of distress. For example, people who have suffered sexual abuse are three times more likely to receive a diagnosis of schizophrenia; people who are subject to poverty and ethnic discrimination are three times more likely to receive a diagnosis of psychosis other than schizophrenia; childhood neglect and abuse are highly correlated with lower academic achievement, problems with peers at school, earlier age at first admission to psychiatric care and a higher number of admissions (Read, 2006).

- Distressed people are subjected to a range of chronifying 'treatments' such as incarceration in frightening, violent, abusive, iatrogenic environments, and the administration of poisonous iatrogenic chemicals (see Moncrieff 1997, in press). There are further widely-reported negative effects of pathologisation and the stigma of a diagnosis of 'schizophrenia' or

'personality disorder' (see Read & Haslam, 2004).

It is reasonable to conclude that the symptoms of so-called mental illness are understandable responses to a noxious environment. Brains have evolved to be affected by the environment. More than that, the human brain is the most adaptable biological entity we know. It changes its structure and way of functioning according to the environment and remains plastic throughout life. When you look at brain structure and function you are actually looking at the environment through a mediator: the self, and the person whose brain it is and whose environment it has been. Here we have the three salient factors of the model we must all subscribe to if we are to call ourselves *social* scientists: environment, brain and person. This is not a bio-bio-bio model of genes, neurochemistry and brain, nor a psycho-psycho-psycho model of personality structure, self and person, but a model which embraces each without favour or prejudice: a socio-bio-psychological model encompassing environment, biology and person.

Person-Centred therapy: Radical but absent

In 1950 client-centred therapy was the radical option in psychology. Its radical nature has its foundation in the theory and in how the theory demands practice with integrity, that is, practice congruent with, in harmony with, the values and principles lying at the core of the approach. These core principles are all in opposition to the

medicalisation of distress. But where are the person-centred therapists in the 21st century and what has happened to this once-radical tradition?

Actualising tendency

At the heart of any therapy theory is a view of human nature. Does fulfilment come through release of potential or regulation of destructive impulses? Rogers' basic humanist declaration of the actualising tendency was, according to Merry (2003) a biological view which can be summarised as a directional tendency towards greater differentiation and fulfilment of the organism's constructive potential. Specifically Rogers (1959: 196) defined it as follows:

This is the inherent tendency of the organism to develop all its capacities in ways which serve to maintain or enhance the organism. It involves not only the tendency to meet what Maslow terms 'deficiency needs' for air, food, water, and the like, but also more generalized activities. It involves development toward the differentiation of organs and of functions, expansion in terms of growth, expansion of effectiveness through the use of tools, expansion and enhancement through reproduction. It is development toward autonomy and away from heteronomy, or control by external forces.

To contain or categorise such a general, positive tendency would, in practice, be illogical, unhealthy and anti-life. Practice in harmony with the actualising

tendency construct would be cooperative and phenomenological, dedicated to removing obstacles to actualisation within the personality and the environment. Medicalisation of reasonable human responses to a noxious environment has no place here.

Non-directivity

Grant (2004: 158) wrote: 'Client-Centered Therapy is the practice of simply respecting the right to self-determination of others'. This is achieved by principled (rather than instrumental) non-directivity, a distinction made earlier by Grant in 1990. In his earlier paper, Grant (1990) outlined the difference between *using* non-directivity as an instrument or tool (as do integrationists, for example) rather than holding it as a fundamental quality or core value of human living. The principle of non-directivity or non-interference only makes sense as a way of living with the actualising tendency. If human nature had a basic tendency towards the destruction of self and others, then such a principle would obviously be naïve. However, the principle of non-directivity as a core value and attitude follows logically from the actualising tendency. Non-directivity as a principle for living can be traced back at least to 600 BC and the *Tao Te Ching* (see Raido's article in this issue). It has many names: non-interference, non-action or the principle of *wu-wei*; where *wu* means 'not' and *wei* means 'artificial, contrived activity that interferes with natural and spontaneous development' (Ames, cited in Marshall, 1992:

55). This is the *mindful* application of actions which follow, rather than act contrary to, nature.

To have such a principle actively informing practice helps determine the whole attitudinal framework of the practitioner towards the client as a member of the human race. It points towards an organismic appreciation of humanness (the person as an organism in process), with *growth* (or adaptation) and *flourishing* as metaphors for change. It militates against an instrumental appreciation of humanness (the person as machine or computer), with *manualised repair* and *adjustment* as metaphors for change. It points towards ethical human relational *healing* and militates against invasive, disrespectful, quasi-medical *treatment*. In short such an irreducible principle determines our entire perception of what therapy is for and how to do it.

Holism

Classical client-centred therapy is intrinsically holistic. From Rogers' writings in the early 1950s onward, the idea that the organism is an 'organised whole' and should be viewed as such and responded to as such is paramount in theory and practice. In terms of the present discussion, any theory or treatment paradigm which is partial in its regard to the person is antagonistic to the person-centred approach. In particular, the reductionist medical model of distress, with its almost exclusive focus on the biological dimension of the human being, is clearly out of step with person-centred

therapy. The physical, somatic, cognitive, affective and spiritual domains of human existence are given equal opportunity for expression in person-centred therapy, depending upon the client's own biases and partialities with regard to their experience of themselves.

An anti-diagnostic stance

A logical progression from the actualising tendency, non-directivity and holism is the classical client-centred position on diagnosis. Beginning with Rogers (1951), classical client-centred therapy has strong objections to diagnosis for both clinical and ethical reasons. Rogers addressed the distinction between a model of pathology for organic disease and a model for psychopathology. His argument for a client-centred 'rationale for diagnosis' was made when it was still possible to hope for a future where psychological therapies were not forced to practise under the shadow cast by the medical model. However, even within this psychological domain, Rogers did not address the inherent redundancy and potential for damage in detailed diagnosis given the phenomenological nature of client-centred theory. Shlien (1989: 160) is critical of Rogers:

Rogers did not really develop a 'rationale for diagnosis.' He made one of his many mistakes of a particular academic sort: he paid momentary lip service to the positivistic logic he felt stuck with at that period. The mistake was to call his own statement...a 'rationale for diagnosis'...On the same page

Rogers says it is really a rationale for psychotherapy *without* (not built upon) external diagnosis. It does not pay to make even temporary concessions to logic you believe to be false, or professional conventions you believe unworthy. They haunt one forever.

With the exception of the lone voice of Patterson (1984/2000), the person-centred position on psychodiagnosis was left in limbo until 1989 when Boy conducted the most extensive person-centred exploration of psychodiagnosis to date in a 'Symposium on Psychodiagnosis' published in *Person-Centered Review*. Boy's purpose was to 'review some historic questions about the usefulness of psychodiagnosis' but his conclusion was one which has become more familiar in recent years, suggesting that client-centred therapists either help revise and improve the medical model, or provide an alternative diagnostic tool. Again Shlien (1989: 160-1) is robust in his criticism:

...diagnosis is not good, not even neutral, but bad. Let's be straightforward and flat out about it. The facts might be friendly, but what are the facts? Diagnosis comes not just from a medical model, but from a theory of psychotherapy that is different from ours, antagonistic to ours. It is not only that its diagnostic predictions are flawed, faulty, and detrimental to the relationship and the client's self-determination, they are simply a form of evil. That is,

they label and subjugate people in ways that are difficult to contradict or escape.

Therapists dedicated to emancipation, freedom, self-determination, growth, fulfilment, and empowerment, are in poor company with the medicalisers of distress. Furthermore, an important dynamic of the healing process is highlighted here. The journey through emancipation, empowerment, self-determination and growth to fulfilment represents the very heart of the process of healing identified by Rogers (1951) and is increasingly implicated in psychological health by others (e.g. Bentall, 2003). The medical model, however, requires an already vulnerable person to submit to the arbitrary, damaging 'authority' of the expert. Moreover it is an unscientific, amoral authority borne out of historical precedent, political expediency, and maintained by professional interests. Person-centred therapy is the only approach which enshrines the client's right to access healing without sacrificing their personal power. The client is the expert, and the person-centred therapist goes 'back to the client' for authority.

This right must be re-established by repeated re-presentation of these views in a hostile medically-dominated system. This situation is not new. Rogers wrote of his 'fear and trembling', because of a 'heavy weight of clinical opinion to the contrary' (cited in Hirschenbaum and Henderson, 1990: 230). In the same paper he asserted that diagnosis was 'for the most part, a colossal waste of time...There is only one useful purpose...Some therapists cannot feel secure in the relationship with the client unless they possess

such diagnostic knowledge' (*ibid*: 232).

Conclusion

Mearns (2006) poses a dilemma for person-centred therapists: 'Will the humanity of the counsellor corrupt the medical model of mental illness? Or will the medical model of mental illness corrupt the humanity of the counsellor'. Either is possible, but in order to influence the future in the direction of person-centred philosophy, theory and practice, we must be more active. As yet, Sanders and Tudor's (2001: 157) prescription is unfulfilled, that psychotherapists:

Base their practice on a thorough and critical understanding of psychiatry and psychotherapy *in context*...Strive to facilitate the reclaiming by clients of personal power in therapeutic relationships characterised by collaborative power...[Reflect in their practice] the awareness that the struggle for mental health involves changing society...Organise and challenge oppressive institutions, especially psychiatric hegemony in the organisation of mental health services, professional monopoly on the control of service provision and direction, and the colonisation of the voluntary sector in mental health...Support the service user movement in general and, in particular, service user involvement in mental health service development and service user-controlled alternatives to psychiatric services...[Remain] open to alternatives (e.g. as regards 'treatment') and seek to build alliances which emphasise user/survivor perspectives (on, amongst other issues, hearing voices and survivor-controlled alternatives), and encourage and promote greater public access to

information through new technology as challenging the knowledge-based power of professionals.

A clinical psychologist, a psychiatrist and professor of psychiatry, and a professor of experimental clinical psychology recently wrote:

The notion that mental illness is an illness like any other, promulgated by biological psychiatry and the pharmaceutical industry, is not supported by research...The medical model has dominated efforts to understand and assist distressed and distressing people for far too long. It is responsible for unwarranted and destructive pessimism about the chances of recovery, and has ignored — or even actively

discouraged discussion of — what is actually going on in these peoples' lives, in their families and in the societies in which they live. (Read, Mosher & Bentall, 2004: 3)

There is still good reason for us to be afraid and tremble since, until person-centred psychotherapists publicly join these and other radical practitioners and tell the truth about the medicalisation of distress, we may be counted amongst the collaborators. As Shlien (1989: 161) reminds us: 'There is no advantage in cooperating with the dominant clique. The lion and the lamb may lie down together, but if it is in the lion's den, the lion is probably quite relaxed, looking forward to breakfast in bed.'

Further reading

Boy, A., Seeman, J., Shlien, J., Fischer, C. & Cain, D.J. (1989) Symposium on Psychodiagnosis. *Person-Centered Review*, 4, 132–82.

Newnes, C., Holmes, G. & Dunn, C. (eds) (2001) *This is Madness*. Ross on-Wye: PCCS Books.

Moncrieff, J. (1997) *Psychiatric Imperialism: The Medicalisation of Modern Living*. Article available online at www.academyanalyticarts.org/moncrieff.htm

Patterson, C.H. (2000) Is psychotherapy dependent upon diagnosis? In C.H. Patterson *Understanding Psychotherapy: Fifty Years of Client-Centred Theory and Practice* (pp. 3–9). Ross-on-Wye: PCCS Books. (Original work published 1948)

Read, J., Mosher, L.R. & Bentall, R.P. (eds) (2004) *Models of Madness*. London: Brunner-Routledge.

The complete list of references for this article is available from the author – pete@pccs-books.co.uk

Pete Sanders retired from practice after more than 25 years as a counsellor, trainer and supervisor. He continues to have an active interest in mental health issues, the politics of therapy and following the developing theory and practice of client-/person-centred therapy.