

## **Serfing\* Psychiatry: Critical Reflections on Lisbeth Sommerbeck's book 'The Client-Centred Therapist in Psychiatric Contexts'**

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*(Person-Centred Practice, 2003, Vol. 11, No. 2, pp. 106-113)*

### **Wonderful and good**

In Internet discussion, two pillars of the person-centred approach recently pronounced '*The Client-Centred Therapist in Psychiatric Contexts*' by Lisbeth Sommerbeck (2003a), 'wonderful' (Jerrold Bozarth), and a 'clearly and beautifully written' book that should be read by 'anyone working in a medical or psychiatric context' or 'anyone working with seriously disturbed clients outside these setting' (C. H. 'Pat' Patterson).

There was also a further positive endorsement which (rather unusually) came from Lisbeth Sommerbeck herself (hereafter I'll use her first name as knowing her personally it seems over formal and stuffy to refer to her as 'Sommerbeck'). Lisbeth records that having the book in her hands for the first time and reading 'a little of it', she thought it 'a good book', albeit that she 'found some points that I think the author could have clarified better, and even some points that I, perhaps, disagree with, or may come to disagree with, although, for the moment..., I find myself in as close agreement with the author as it, I think, is humanly possible' (2003b:1).

Leaving aside the conundrum of Lisbeth critiquing her own work from an external frame of reference by entering into an internal frame of reference of an external framing of her own internal frame of reference, is the *Client-Centred Therapist in Psychiatric Contexts* 'good', 'wonderful', a must read—especially for someone like me working in what Lisbeth dubs 'a psychiatric context'?

Well it certainly was 'a must read' for me, given that I'd accepted a free copy of the book on condition that I provide a written comment.

As to whether it is 'wonderful' or 'good', I certainly agree that there are major parts of Lisbeth's book that are wonderful and good—especially those parts that deal with the nitty-gritty of being an effective client-centred therapist with individual clients whose psychological processing is that of *madness* or *near-madness*. I am sure that other person-centred practitioners apart from myself will find especially valuable the case study vignettes that Lisbeth employs to illustrate her way of working with individual clients, clients who are 'out of contact' and whose 'destructive potentials' are easily triggered. In these vignettes Lisbeth includes transcripts and a clear explication of Garry Prouty's pre-therapy techniques. They are accounts that leave me in no doubt that Lisbeth does a good and sometimes wonderful job with her clients.

## Major difficulties

This said, it would be incongruent of me not to admit that in another respect I had major difficulties with Lisbeth's book. These difficulties relate to the general principle that Lisbeth sets forth as the guiding principle for the client-centred therapist wishing to work in an effective and harmonious fashion in a psychiatric institutional context. In this regard, I have to admit that I would have had fewer difficulties if Lisbeth had not adopted such a broad frame of reference; if she had adopted a focus that was more specific and personal and chosen a title like, 'My work as a client-centred therapist in a psychiatric hospital'. However, she doesn't and instead uses the general term 'the client-centred therapist', asserting that 'although this book is written from within the context of a psychiatric hospital, much of it should be easily applicable to other less extreme, psychiatric contexts' (2003a: 1).

Well I am afraid to say that key aspects of what Lisbeth proposes in her book are not applicable to the less extreme, psychiatric context that I work in, certain of which I shall detail later. Such lack of applicability is closely bound up with Lisbeth's aforementioned guidance principle for the client-centred therapist working in a psychiatric institution. It is upon the nature of this principle and Lisbeth's explication of it that I wish to focus some critical reflections. Adoption of the principle, claims Lisbeth, enables the client-centred therapist to transcend the fundamental divide generally taken to exist between, on the one hand, the theory and practice of client-centred therapy and the person-centred approach, and, on the other, the theory and practice of psychiatry.

## Real or illusory?

That such a divide is concrete and real certainly seems to have been the view of Carl Rogers, founder of the person-centred approach. Consider what he has to say about the person-centred approach as a whole, and by implication client-centred therapy:

A person-centred approach, when utilized to encourage the growth and development of the psychotic, the troubled, or normal individual revolutionizes the customary behaviors of members of the helping professions. It illustrates many things: (1) A sensitive person, trying to help, becomes more person-centred, no matter what orientation she starts from, because she finds that approach more effective. (2) When you are focused on the person, diagnostic labels become largely irrelevant. (3) The traditional medical model in psychotherapy is discovered to be largely in opposition to person-centredness. (4) It is found that those who can create the effective person-centred relationship do not necessarily come from the professionally trained group. (5) The more this person-centred approach is implemented and put into practice, the more it is found to challenge hierarchical methods of 'treatment' and hierarchical methods of organization. (6) The very effectiveness of this unified person-centred approach constitutes a threat to professionals, administrators, and others, and steps are taken—consciously and unconsciously—to destroy it. (1977: 28)

Obviously, therefore, if one accepts the views of Rogers, it is a highly challenging matter to function as a client-centred therapist in a psychiatric context and retain one's integrity—and it is not as though Lisbeth is not aware of such challenges and has not dealt with them, nor that she has not retained her integrity in a commendable way over what must have been many gruelling years. But the rationale to her survival manual for client-centred therapist sojourning in the world of psychiatry is, I'm afraid, one to which I take serious exception. Because what is entailed in accepting Lisbeth's rationale is essentially saying to Carl: 'Yes I know you may think an exclusive divide exists between the medical model of psychiatry and that of the person-centred approach and client-centred therapy, but, in fact, real as it may seem to you, it is not ultimately real but an illusion'. In other words, as Lisbeth herself puts it, the 'mutual exclusivity of the viewpoints of client-centred therapy and the medical model' is not a real exclusivity but only '*seeming mutual exclusivity*' (2003a: 29).

### **Superman and super-physics**

The argument that Lisbeth puts forward for Carl Rogers being the victim of such an illusion constitutes a form of relativism. It rang bells for me with the relativism of the porridge of ideas known as postmodernism, although Lisbeth herself links it to the principle of complementarity in modern physics. I like to think of it, though, as the Superman argument: 'It's a bird', says Rogers; 'No, it's a plane', say the psychiatrists; when in fact both are talking about the same mysterious something that neither has yet been able to comprehend for what it is, i.e. the flying man, Superman. In the face of the mysteriousness of the unknown something, both Rogers and the psychiatrists are right; only in the 'real' world the unknown something to which they refer is the mysteriousness of the body/mind way of being of the psychiatric 'patient', namely, the nature of madness.

Preferring to refer to the 'super-physicist' rather than Superman, Lisbeth postulates that the mysteriousness of the condition of the psychiatric 'patient' is analogous to the mysteriousness of the nature of the sub-atomic particle (the electron, say). Thus, just as for the physicist the mysterious entity presents as contradictory phenomena (as *either* a wave *or* a particle, not both at the same time), so, says Lisbeth, the mysterious condition of the psychiatric patient can legitimately be viewed as *either* a medical (i.e. physical condition) *or* a disturbance of the person's phenomenological field. Because, on Lisbeth's view, 'Client-centred therapy is based on a heuristic/phenomenological model, whereas psychiatry is based on the classic scientific model, i.e. the client-centred therapist strives to understand from the client's frame of reference, whereas the psychiatrist strives to explain from his own (theoretical) frame of reference and treats the client from this point of view' (2003: 29). 'The client-centred therapist', Lisbeth further elaborates,

is in no way concerned with explaining the conditions and symptoms of the client. He is solely concerned with trying to understand the client from the client's frame of reference and checking the accuracy of this understanding with the client, thereby communicating his unconditional positive regard for the client. This, according to client-centred theory, is helpful to clients whether there exists an (objective) explanation for their ailment or not. Understanding people and explaining people are...two very different things.

It is thus the case, according to Lisbeth, that,

these seemingly conflicting viewpoints....can very helpfully be conceptualised as complementary viewpoints in analogy with the wave/particle duality: you see different things from the two viewpoints, and what you see and do from one viewpoint is neither more nor less true than what you see from the other. However, you cannot hold both viewpoints at the same time: instead, you use one or the other viewpoint depending on your purpose. (p. 31)

That is to say, to employ a further analogy, the situation is akin to the views provided by an either-or visual gestalt, viz., the images of the young woman/old woman, the two faces/chalice, the cat/rabbit.

Or is it? I, for one, definitely don't think it is.

### **A principle or strategy?**

Without doubt, as a client-centred therapist in her specific psychiatric context Lisbeth has developed a successful survival methodology—a methodology that in all innocence she names 'the principle of complementarity' and thereby gains 'mutual respect' from her psychiatric colleagues when they are told that 'this principle is employed in physics which is often taken as a model for other scientific disciplines' (2003a: 32). However, in my opinion, what Lisbeth has come up with is not a generally applicable principle but a pragmatic strategy, a strategy not only specific to her situation, but based upon confused thinking. For, as I see things, Lisbeth's guidance 'principle' is more a rationalization of the irrational than genuinely rational.

### **Dissociated relativism**

In an article I wrote about a year ago (Ellingham, 2002), I made reference to the radical postmodernist view regarding the truth value of different theories of psychotherapy. I referred to postmodernists asserting that no theory is more true than any other except their own theory that no theory is more true than any other. Lisbeth, it appears to me, falls victim to exactly this same type of relativism and self-contradictory logic, a state of affairs evidenced in particular when she refers to the psychiatric and client-centred perspectives and asserts that 'one viewpoint is neither more nor less true than what you see from the other', and that 'both worlds are true' (2003a: 31 & 48). Now while it may be true for Lisbeth that 'both worlds are true', there is no reason why I for my part shouldn't assert the alternative view that the client-centred theoretical perspective is more true than its psychiatric counterpart, or vice versa? What, it is legitimate to ask, is the basis on which Lisbeth grounds her personal assertion of the equal and complementary truth of the person-centred and psychiatric viewpoints? My own personal assertion of the truth is that Carl's view of the real incompatibility of the person-centred and the medical model perspectives is a sound one, a position in part supported, I would argue, by the questionable nature of Lisbeth's efforts to substantiate her own hypothesis of a clear-cut division between two perspectives of equal status. For, when it gets down to the practicalities of how the client-centred therapist is to implement her principle of complementarity, Lisbeth, for me, engages in a form of mental dissociation.

## Understanding explaining, explaining understanding

Take, in particular, Lisbeth's claims for a complementarity division between client-centred therapy and psychiatry on the basis of 'understanding' versus 'explaining'. According to Lisbeth, the brief of the client-centred therapist is to *understand* the client from the internal (phenomenological) frame of reference, whereas that of the psychiatrist is to *explain* the client's body-mind way of being from an external frame of reference. The client-centred therapist's job is to understand, that of the psychiatrist is to explain. To sustain this 'no-mind' conception of the client-centred therapist, Lisbeth firstly tells us that while she considers herself 'among those client-centred therapists variously called 'traditional', 'classical', 'purist', 'non-directive', and 'orthodox', she also counts herself 'probably somewhat "radical"' since her 'definition of the essence of client-centred therapy is behavioural, i.e. responding with tentative, acceptant, empathic understanding, or acceptant empathic reflection' (2003a: 16). Such a behavioural definition of client-centred therapy, I would argue, conveys the impression that all one needs to do to become an effective client-centred therapist is to attend a behaviourally based counselling skills course without concern for theory. It is a conception that de-emphasizes the fundamental theoretical hypothesis of the actualizing tendency, the theoretical assumption that mentally guides the therapeutic practice of the non-radical purist client-centred therapist. It is one, furthermore, that leaves Rogers' theoretical explanations in general (his 1951 and 1959 theory statements, for example) sucked out of existence into some kind of psychiatric black hole. The client-centred therapist doesn't need such explanations apparently, since explanations are provided by the psychiatrist.

Just why, in particular, Lisbeth should de-emphasize the actualizing tendency quite as she does is perhaps not surprising, given that it is the actualizing tendency that constitutes Rogers' core construct when *explaining* the nature of madness. Thus in the cases of 'men and women on the back wards of state hospitals' we find Rogers *explaining* that the lives of these individuals, lives that 'often seem abnormal, twisted, scarcely human', have come about due to 'unfavorable conditions' that have caused the individuals' actualizing tendency to become 'thwarted or warped' (1980: 118-9). More specifically, Rogers (1959: 228-9) *explains* 'acute psychotic breakdowns' on the basis of 'incongruence between self and experience', while later he speaks of 'dissociation' as a 'perverse channelling of some of the actualizing tendency' that forms 'the basis of all psychological pathology in man (sic.)' (1963: 19 & 21). Interwoven with such an explanatory scheme—one decidedly at odds with the psychiatric explanation that madness is essentially a physical disease akin to syphilis—is Rogers' hypothesis that the 'unfavorable conditions' that the psychotic individual has experienced are primarily lack of the psychological conditions of empathy, unconditional positive regard and congruence; allied to which again is the corollary hypothesis that provision of these conditions to such an individual by the client-centred therapist will help restore 'unity and integration in the individual' (p. 22).

## Necessary and sufficient with drugs and ECT

Lisbeth in her behavioural fashion does, in fact, emphasize the importance of these 'core conditions' in the way of working of the client-centred therapist in a

psychiatric context. She even mentions that together with the conditions of psychological contact, client incongruence and the client's perception of empathy and unconditional positive regard, the core conditions are hypothesized by Rogers 'as being the necessary and sufficient for therapeutic change to occur' (2003a: 9). But what she doesn't seek to emphasize is that governed by the complementarity principle she can't repudiate the psychiatric view that drugs and ECT are a necessary condition for therapeutic change in her clients. And indeed, far from keeping the client-centred and psychiatric perspective in their separate boxes she essentially is led to repudiate Rogers' hypothesis of the six necessary and sufficient conditions. What this means is that she fits into the same category as the experiential therapists that she has recently been so vocal in criticizing on the Internet. That is to say, she adopts the position that Rogers' six conditions are necessary but not sufficient—a seventh necessary condition referring to physical 'treatments' such as drugs and ECT needs to be added for sufficiency.

Which is as it may be, since the client-centred therapist's acceptance of the use of drugs and ECT as viable modes of treatment for the psychiatric patient, are, in my view, legitimate subjects for debate within the person-centred approach. Guided by her complementarity principle, though, Lisbeth has already decided the matter in favour of acceptance of the status quo: of drugs and ECT being necessary if the psychiatrist from her/his point of view says they are appropriate for a particular patient. She has closed her mind to, mentally dissociated herself from, the mind-blowing possibility that Rogers' hypothesis of the necessary and sufficient conditions might actually be correct with regard to psychotic and near-psychotic individuals.

### **The necessary and sufficient condition of Diabasis**

Of profound significance in this respect is the work of John Weir Perry, work that Rogers directly had in mind when penning the statement quoted above regarding the person-centred approach and the medical model. In *On Personal Power* (1977), Rogers writes of Perry's establishment of Diabasis as 'a center for dealing with acutely schizophrenic young persons', and of how Perry 'had become increasingly convinced that most schizophrenic episodes were actually a chaotic attempt at growth and self-healing, and that if such an "Individual" (he dropped the term patient) were treated as a person and provided with a close and trusting relationship, she could, in a relatively short time, live through this crisis and emerge stronger and healthier' (p. 23).

If we consider the words of Perry himself for such a close and trusting relationship, it is remarkable how they accord both with Rogers' description of the core conditions and with his theory of personal growth. 'If', says Perry (1999: 4), 'we listen to the individuals in the [psychotic] episode in an empathetic and caring manner, without the need to manipulate and control, or make them be quieter or different in some way, we find much to our surprise, that they may change spontaneously in a quite short period of time'. 'Setting up in this way a bi-personal field of relationship, that is, one in which two psyches are in the process of opening up to each other, may establish an organizing effect that stimulates integrative process'. 'Growth', asserts Perry, 'proceeds in a cyclic fashion, with alternating periods of calm and turbulence, progression and regression'. But if one operates from 'the medical frame of mind', he elaborates, and is concerned to 'repair' the disorder

through ‘suppression by medication’ ‘a disintegrative phase of what may be regarded as a developmental process becomes disqualified and ruled out’ (pp. 3 & 28).

Not surprisingly, therefore, Perry like Rogers is under no illusion that such a theoretical perspective, congruent as it is with the theory and practice of client-centred therapy, is inherently incompatible with the perspective of psychiatry. ‘To propose a therapy of this kind in the psychiatric field’, affirms Perry, ‘evokes quite a negative response since it collides with a number of assumptions held in the medical frame of mind’ (p. 3).

### **Another personal psychiatric context**

I remarked earlier that key aspects of Lisbeth’s book are not applicable to the less extreme, psychiatric context that I work in. In bringing my critical reflections on Lisbeth’s book to a close, allow me to point up one or two concrete examples of what I had in mind. Significant differences between my situation and that of Lisbeth are: that I work with outpatients in a ‘mental health’ context; that I am, like Rogers, a psychologist; that my line manager is not a psychiatrist but has a background in social work; that I work with clients referred by a multi-disciplinary mental health team. What such differences mean, as far as I can tell, is that I am much more of an autonomous professional than Lisbeth. To put it bluntly, a psychiatrist or team of psychiatric professionals cannot tell my colleagues or myself what to do with regard to a particular client. So, for instance, if a psychiatrist or even a whole multi-disciplinary team told me to stop providing therapy to a certain individual on the grounds that they judged it to be detrimental to that individual’s psychological well-being, I could respond by saying that while I empathized deeply with their perspective, it was my judgement that what seemed to them a wholly disintegrative process was in fact a ‘disintegrative phase of...a developmental process’. For under such circumstances, I am not only ethically bound as a qualified psychologist to provide the appropriate help but legally bound so to do. Thus, if in a court of law it was found that I had gone against my professional judgement in complying with a psychiatric request and a client had committed suicide, I would have a legal liability.

What such an extreme example highlights is that in my ‘psychiatric’ context I conjoin the practice of client-centred therapy and psychological assessment. My schooling with Professor Patterson taught me how it was possible to seamlessly integrate these two responsibilities, as well as how to be both a client’s therapist and her/his advocate in the larger institutional setting. On the basis of her complementarity principle Lisbeth doesn’t mess with such matters. Not for her, seemingly, is the tabling of complaints to the psychiatric team that the amount of drugs her client has been given has aversely affected that person’s thinking processes or that the continued use of ECT is impairing her client’s memory—not such a rare matter in England where approximately 11,340 patients were given ECT in 1999 (Johnstone, 2003: 236). According to Lisbeth (2003a: 142), ‘if the client-centred therapist, from a position of “knowing the right way”, criticises the practices of individual psychiatrists, nurses, etc., towards one of his own clients, he puts himself in the position of an expert on his client, and thereby risks jeopardising the therapy process with his client’. One should not indulge in individual criticism, she declares, but discuss matters in a general and theoretical way.

In this regard, my own judgement is that Lisbeth's expert judgement is decidedly shaky. I can imagine a psychiatrist or nurse saying in response to a general theoretical critique, 'I hear you raising these matters generally and theoretically, but I get the impression you are in fact referring to me. If you think I've erred in my treatment strategy, why not say so. You talk about congruence, what about a demonstration!'

Lisbeth, for her part, equates levelling such personal critiques with treating 'individual employees in the psychiatric system as "ogres"', thereby, she asserts, bringing about a situation in which the client-centred therapist 'will, naturally, be expelled' (p. 142). Lisbeth's position, therefore, is that by indulging in a personal/professional critique of the psychiatric powers that be the client-centred therapist *might* jeopardise the therapy process with the client, but *definitely will* be booted out of her/his job. Handy, then, how espousal of the complementarity principle ensures job survival!

### **Humanistic clarity**

Lisbeth's hope is that in writing her book she will have 'succeeded in demonstrating that the...predominant anti-psychiatric stance among client-centred therapists...need not be the only perspective of client-centred therapists with respect to psychiatry' (p. 142). For in 'the general person-centred critique of psychiatry' she discerns a tendency 'to see psychiatry as an "enemy" or "an ogre", a tendency that she finds 'counterproductive with respect to any intention to humanise the psychiatric system' (p. 141).

Whether it is possible from a person-centred perspective to humanise the psychiatric system, or whether the more rational approach is to get rid of the psychiatric system per se and develop a more humanistic alternative: these are matters for debate and clear thinking. I feel sure that Lisbeth's book will stir up such debate. As to clear thinking, I can only express my regret that Carl himself is no longer with us.

\* 'Serfing' is a complementary term that juxtaposes being a server, serf and surfer in relation, in this case, to the turbulent world of psychiatry.

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