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Contributions Person-Centred Psychotherapy to Personcentred Psychopathology

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Abstract: The scope of psychopathology as a discipline, its method and targets are important to understand mental disorder as well as define what is to be assessed in the mental state examination. For more than a century the request of objectivity and reliability for research, strict insurance policies and the increase of clinical workload have enforced categorization and operationalization of psychopathological phenomena. This move was blamed to have led psychopathology into a dead end, undermining present research and clinical diagnosis. By revisiting the some of the missteps of XXI century psychopathology we find assorted phenomenological and ontological predicates that might have contributed to such damage. They include changes in the nature of the approach necessary to access and collect psychopathological phenomena as well as a reductionism in the dimension of meaning that is relevant for psychopathology.
This essay suggests that the foundational stones of the Person-centred Approach (PCA) are a relevant training by addressing most the previous qualms. It is our belief that psychopathologists trained in PCA could improve their relational framework and acquire the ontological precepts to correctly access and assess a wider range of mental phenomena.

Keywords: Person-Centred Approach; Psychopathology; Phenomenology; Psychiatric Interview; Training

Introduction

The scope of psychopathology as a discipline and its ability to[1] shape what is disturbed or normal and[2] to be assessed in the mental state examination is central to Psychiatry. For more than a century the increase of clinical workload, strict insurance policies and the request of objectivity and reliability for research have enforced categorization and operationalization of psychopathological phenomena. This move has been blamed as having led psychopathology into a dead end, undermining research and clinical diagnosis[1-5].

The search for objectivity was spearheaded by the belief that standardization would (1) help increase its ever-low reliability[6], (2) diminish the exposure of Psychiatry to scientific criticism[1] and most of all (3) restore the reputation of psychiatrists for they were reckoned as lacking scientific validity[7]. This effort however has failed to prove suitable and raised general negative reviews of the consequences of the setting, format and duration of the interviews[8] as well leading to specific problems, including "procrustean errors"[9], and "the looping effect"[10]. The worst-case scenario is that Psychiatry has dismissed the relational proxies of meaning (overlooking the conversational structure of the inquiry) accepting checklists of symptoms as proxies of patient's rapport even if performed by untrained interviews, in eerie settings (e.g. telephone or email). These markdowns on the quality of the assessment were taken as "means to an end" in the search for a never reached reliability (e.g. DSM5).

Whilst Psychopathology didn't reach the expected reliability, other phenomena resisted to operationalization and were basically removed from our interviews, as is the case of first and second person perspectives. So the very nature of phenomena psychopathology accesses and studies today is distinct from that of the symbols inscribed in descriptive psychopathology (which included such experiential tracks). Other ontological precepts, as relational and conversational features were discarded, sanctioning direct questions as equivalents of narratives to meaning. Current assessment asks patients recognize externally given symbols and not to explore their experiential meanings weaving and collecting person-centred meanings. Also by keeping a fixed set of external symbols, psychopathology might have become a rigid and obsolete system with no conceptual research[3,4]. All these congregate in a three dimension problem: (1) the reduction in the quantity and quality of symbols we are assessing, (2) the loss of first and second person perspective symbols, (3) the forfeiture of the particularity of meaning leading to a crystallization of psychopathological symbols (out-dated).

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Psychopathological enquire requires overwhelming and painful self-disclosure and so creating safe and receptive environments is fundamental to ease the willingness and depth of enquire. Rushed and superficial encounters can be misleading by providing deceptive negative accounts which, rather than no psychopathology, could indicate that the person is not willing to share his experiences. psychopathological phenomena are not segregated experiences but a structure of elements (meaning and experiences) which can only be seen together. Direct questioning or keeping interviews to a set of items (or to yes and no answers) causes the loss of narrative arrangement (structure) as well as a disturbance of personal meaning process and symbols[3,11].

Present day assessment focuses only on signs and objective symptoms as private subjective and inter-subjective appraisals were dismissed as unreliable. Moreover signs and objective symptoms aspire to help the creation of reliable a-theoretical constellations of syndromes. Yet this hasn't improved reliability. Yet it has restricted dialogical properties of the encounter. These include the process of giving meaning to experience (person) and translating experiences (interpersonal) relies in a private process that is contingent to linguistic and cultural background. The meaning of being mentally ill comprises psychopathological units many of which mental phenomena are pre-symbolic at time of complaint making it difficult to process and communicate (e.g. subjective vague restlessness or inter-subjective clinical impression of diagnosis)[12]. Also those experiences require additionally subjective and intersubjective integration[1,2,13-16], for instance, crying is not universally psychopathological. The availability of such meaning relies on the interviewers ability to (1) facilitate the exploration of personal symbols; (2) detach themselves from prejudiced imports from their personal experience/studies and (3) assess and clarify their own experiential features in the encounter. This essay focuses on these dimensions believing in their critical role to increase the scope, magnitude and validity of psychopathological enquire. It advocates that Person-Centred Attitude (PCA) of the Person Centred Psychotherapy (PCP) is similar to the phenomenological and aesthetical attitudes. Yet contrarily to the latter, which are mainly theoretical undertakings problematic to demonstrate or to communicate, the PCA is predominantly a hands-on practical model. Therefore acquiring proficiency in such complex attitudes could rise from training PCA. These include the foundational stones of Person Centred Psychotherapy put forward by Carl Rogers (6 ontological principles) as well as its non-directive stance[13]. It is suggested that the PCA can improve the quality of psychopathological enquire by allowing (1) enhanced relational features, (2) an ontological framework which details and preserves phenomena including (3) subjective and inter-subjective experiences and meanings.

Known links between PCP and Psychopathology

A contempt for descriptive psychopathology (and nosology)

A notorious relation between PCP and descriptive psychopathology is of contempt for their positions in assessment and diagnosis. PCP does not endorse psycho-diagnosis or any predetermined symbols to patients' experiences and meanings. PCA foundational structure takes experiences and meanings to be person centred in that no external symbols could help framing the phenomenon that is being described. There are therefore no phenomenological marks or epistemological pathways aprioristically recognizable. If we take descriptive psychopathology as a list of symbols that portray psychopathological phenomena representative in mental disorder its easy to understand the antimony of PCP. However, the original agenda (of the eidetic reduction of the symbols that today characterize descriptive psychopathology) entailed an attitude and method that shares many features with the PCA. The "phenomenological method" characterized by "epoché" as well as other contributions is discussed in the next section.

Another elucidation is that no matter how unsullied the PCA might look, PCP therapists can (and should) learn the various epistemologies, specially descriptive psychopathology, which ultimately allows (1) dialogical determinations with their clients (2) cooperation with other mental health providers and (3) increasing their awareness to other forms of conceptualization of human strains[17]. The nature and the quality of the PCA therapeutic relation are not changed by theoretical erudition, as it is ontologically principled allowing for all epistemological frameworks. And also, some PCA-based therapies including Focusing, Emotion-based or Gestalt therapies require assessment to attain a degree of adequacy of their approaches[18 20].

Consequently neither (1) psychopathology ought to be reduced to a dictionary of symbols nor (2) PCA derides the theories (or symbols) included Psychiatry and Psychopathology.

It's own theory of psychopathology

Another link between PCA and psychopathology is its own theory of mental health and psychological disturbance[13,21]. Mental health in PCA is comprised by a (1) outstanding openness to the world, (2) an enduring and permanent clarity in the subjective appraisal of meaning of experiences (congruence) and (3) a self-concept that is self-acceptant is self-considerate. Psychopathological disturbance on the other hand is considered weathering incongruence which includes (1) experiences to which no meaning is attached to (e.g. despairing or feeling anxious for no apparent reason), (2) meanings and behaviours without experiential features – detachment from experience as in depersonalization or involuntarily experiencing

that one is façade and (3) the inability to update negative behaviours and meanings – inability to leave interpersonal enslavement. Interestingly the process of psychological healing is one that involves the achievement of person centred clarity (both symbolic and experiential) and so ultimately recovery allows interpersonal explanation of mental phenomena.

Cooperating with phenomenological psychopathology.
The fact that PCA shares many features with Phenomenological Psychopathology (PhP) method as both aim to unfold untouched personal experiences and meanings was already stressed. While in PCP this process is deemed the heart of therapy, in the PhP it is the foundation of the eidetic reduction necessary to adequately portray phenomena. The experiential/attitudinal features, the degree of relational depth, the non-interpretative methods of framing patient experience, the self-exploration of meanings and the permanent awareness of shared and non-shared experiential landscapes in the encounter are ontological principles that PCA shares with PhP. The possibility that PCA training might liaise with phenomenological psychopathology training is what stands as the basis of this paper.
In what can the PCA help Psychopathologists?

Learning the phenomenological method through PCA
Various features of the PCA are shared with the phenomenological method. These include (1) actively aiming to collect phenomena through non-interpretative empathic understanding, (2) experientially focused dialogically attuned reframing and reformulation and (3) "letting things be as they are" by unconditional positive regard.
Non-interpretative empathic stance aims at understanding phenomena free from outward interpretations. It involves setting aside ideas, beliefs, expectations or previous understandings[22]. It aims to an unambiguous congruence between the experiential features occurring in the encounter. This dynamic listening of the client's world to reformulate what is central, critical, alive, or poignant accompanying the other sudden sense of insight. Reformulations should orchestrate rhythm and affect so that the structure of experience is unspoiled. The unconditional positive regard empowers the entire exploration of the person's way of being in the world. Overall the PCA aims to an active receptiveness to the Other's otherness progressively more proficient in framing their experience in their meanings and the links between them.
There is presently a thought-provoking discussion on Rogers's idea of non-directivity as he seemed to suggest that one is educated in remaining close to person's experience. If directivity has an overall agreement in PCA as guiding clients in the content of their speech appraising what is important, what is not and where to go and therefore constraining the exploration of experience[21]. But some PCA therapists consider that they actively steer clients into the unfolding of their experiences rather than remaining at factual or abstract level (discussion on potential transgression of non-directivity[23]. Some acknowledge even that the PCA paradigm isn't non-directive but indeed experience-oriented[24]. Yet I believe that such expresses a paradoxical nature of non-directivity similar to the phenomenological epoché[25]. The overall tone PCA aims for neutralising previous biases (natural attitudes and value conditions) remaining at the right distance that allows the interviewer to be experientially moved whilst remaining separated from the patient. At the same time (1) an active effort to collect the experiential essence of each narrative but also letting things be for themselves (leghein) and (2) "attempt to leave their client's way of placing their experience untouched by the therapist frame of reference.

Learning Person-centred Structural Psychopathology with PCA
Person-Centred Structural Psychopathology proposes that psychopathological phenomena are not experiences or symbols but a network of experiences and symbols in which the links between the elements have meaning. The meaning of a phenomenon is structural – "an autonomous entity of internal dependencies". Its autonomy means that adding external symbols (e.g. symbolic interpretations or genetic explanations) intrudes the phenomenon risking changing its symbolic nature. External symbols (e.g. medical or psychoanalytical) are foreign connections that disturb the symbols and their structure. If psychopathological meanings are structural one must (1) avoid contaminating patients' descriptions with any form of external reasons or causes and (2) but must not be satisfied by the assessment of simple experiences but, remaining in the person's frame of reference, understand explanations and interpretations that the patient provides for himself. Such integration of different dimensions of meaning in context (pre-reflexive, reflexive and narrative) is the more basic unit of psychopathological assessment.
There is a similar idea in PCA coined frame of reference consisting of the person-centered structure of meanings and experiences. The therapist must remain within it whilst the patient explores and weaves his experiences. This requires refraining "from questioning, probing, blame, interpretation, advice, suggestion, persuasion, reassurance"[26] and also helping the other "explores his own attitudes and reactions more fully than he has previously done and will come to be aware of aspects of his attitudes which he has previously denied" [26]. The attitude enforces in the awareness of such experiential structure, on the clarity of the meanings that it involves as well as an increased possibility to share and reinvent the symbols they attach to them. Inadvertently the process of healing in the PCA

tradition (ultimately aiming to restore self-representation through an openness to experience) encourages both (1) paramount care for intact patients' references and symbols and (2) an in-depth exploration of experiential links of each of such symbols[27].

The interviewer with a PCA assesses by rearticulating the phenomena in the way they are being structured by the client frame of reference so that he can be the judge of the disturbances of such links (including major beliefs about oneself, one's behaviour and the world). Such encourages the Other's integration of experiences and inventiveness and unclutteredness of meanings (self-determination). Medical and psychological interviews are mostly bound to external symbols (medical, psychoanalytical etc) to explain and understand what is happening to their clients. If for PCP these carry nefarious implications in therapy they also seem taint the phenomena that ultimately must be portrayed and described.

Valuing Otherness through PCA

The concept of otherness has been discussed in philosophy, sociology and psychology to communicate the difference in the other in an encounter that cannot be reducible or altogether explicable by one's resources. There are some situations that involuntarily make us experience otherness in an encounter including (1) feeling that the other is not meaningful in a psychotic break or (2) not being able to understand by cultural or linguistic barriers. Yet in most clinical encounters the overall experience is of understanding – the possibility of encompassing the other in my own experiential realm and/or psychopathological symbols. Todays' psychopathological assessment is therefore a translational effort of navigating the otherness and turning it into sameness[28]. But ineptness in dealing with otherness can lead to (1) misleading analogies (taking dissimilarity as similarity), (2) frustrating endeavours (irritation or annoyance by longstanding incomprehension) and (3) conveying to the patient a sentiment of isolation reification or detachment. Indeed a much forgotten feature of otherness is that it involves an appreciation of their potential to reshape one's world, to transform to varying degrees the possibilities they offer… The sense of …is not principally a matter of ignorance about the ingredients of their heads, it is a constituent of their personhood."[29]. Overall, in the process of assessing otherness the interviewer should be able to keep ascertaining the otherness as valuable and irreducible[28].

Caring for otherness is very much at core of the PCA including (1) ascertaining the other difference by upholding a reserve and avoiding analogies, (2) encouraging that the personal experiential meanings should rule over external conditions of worth and (3) supports "difference" also as ever-changingness in the "actualizing tendency". First PCA advocates a precise experiential distance between the therapist and the client that allows a non-engulfing presence and acknowledges and respects the radical difference of the person he finds (otherness). To develop a PCA one must first consolidate previous life experiences (which are helpful in other relations) and bracket them as they might hinder the empathic process by risk of analogy (correspondence to his own life).

Second relational warmth, matured acceptance and respect are expected, together, to trigger the person's own resources in reclaiming and restructuring meanings. Becoming a PCA therapist involves developing a "structure of care" that is not felt by the person as coming from the outside (not coming from carers or supportive-egos) but from his own "inner capacities". Such acceptance, safety and permissiveness also create an increasing sense of responsibility for such changes and decisions. In the process of creating such an environment therapists become available for "being with their clients" in the sessions rather than contemplating and understanding their experiences. This attitudinal feature is of the utmost importance and qualitatively distinguishes different stages in training of therapists – established therapists are not only attuned but also actively engaged in their therapies (they are spectators but players in therapies)

The third paradigm of PCA is that humans have "one basic tendency and striving - to actualize, maintain, and enhance the experiencing organism"[30]. In PCP persons are regarded as striving in a centrifugal movement in which they reach towards novelty and enhancement. A PCA should trigger "within the client (…) constructive forces whose strength and uniformity have been either entirely unrecognized or grossly underestimated"[13]. This idea matches contingency of psychopathological syndromes to the person's active and permanent symbolization of experiences and Mayer-Gross idea of "drive for the intelligible unity of life-construction" (Stanghellini citing Mayer-Gross[31]). Jaspers also provided a detail of the effort of humans to continuously strive through "their existential passivity towards an unknown meaning" (adapted from[32]). Hampering of such internal drive can also be traced in the history of psychopathology, to alienists[33] where persons were still seen as remaining active in shaping their disorders and the constellation of symptoms. Moreover the feeling of being mentally ill entails a sense of having lost this "space of possibilities" as if the patient was constricted to a crystallised reality. Recovering the handiness self-awareness and the emergence of the actualizing tendency[34] commands the beginning of the symbolization (and some times re-symbolization) of life events which becomes progressively more private and esteemed.

The aim for congruence readiness (Rogers in [35]) to one's experiential features would be interiorized by the person undergoing therapy, a step further in becoming a fully functioning person – the permanent awareness and res-

pect to the experiential and existential features of our life[36]. But such experiential focus is relevant to psychopathology, as disturbances of subjective experiencing could remain veiled by explanations.

Intersubjective experience and meaning in the PCA

In psychopathology the objects of study are defined not only arising from the third and first person (subjective experience) viewpoints but also as disturbances of inter-subjective experience including (1) the way a person experiences when in relation with others or (2) in certain settings. The prominence and role of the encounter in PCA seems relevant for the attempt of enunciating it in phenomenological terms. Rogers captures the encounter by saying that "every form of therapy more or less lives on the encounter between therapist and client … but there are not many theories which understand encounter . . . as the central source of healing and not as a subordinate one"[37]. Indeed most therapies rely on the therapeutic relation as instrumental mean to allow techniques in practice (CBT) or for interpretations. Rather in the PCA its importance is not as a mean but as an end – PCA therapeutic endeavour is the encounter [38]. In other words empathy in PCA is not just relevant in therapy, the mean to an end as in other schools of psychotherapy, but the attitudinal centre of the therapeutic enterprise.

The empathic structure in PCA includes also a balance between distance without detachment and closeness without fusion or, as Roger asserted "being empathic, is to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the 'as if' condition. Thus it means to sense the hurt or the pleasure (…) without ever losing the recognition that it is as if I were hurt or pleased and so forth. It is this 'as if' quality is lost, then the state is one of identification" [13]. The importance of knowing the boundaries of my world and the other is fundamental for allowing the depiction of the three aspects (third, first and second person perspectives). Many other contributions, in particular by Bozarth and Greenberg have deepened such considerations on empathic efforts and accuracy in the PCA model[39,18].

Buber claim that "all real life is encounter" [40] reinforce the importance of meaning that cannot be captured by narratives and that meaning is dialogical – "the real dialogue… comes from the existential centre of the person, it is not a question of information transfer, but of participating in and sharing the being of the other" (Rogers cited by [21]). Relational depth is not a mean to allow the enfolding of first and third person meaning but carries meaning itself. Rogers extensively supported the idea that knowing the other is primordially the interpersonal attendance of a fully congruent individual. By allowing them to fully exist in the encounter the therapist or the psychopathologist can aim at assessing their way-of-being. Empathy in PCA seems relevant for the phenomenological description of the interpersonal features, as they will be available for portrayal in an intact way. The next section includes a critical appraisal of how empathic understanding in PCA is attuned with the *heterology* stance about empathy that was deemed relevant for the psychopathological enquire[28].

PCA, Aesthetics and Atmospheres

This is different from the way that the present psychopathological exam is being taught. Following the current medical trend, we endorse as a prescriptive approach to the psychopathological examination that is active and where the psychiatrist should externally contemplate or describe experiences and select, depict and analyse content. He should then integrate it into an epistemological structure, ultimately an analytic-synthetic scrutiny according to strict external symbols and norms. Yet as psychiatrist don't develop a "passive momentum" they risk hindering their attention to a large dimension of meanings (dialogical), to limit the availability of symbols outside of their framework, to fracture narratives and to remain an active intervenient in the symbolization. Cristina Costa argues that it is important to recover an "aesthetic attitude" meaning "as if one was attending art"[41]. In such moments one is passive and is moved by the experiential features of the moment – he actively lets go of prejudiced ideas and predisposes to wonder. There the person assesses subjective and intersubjective phenomena that would otherwise be elusive[41]. Such is very similar to the PCA attitude and those skills are particularly present in the PCA training. First they need to let go of prejudices and pre-arranged understandings and allow a non-directive flow of the narrative (and phenomena) being shared in the encounter. Also they are focused on the atmospheric appreciation of themselves in the relation but more specifically the setting and the person they are encountering. Rogers discussed the idea of presence and the relevance of the immediacy of "moment-to-moment encounter of psychotherapy" (Rogers in [35]) The PCA training includes (1) therapists developing an interpersonal thoughtfulness that increases intimacy and closeness; (2) aesthetic appreciation of their clients' experiential field. The first is found in Mearns portrayal of one such appreciation "I could see her there, but I couldn't say anything. I wanted to tell her that I could see her there, but I couldn't tell her – it was scary – maybe it was like having a stroke and being paralyzed so that I could feel her but I couldn't tell her. She must have understood me, because she never asked me any questions – you can't answer people's questions when you are like that. She would say some things – things which went along with what was going on in me, things like ... well, I don't remember any particular things – but I do know that she was close – she

was close inside me."[17]. This idea is particularly present in Pre-therapy for psychosis (Van Werde in [42]) includes in the most disengaged relationships "restoring, strengthening and sustaining contact" [35]. The second is found in the use of reformulations centred in aesthetic features extant in the encounter conveying back to their clients if the atmosphere is tense, edgy, joyful or insecure.

Conclusion

Today, psychopathology sees the revitalization of the relevance (1) of first-person (subjective symbolization) and second-person perspectives (inter-subjective features to meaning) and (2) of maintaining the dialogical structure of relation and interview. For long now clinical diagnosis and empirical research (in particular neurolocalizationism) have disregarded such mind-sets. This is said to be damaging the relation between the phenomena that lived and those that are measured and through this damaging the validity of current categories (and research). Indeed, psychiatric and psychological training despite being remarkably focused on research, do not comprise (1) training in relational features or (2) understanding how subjectivity can be assessed. On the contrary they are largely focused on keeping within the standards of objectification and primarily concentrated in nosology. This essay reviews aptitudes such as the relational skills and depth and other attitudes that could allow us a larger range of assessed phenomena. Moreover it stresses how these features are attitudinal in nature and so unapproachable by reading or theoretical lessons.

Also it was implied that training in Person Centred Approach might help mental health providers and researchers in these efforts by (1) reducing cognitive interpretations and empathy by analogy; (2) attaining a facilitative warm, receptive and positive regard considering stimulating interpersonal exploration of meanings; (3) increasing the focus on experiential features of meaning; (4) acquiring an heterology stance by maintaining both congruency and emotional awareness and particularising the otherness (regarding alterity) throughout the encounter and (5) increasing presence and possibly an aesthetic attitude that could reveal significant personal and interpersonal features. Acquiring skills in PCA in future psychiatric programmes, might improve the range and the validity of psychopathological meanings accessed for diagnosis and research.

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