A Person-Centered Approach to Schizophrenia

Ein personzentrierter Zugang zur Schizophrenie
Un enfoque centrado en la persona a la esquizofrenia
Une approche centrée sur la personne de la schizophrénie
Een persoonsgerichte benadering van schizofrenie

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Abstract. The person-centered approach has paid little attention to persons with schizophrenia. There has been a reluctance to work with a medical diagnosis. Instead of that people with schizophrenia have been saddled with dubious psychological diagnoses. Schizophrenia is a noun that describes the objective side of a human suffering. The author calls for an acknowledgement of the illness. He argues that only when one is willing to give the illness its proper place is one able to see the interrelatedness between illness and person. In the case of a severe mental illness the person cannot be separated from the illness. There is no reason to carry on a controversy with present-day psychiatry. The person-centered approach can do invaluable work helping the person with a severe mental illness to retrieve a valued self.

Zusammenfassung. Der Personzentrierte Ansatz hat Menschen mit Schizophrenie wenig Beachtung geschenkt. Es gab Widerstand, mit einer medizinischen Diagnose zu arbeiten. Stattdessen wurden Menschen mit Schizophrenie dubiose psychologische Diagnosen aufgeladen. Schizophrenie ist ein Wort, das die objektive Seite eines menschlichen Leidens beschreibt. Der Autor fordert die Anerkennung dieser Krankheit. Er argumentiert, dass man den Zusammenhang zwischen der Person und der Krankheit nur sehen kann, wenn man bereit ist, der Krankheit ihren angemessenen Platz zu geben. Im Fall einer schweren geistigen Krankheit kann die Person nicht von der Krankheit getrennt werden. Es gibt keinen Grund, hier eine Kontroverse mit der heutigen Psychiatrie fortzusetzen. Der Personzentrierte Ansatz kann hier unschätzbare Arbeit dabei leisten, einer Person mit einer schweren geistigen Krankheit zu helfen, ein Selbst wiederzugewinnen, das wertgeschätzt wird.

Resumen. El enfoque centrado en la persona ha prestado poca atención a personas con esquizofrenia. Ha habido reticencia a trabajar con un diagnóstico médico. En cambio las personas con esquizofrenia han sido asignadas diagnósticos psicológicos dudosos. La esquizofrenia es un sustantivo que describe el lado objetivo de un sufrimiento humano. El autor llama a un reconocimiento de la enfermedad. Sostiene

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que sólo cuando uno está dispuesto a darle a la enfermedad su lugar adecuado, uno puede ver la interrelación entre la enfermedad y la persona. En el caso de una enfermedad mental severa la persona no puede ser separada de la enfermedad. No hay razón para continuar una controversia con la psiquiatría de hoy en día. El enfoque centrado en la persona puede ofrecer un trabajo muy valioso al ayudar a la persona con una severa enfermedad mental a recuperar un sentido de sí misma valorado.

Résumé. L'approche centrée sur la personne s'est peu préoccupée des personnes souffrant de schizophrénie. Par le passé il y a eu des résistances au fait de travailler avec un diagnostic médical et, de ce fait, des personnes schizophrènes ont subi des diagnostics psychologiques peu fiables. Le nom 'schizophrénie' est un descriptif de l'aspect objectif d'une souffrance humaine. L'auteur appelle à une reconnaissance de cette maladie. Il affirme que c'est seulement quand on est prêt à donner à cette maladie sa vraie place, qu'on peut percevoir les inter-relations entre la personne et sa maladie. Dans le cas d'une maladie mentale grave, on ne peut pas séparer la personne de la maladie. Il n'y a pas de raison de perpétuer une controverse avec la psychiatrie d'aujourd'hui. L'approche centrée sur la personne peut faire un travail précieux en aidant la personne qui souffre d'une maladie mentale grave à retrouver un self pour lequel elle a de l'estime.

Samenvatting. De persoonsgerichte benadering heeft weinig aandacht voor mensen met schizofrenie. Binnen deze traditie werkt men niet graag met een medische diagnose. In plaats daarvan worden mensen met schizofrenie opgezadeld met een dubieuze psychologische diagnose. Schizofrenie is een zelfstandig naamwoord dat een objectieve kant van het menselijk lijden beschrijft. De auteur roept op tot een erkenning van de ziekte. Alleen wanneer men bereid is de ziekte een plaats te geven, is men in staat de verbondenheid tussen persoon en ziekte te zien. In het geval van een ernstige psychiatrische stoornis is het niet mogelijk de persoon van de ziekte te scheiden. Er is geen aanleiding een polemiek te voeren met de huidige psychiatrie. De persoonsgerichte benadering is van onschatbare waarde om mensen met een ernstige psychiatrische ziekte weer waardering voor zichzelf te laten vinden.

Key words: schizophrenia, person-centered, psychiatry, diagnosis, culture, anthropology

WHAT IS SCHIZOPHRENIA?

Schizophrenia is known as a chronic disease. The common interpretation of a chronic disease is a disease that never heals. In part this is true for schizophrenia. After five years more than 50 percent of patients still show impairment, persistent psychotic symptoms and several relapses (Shepherd, Watt, Falloon et al., 1989). Within the course of five years 80 percent of people with schizophrenia have experienced *at least* one psychotic relapse (Robinson, Woerner, Alvir et al., 1999; Birchwood, 2000, p. 39). This illness destroys the lives and expectations of many young people and their families.

The first psychiatrist who described schizophrenia as an illness entity in its own right was Kraepelin in 1899 (Kraepelin, 1999). He saw the unfavourable course of the illness as its main aspect. Kraepelin did not speak of schizophrenia but of *dementia praecox*, which he considered an appropriate description because it concerned an early (*praecox*) decay of the mind (*dementia*). It was the Swiss psychiatrist Bleuer (1908) who coined the term

schizophrenia. Bleuer had had a lot of experience with people with schizophrenia, with whom he related in a personal way (Hell, 2001). His sister suffered from a severe psychotic disorder, which was the original reason for his choice of profession (Hell, 2001). He made it clear that in schizophrenia there is no question of the extinction of the human mind but that there is an inner, personal life that leaves much to be understood.

The literal meaning of chronic is 'time' (*chronos*) or 'in time'. That is another aspect of schizophrenia: it is an illness that evolves over time. Several long-term follow-up studies around the world have demonstrated that schizophrenia is not the deteriorating disease that was once imagined (Bleuer, 1972, 1978; Ciompi & Müller, 1976; Huber, Gross & Schütller, 1979; Harding, Brooks, Ashikaga et al., 1987a and b; McGlashan, 1988; Kua, Wong, Kua et al., 2003). Although there are many questions left to be answered we do know that there is considerable variety in the long-term course and outcome, and that, except in ten percent of cases where the course of the illness leads into a severe state, recovery is possible.

Schizophrenia is an illness that fills one with modesty. 'With the current mix of interventions we can only reduce 13 percent of the burden. If we improve efficiencies within the current services, we can do somewhat better (22 percent)' (McGrath, 2005, p. 9). There is no treatment we know of that can definitely alter the natural long-term course. There are many explications of schizophrenia. These range from a purely biological interpretation of schizophrenia as 'a disabling brain disorder' (McGrath, 2005, p. 9) to political, mainly 'anti-psychiatric' explanations which state that 'there is no such thing as mental illness' (Shorter, 1997, p. 275). In between we find psychological, interpersonal and socio-cultural explanations. To explain something is one thing, to understand another. There are many metaphysical and psychological explanations that are at odds with the tremendous suffering caused by a serious mental disorder (Rasmussen, 2001).

Jaspers (1912a, b, 1969, 1973, 1974, 1997) made a distinction between *Verstehen* (to understand) and *Erklären* (to explain). *Verstehen* means 'to bring as precisely as possible to mind (*Vergegenwärtigung*) what the patient feels and is aware of' (Blankenburg, 1980, p. 55). Interestingly Jaspers (1973, p. 483) thought that many people with schizophrenia were *unverständlich* (incomprehensible). With his phenomenological approach however he introduced a very important element in psychiatry, *verstehen*, which 'requires a more *intimate* mode of experiencing, a willingness to identify, in short: *empathy*' (Blankenburg, 1980, p. 55, original emphasis). Jaspers (1997, p. 778) criticized 'metaphysical interpretations of illness', he states that 'the fact of the psychoses is a puzzle to us … by interpretations man reassures himself about this really unbearable fact'.

> Dave was presumed to have a severe conduct disorder. His parents were advised to take on a 'consequent attitude'. But when Dave stood before a locked door at 3 a.m. he broke the window and just stepped into the house. His bizarre behaviour was seen as related to his abuse of drugs. It escalated. He thought that his mother put poison on his pillow. He was afraid to eat his sandwiches at work. In conversation he started sentences that led nowhere. At night he visited the churchyard, lit candles and cried in the dark. He was involuntarily committed. He spat in my face when he was taken

> away by ambulance. Once in the hospital it became clear how sick he was. The antipsychotic medication made him calmer, but the spirit was gone. He turned completely inside himself. Mother did not recognise her own son. There was nothing left of her unmanageable, aggressive boy. But for years he continued to fight his voices. He responded to his voices like a wild animal. 'Piss off', he begged and shouted, 'Piss off, the lot of you!' During recent years he has become calmer, possibly his voices are gone. Every now and then he still is laughing to himself. But it is possible to exchange a few sentences with him. During the day he is passive. He gets his tobacco, watches television and sleeps a lot. During the summer he takes walks through the city and drinks a few beers.

In the USA we find in the last decades of the 20th century a 'revival' of phenomenological ideas with well-known schizophrenia specialists such as Carpenter, Strauss and Davidson (see Carpenter, Strauss & Bartko, 1981; Davidson & Strauss, 1995). These psychiatrists acknowledge the devastating effects of the illness on the person suffering from schizophrenia. They call for, 'two senses of phenomenology' (Davidson & Strauss, 1995, p. 53) — the objective-descriptive sense of phenomenology of which they consider the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* an example and a subjective-descriptive sense of phenomenology, with the possibility to study the lives of people with a severe mental disorder in the context of subjective experience, time and meaning.

Corin approaches the *life-world* (*Lebenswelt*) of people with schizophrenia from an anthropological and European psychiatric phenomenological tradition (Corin, 1990, 1998; Corin & Lauzon, 1992; Corin, Thara & Padmavati, 2004). Corin (1998, p. 134) claims that 'it is still uncommon for researchers in psychiatry to consider other philosophical and social science perspectives for the renewal or deepening of our common understanding of experience and subjectivity'. She posits a complex model of reality that does justice to *the thickness of being* — different from the apparent, 'transparent reality where meaning is directly accessible' (1998, p. 134). In using the term 'thickness of being', Corin means the complexity of a person's existence, wherein a person's life is determined by many layers, for example, the way a person with schizophrenia expresses themselves is connected with their unique being, the disease process, and the culture in which they live. To capture this in understanding is a considerable, but meaningful, challenge.

In another refreshing rebirth of phenomenological philosophy we find the work of social anthropologists such as Arthur Kleinman (Kleinman & Kleinman, 1991). Kleinman and Kleinman (1991, p. 277) emphasize the *overbearing practical relevance* of experience. *Something is at stake* — in the case of an illness, it is the suffering that is most at stake (p. 280). When we look from a purely medical (or cultural) point of view at schizophrenia and disentangle the hallucinations, the disordered thoughts, the suspiciousness, in short the symptoms, from the person, then we ignore this human being's suffering.

I will not give an in-depth description of schizophrenia. Nor is this the place to discuss the concept of schizophrenia per se with respect to the validity of the diagnosis (Vlaminck, 2002). Many authors agree that it is an invalid scientific diagnosis for a wide range of syndromes,

but so far no one has been able to come up with a valid construction of discrete types. Nor will I launch myself into the discussion of whether we are justified in giving people a diagnosis. The profession of psychiatry is always a delicate balance between illness and person. By only looking at either the illness or the person the specific quality of psychiatry is lost. In fact all the schools I have mentioned struggle with the balance between illness and person. For me, the validity of the diagnosis of schizophrenia is given in the suffering of the people with whom I work.

To understand schizophrenia fully as an illness suffered by a human being requires an interpersonal relationship between patient and clinician. What is *not* required is 'an etiologic or therapeutic theory. What is required is the structure in which a relationship can develop with a clinician trained in the interpersonal skills required to establish those language and empathetic communications by which one human conveys the nature of his inner world to another' (Carpenter, Strauss & Bartko, 1981, p. 952). In that sense the person-centered approach is the method par excellence to learn more about severe mental disorders. In no other therapeutic tradition is there more expertise to establish a relationship in which one human conveys the nature of his inner world to another. Why then, has there been so little work and research done by person-centered experts in the field of schizophrenia? There are some exceptions that we will discuss later (Rogers, 1967a; Prouty, 1976, 1994; Teusch, 1990; Binder & Binder, 1991; Binder, 1998; Van Werde, 1998, 2005; Prouty, Pörtner & Van Werde, 1998; Warner, 2002; Sommerbeck, 2003). The smallest effects of experiential psychotherapies are found for chronic and severe problems such as schizophrenia (Greenberg, Elliott & Lietaer, 1994, p. 509). This knowledge in itself cannot explain why there has been so little attention paid by the person-centered field to schizophrenia. As has been said, we have to be modest in general concerning the therapeutic effect in regard to schizophrenia.

The main purpose of this article is to outline a person-centered approach to schizophrenia. I will discuss a lot of work and findings from schizophrenia research in the last decades, especially from the fields which take a broad phenomenological, anthropological and cultural view on schizophrenia, while keeping an eye on the disease's medical aspects. Surprisingly, one will more often find person-centered elements with respect to schizophrenia in the work of the authors I introduce, than from within the person-centered tradition itself.

With respect to the person-centered approach and schizophrenia I hope to make it clear that, so far, this tradition has missed an essential ingredient in regard to persons with schizophrenia because of the unwillingness of the approach to name it as a disease. *A noun is a terrible thing to waste*, says John Strauss (2005) in the title of his paper. A noun is necessary to describe the disease process. It is the objective side of the human suffering. If we ignore this objective side, all the burden of the illness is piled on the individual person. With respect to schizophrenia (and other severe mental illnesses) this weight is more than a person can bear. I will argue that a proper person-centered approach to schizophrenia is only possible if we acknowledge the disease process the person is suffering from. Only when we explain the illness, can we understand the person with schizophrenia.

SCHIZOPHRENIA AND THE PERSON

We no longer speak of 'schizophrenics', 'schizophrenic patients', or 'psychotics'. The common, and in my opinion correct, nomenclature is 'people (or clients) with schizophrenia' or 'a person with a psychotic disorder'. This change of names reflects the way we nowadays look at the nature of this illness. There is a person and there is a disease. This view fits the modern approach towards severe mental disorders. Davidson and Strauss (1995, p. 45) speak in respect to this approach about the *disorder* model: 'the illness … is an entity in and of itself that has entered into the life of an otherwise healthy person'. Schizophrenia is an illness like diabetes, people suffer from it, but with the help of medicine and good treatment advice, they can live with it.

This approach towards mental disorder, which is based on a biomedical model, links up nicely with psychosocial rehabilitation practice. 'The psychosocial rehabilitation concept of the person is based on a literally physical interpretation of the self, applying the metaphor of handicap and broken body to impairments of the person' (Estroff, 1995, p. 85). It is a useful and practical model, in which psychiatrists, psychosocial workers and 'consumers' meet one another — this model reflects the daily practice of Western psychiatry.

However the question is to what extent this distinction between person and disorder really corresponds with the experience of a person suffering from a severe mental disorder. Von Trotha, (1995, p. 185) describes strikingly *die Unmöglichkeit, eine Psychose zu erfahren* (the impossibility of experiencing a psychosis). One experiences no 'psychosis' but a vision, mortal terror or a persecution by the CIA. A person with a psychosis is — at least in part — the psychosis itself.

> They gossip about me, all over town. They call me a whore and they publish in the newspaper that I'm dead. The terrible thing is that I cannot do anything about it. Everybody knows about it except me. I'm always asking my brother and my sisters, what's going on? But they act as if they just don't know. It's a shame that the only person in town, who knows nothing about it, is me. I have a right to know. It's really frustrating to live like that.

The differentiation between person and illness might be an adequate coping strategy but it is often not in accordance with the patient's experience. For the one who should relate — the person or the 'self' — is psychotic (Kusters, 2004, p. 27). The person has to deal with a reality which apparently no one shares and is completely thrown back on his own. 'The idea of fighting the disease, having distance from symptoms, making the separation between a sick or not sick self — all these require an intellectually unacceptable separation of symptoms from subject' (Estroff, 1989, p. 195). More often mental health workers are helping themselves rather than the patient by using this distinction. When there is a distinction between persons and symptoms we can *do* something with the patient. We can help the patient to handle the symptoms. Without this distance there is only the psychotic person left with a strange fever in the eyes. We must be aware of 'the depths to which mental illness may implicate and unsettle one's sense of self' (Estroff, Lachicotte, Illingworth et al., 1991, p. 363).

> I'm the prince of the Seraphim. They have chosen me three years ago and because of that they are playing tricks with me. They put a bug in my back tooth and they broadcast everything I say on the radio. I cannot study anymore. In fact I can do nothing all, because they are playing these games. One day they will build a castle for me. They told me. But know I can do nothing. I have to wait.

If we really want to know a person with schizophrenia, we need a broader concept than the contemporary mix of the biomedical model and the psychosocial rehabilitation. This model fits our society because 'psychosocial rehabilitation is based on and embodies a particularly Western and idealized concept of personhood — a formulation that equates health with factors and attributes such as agency, autonomy and social activity' (Estroff, 1995, p. 84). What we really want from people with schizophrenia is for them to be normal again. This in itself is not the problem — the problem is that our Western society has this particular definition of normality: to be independent, productive and socially engaged. What Estroff (1995, p. 88) is asking for is more attention to the *interior* life of people with a severe mental disorder, 'self determination is not the issue here — subjectivity is'.

Davidson and Strauss (1992, 1995) represent a group of scientists and clinicians who see the person themselves as a crucial factor in the long-term outcome and the process of recovery. They assume that the 'rediscovering and reconstructing of an enduring sense of the self as an active and responsible agent provides an important, and perhaps crucial source of improvement' (1992, p. 131). They propose a *life context* approach, in which 'the *person's life* is the organizing construct' (1995, p. 49, original emphasis). We can regard this model as a first step towards a person-centered approach to schizophrenia.

But we should not lose sight of Estroff's critical look upon the particularly Western concept of *personhood.* The question remains how this *reawakening* of a sense of self develops. Partly it will be by executing activities, however trivial in the eyes of outsiders, like keeping turtles in a terrarium or a job as a doorman in a supported-housing project. In addition to that, people with schizophrenia will have to experience themselves again as a person: as a meaningful unity. Attention to their own peculiar meaning, their personal experience and life history, is a necessary condition for recovery wherein health and illness should no longer be regarded as opposites, but as a unity within that one unique person. The experience of oneself as a meaningful unity is never an individual matter; a person becomes his/her meaning in a specific culture. Therefore we need to take a closer look at the anthropological contribution to schizophrenia.

SCHIZOPHRENIA, CULTURE AND THE PERSON

Schizophrenia exists in 'all corners of the earth' (Lin & Kleinman, 1988, p. 555). We find patients with the symptoms of schizophrenia in Western and non-Western societies, in urban and rural areas, in small, isolated villages upon the mountains and in extremely isolated island societies. 'This mental illness is no myth' (Kleinman, 1991, p. 35). A still unexplained

finding however is the more favorable course and outcome of schizophrenia in developing countries compared to Western countries as demonstrated in several WHO studies of schizophrenia (Jablensky, Sartorius, Ernberg et al., 1992; Hopper & Wanderling, 2000; Hopper, 2004). Lin and Kleinman (1988, p. 563) even speak of this as 'the single most important finding of cultural differences in cross-cultural research on mental illness'.

Although we are not sure how this difference in outcome can be explained, social isolation is regarded as one of 'the few strong predictors of the outcome of schizophrenia' (Lin & Kleinman, 1988, p. 561). 'Most developing societies are "sociocentric" with an emphasis on social relations … that make isolation unusual even for the disabled. In contrast, Western societies are "egocentric". In these societies, relationships are more likely to be bilaterally defined … and subject to constant re-evaluation' (Lin & Kleinman, 1988, p. 561). For example, in India there are many more married people with schizophrenia compared to Western countries (Hopper, 2004). Marriage seems to be associated with good outcome. Most marriages in India are still arranged. The *institution* takes over the responsibility of the individual.

Findings like these cannot be translated easily in our Western society. It is not credible to 'prescribe' marriage as a remedy for an unfavorable course of schizophrenia. A prearranged marriage is at odds with our value of free will. But we cannot ignore the fact that the most vulnerable individuals in our society have trying times with the fierce competitiveness that forms the other side of personal freedom. In the way schizophrenia manifests itself through the individual in Western society, it is not only symptoms of the disease that are reflected but also the inherent values of modern times.

In research carried out in Montreal, Corin compared a group of men with schizophrenia who were regularly re-hospitalized with a group who had been without hospitalization for four years. 'Unexpectedly', she finds, 'that the group of non-rehospitalized patients is significantly characterized by features indicating a position "outside" of the social world' (Corin & Lauzon, 1992, p. 269). Both groups lived a marginal life. There were some contacts with relatives. Now and then they visit a friend. But the difference was that the more regularly hospitalized group felt excluded while people from the second group experienced the social distance as a positive thing.

This research teaches us to look at the meaning of symptoms in a different way. The so-called 'negative symptoms' express themselves in the form of a withdrawn and *apparently* flattened existence. We can regard these negative symptoms as a part of the disease, but we can see them also as an expression of how a vulnerable individual with a history of psychotic episodes relates to the world. In this way so-called negative symptoms are in fact a positive construction that enables a vulnerable individual to stand their own ground in Western society. Corin (1990, p. 172) speaks of a *positive withdrawal.* The prevention of relapse seems to be connected with keeping the world at an appropriate distance.

Each person has their own way of *being-in-the-world.* We all look for a meaningful relationship to the world. The kind of relation depends on who we are, the culture we are brought up in, and the world we are living in. The same goes for people with schizophrenia — apart from the fact that, at the beginning of their adult life, they suffered one and usually

more psychotic episodes that destroyed their original way of relating to the world. They are faced with the task of forming a new connection. Corin (1990, p. 182) speaks of *secondary relating elements*, building a new bridge to the world.

It is about very concrete matters, like visiting a friend now and then — frequenting small, anonymous restaurants (like MacDonalds), with superficial but recognizable contact with the waitress — doing little jobs — making preparations for a large project (which will never get off the ground) — reading for hours and hours in an etymological dictionary — trying to link up with a religious group. Corin claims that two trends are conspicuous in 'the positive withdrawal'. Firstly, 'withdrawal is described as enabling the person to find inner peace, to settle things with oneself; in solitude'. Second is the important role of religion: 'reference to a broadly defined religious frame borrowed from marginal religious groups allows them in someway to *inhabit* their private world, to protect and reinforce their withdrawal by giving it a positive value' (Corin, 1998, p. 139).

At first sight, living in the margins seems to be in contradiction with the lifestyle of Western culture. However, Corin (1990, p. 183) claims that this way of being-in-the-world reflects the most important values of our Western culture: autonomy and self-reliance. These people are too vulnerable to function autonomously in the usual way. In the absence of the social institutions of non-Western societies, where people with schizophrenia can find support, they have to find another way to keep at pace with the culture they are brought up in. By keeping the necessary distance from society, which they bridge over with these peculiar secondary relating elements, they can stand their ground in their own autonomous way.

In our Western society there is little room for difference. You are in or you are out. We strongly value freedom and self-realization, but subsequently they have to be realized in an equal manner. 'In such equalitarian treatment difference is disregarded, neglected, or subordinated and not "recognized"' (Dumont, 1986, p. 266). Apparently we are tolerant towards each individual, but as soon as the individual is leading a truly different life, as a person with a mental disorder, there are only two possibilities. You participate (after hospitalization) in a psychosocial rehabilitation program where you learn to recover according to the uniform values (a regular job, sufficient social contacts, compliance to treatment) or you are forced to live a marginal life. Being different is tolerated but not valued.

> Sheila had these peculiar psychotic episodes. Her eyes raised to the sky, she didn't want to eat, because she was filled with love from Hare Krishna. He gave her food. Her daily life was just the dark side of existence. She refused any medicine because it broke the connection with her godly partner. But in her own life she could hardly take care of her children. Once in a while she was involuntarily committed because of starvation. She was persuaded to take medication, but she complained that it disturbed her relation with the divine. She was reading many books about Hinduism and she wanted to live in a convent.

People with schizophrenia in Western society are more at risk of developing a chronic course. 'Industrialization, capitalism and the shift to different socioeconomic work conditions paralleled the creation of ever more individualistic and autonomous selves' (Fabrega, 1989,

p. 45). There is an *intensive individualism* (Lin & Kleinman, 1988) that 'may interfere with recovery for many schizophrenic patients' (Kirmayer, Corin & Jarvis, 2004, p. 213). The self is singled out in Western society. 'A consequence of this was a change in the appearance, interpretation and treatment of disease states like schizophrenia' (Fabrega, 1989, p. 45).

A psychotic experience questions the fundaments of self. People with schizophrenia are searching for more than a causal explanation of their illness (Corin, Thara & Padmavati, 2004). Problems are 'seen as a sign of something involving their fundamental identity, for example, a sense of a mission that might remain enigmatic, or a sign of their devotion to lord Shiva' (Kirmayer, Corin & Jarvis, 2004, p. 217). Cultures other than our Western culture and subcultures might provide 'meaning systems that allow people to positively reframe frightening or disturbing experiences' and to integrate these experiences in their lives (Kirmayer, Corin & Jarvis, 2004, p. 212).

Schizophrenia 'challenges fundamental notions of who and how we are' (Estroff et al., 1991, p. 332). A person-centered approach should reckon with two visions of schizophrenia. On the one hand there is the work of Davidson and Strauss, in which the person and the sense of self are considered crucial factors in the recovery from schizophrenia. This approach aims for an improvement in the sense of self for a person with schizophrenia. On the other hand there is the social and cultural anthropology which shows that an unfavorable course of schizophrenia might be connected with too much emphasis on the self-reliant person. A person-centered approach should look for ways to embed the self at risk in a larger whole, in a way that is acceptable for the person.

THE PERSON-CENTERED APPROACH AND SCHIZOPHRENIA

From the start, diagnosis was a matter of little account in client-centered therapy. Rogers (1951) spoke about the 'detrimental effects' of diagnosis that 'places the clinician in a god-like role' (p. 221) and that 'lead to a basic loss of confidence by the person himself' (p. 224). To be sure, Rogers spoke about psychological diagnosis — in contrast 'physical diagnosis is the *sine qua non* of treatment' (p. 219, original emphasis). The only rationale he offered for psychological diagnosis is that some therapists feel more secure in the relationship with the client (Rogers, 1957, p. 102).

By and large this opinion about diagnosis holds until today in person-centered therapy. Mearns (2003, p. 53) states that 'knowledge and theory about specific client groups is not a prerequisite for person-centered work with clients from those groups' although, 'it can considerably aid the counsellor's understanding of the client experience'. This last nuance is often to be found with contemporary person-centered authors. Lambers (2003, p. 116) emphasizes that 'working with deeply disturbed clients requires skill, depth, a certain amount of knowledge and understanding as well as acceptance of limitations'. Berghofer (1996) remarks that 'a diagnosis emerges as by itself, especially when the therapist deals with schizophrenic patients' (p. 484) and further on that 'a diagnosis leads *towards* the person and not away from him' (p. 491). Sommerbeck (2003, p. 3) states that 'psychiatric diagnoses are

not an issue for the client-centred therapist'; in psychiatric contexts, however, there are 'some rather characteristic features and difficulties for the therapist, which are related to the psychiatric diagnosis [*sic*] of the client'. This is a remarkable kind of duality, which Sommerbeck (2003, 2005) calls *complementarity* — that enables her to work as a client-centered therapist within psychiatry.

Another ardent opponent of diagnosis in client-centered therapy is Sanders (2005), who says with Shlien that diagnosis is 'not good, not even neutral, but bad' (p. 34). Client-centered therapists working with diagnosis are compared with lambs waiting in the lion's den (the medical model) to be served as breakfast. There is some accommodation with authors like Margaret Warner who, Sanders says, 'presents an alternative psychopathology … based on client-centred and experiential theory' (p. 36). But even then Sanders criticizes that 'Warner's position is founded on the pragmatism of compromise and revision' (p. 36). Warner (2005) describes three kinds of difficult process: fragile process, dissociated process and psychotic process, which indeed can be read as a client-centered/experiential translation of conventional psychopathology.

Rogers had some tough experiences with counseling and schizophrenia. From 1949 to 1951 Rogers had a young woman with schizophrenia in therapy. After a good start, this woman came to see Rogers a lot. Things got out of hand. The therapy wasn't working anymore, but he obviously didn't know how to finish it. She was often psychotic and Rogers was brought to the edge of being psychotic himself. At last he handed her over to a young psychiatrist and immediately took a leave for two or three months (Kirschenbaum, 1980, pp. 191–192). When he came back, Rogers went into therapy, which came to be a turning point in his life (Rogers & Russell, 2002, pp. 164–165).

At the University of Wisconsin (1957–1963) he was leading the Mendota State Hospital Study. It was an ambitious project, aimed at studying the effect of client-centered therapy with people with schizophrenia. The result was disappointing: there was no significant difference between the treatment group and the control group (Rogers, 1967b, p. 80). One of the problems in therapy with people with schizophrenia appears to be that, 'regardless of the degree of understanding, acceptance, and genuineness offered by the therapist, schizophrenic patients tended to perceive a relatively low level of these conditions as existing in the relationship, and only slowly over therapy did they perceive somewhat more of these therapist attitudes' (p. 75). The most striking features in the therapy process with people with schizophrenia were 'the lack of self-exploration' (p. 76) and the reservations about becoming involved in their own experiencing (p. 79).

Looking back, Rogers (Rogers & Russell, 2002, p. 175) stated that the project was very ambitious, maybe too ambitious, 'we were going to do research to end all research'. The interpersonal qualities of the staff could have been better. Another important impediment in this project stated by Rogers was that 'most of the group had not worked with a schizophrenic individual, so we would have done better, had we spent a year or two working with schizophrenics without any attempt to do research' (Rogers & Russell, 2002, p. 175).

In the past, client-centered therapy followed the so-called *disordered-person* model (Davidson & Strauss, 1995) in its approach to schizophrenia. In the disordered-person model

one 'focuses on how the lives of persons with disorders are different from the lives of healthy individuals, viewing this difference usually in psychological terms' (1995, p. 45). In the earlier mentioned *disorder* model the illness is an entity in itself. A (medical) diagnosis is crucial in the treatment of the person. This is a remarkable thing in the client-centered approach to schizophrenia: by trying not to use a (medical) diagnosis for people labelled with a severe mental disorder, the person themselves is described as disturbed. In the end the person receives a dubious psychological diagnosis because one is reluctant to give a medical diagnosis.

Rogers describes a psychosis in psychodynamic terms, 'acute psychotic behaviors appear often to be describable as behaviors which are consistent with the denied aspects of experience rather than consistent with the self' (Rogers, 1959, p. 230). Teusch (1990, p. 637) starts his paper on client-centered therapy with schizophrenic patients as follows: 'a fundamental aspect of schizophrenic disorders is a deep disturbance in the relationship with other human beings. Schizophrenic patients withdraw in an autistic way to a poor or to a bizarre and strange inner world'. Gendlin (1966, p. 12, original emphasis) states, '*it is not so much what is there, as what is not there*'. The interactive, experiential process is lacking, stuck, deadened in old hurt stoppages, and in disconnection from the world. Rogers continues, (1967d, p. 185) 'our schizophrenic individuals tend to fend off a relationship'. Finally Binder (1998, p. 220) states that 'a core problem for psychotic persons is the fact that they have not developed adequate discrimination in the understanding dimension'.

With respect to these statements about people suffering from schizophrenia, I can only conclude that in person-centered therapists there is clearly a considerable lack of (unprejudiced) *Verstehen* (understanding) of the person with schizophrenia and that this lack is filled up with all sorts of *Erklärungen* (explanations). The characteristics ascribed to people with schizophrenia are highly hypothetical and do not justify the earlier-pictured image of people with schizophrenia who are trying their best to hold their own ground in our society given their illness. *Erklärungen* are unlimited but *Verstehen* is bounded (Jaspers, 1973, p. 253). There is so much uncertainty concerning schizophrenia that we really need to be reserved in our explanations of it. This reserve is a fundamental attitude of phenomenological philosophy.

A special case is the work of Prouty (1976, 1994; Prouty, Pörtner & Van Werde, 1998). A lot of contemporary client-centered therapists find Prouty's Pre-Therapy very helpful in their work with psychotic persons (Sommerbeck, 2003; Warner, 2002, 2005; Van Werde, 1998, 2005; Prouty, Pörtner & Van Werde, 1998). Prouty grew up in very difficult circumstances, with a mentally retarded brother and a mother who had psychotic experiences. He struggled to gain his education, during the course of which he was taught by Eugene Gendlin, who touched his creative therapeutic soul in a personal way enabling him to develop his own therapeutic approach at clinics and hospitals dealing with psychotic and retarded clients. In 1966 Pre-Therapy was born in a sheltered workshop, where Prouty did counseling with mentally retarded and schizophrenic persons (Prouty, Pörtner & Van Werde, 1998, pp. 3–8). Prouty states that Rogers' first condition of psychological contact is insufficiently met in therapeutic relationships with clients with schizophrenia. 'Unfortunately, Rogers provides no theoretical definition of psychological contact' or 'any technique for restoring psychological

contact if it is impaired' (Prouty, 1994, p. 26). Prouty (1994) claims that mentally retarded and schizophrenic persons live in a state of *existential autism,* their existence has become a 'void of significance' (p. 34). In Pre-Therapy there is, with the help of *contact reflections*, 'empathic responses that are very concrete and close to the clients' actual words and facial and body gestures' (Warner, 2005, p. 97), a 'movement of consciousness from existential autism to existential contact' (Prouty, 1994, p. 34).

Although it is a very good thing that client-centered therapists, through the work of Prouty, are invited to work with clients with schizophrenia, I have to make some critical remarks. First of all, I find it remarkable that Prouty in his publications nearly always puts the retarded and schizophrenic patients together. People with schizophrenia have to deal with a lot of stigma, one of them that they are mentally underdeveloped; I think it is important to acknowledge the distinctive nature of their illness. Secondly, I do not experience this 'void of significance' in persons with schizophrenia (neither in mentally handicapped persons); on the contrary psychotic persons have often to deal with an overload of meanings which makes their experiential process so complicated. Again, persons with schizophrenia are saddled with a very dubious psychological diagnosis. To be sure Prouty has done invaluable work with a complicated group of persons who suffered mental retardation *and* a psychotic disorder or who were severely regressed, but that is a very small sample of the people with schizophrenia and not at all representative for this group as a whole. Unlike Prouty (2002, p. 596) I do not think that the 'modestly supportive [findings] of Rogers' view' are 'limited to the higher end of the psychotic continuum' and that for 'the more chronic regressed populations' Pre-Therapy is more fitted. When we read the sessions of Sommerbeck (2005), Van Werde (2005) and Warner (2002) with persons with schizophrenia, we find them engaged in a rather normal person-centered conversation under the circumstances that the clients are dealing with a 'psychotic style of processing' (Warner, 2005). I agree with Warner (2002) that it is possible to 'operate within Rogers' core conditions' in conversations with psychotic persons and that these conversations 'are genuine therapy rather than a precursor to some more 'real' kind of client-centered therapy' (p. 464).

When we are willing to acknowledge schizophrenia as an illness that justifies a medical diagnosis, then there is no need for all kinds of dubious psychological diagnosis and explanations. Persons with schizophrenia are afflicted by a severe illness. This illness has a profound influence on the way they relate to themselves and the world. We need to recognize this influence of the illness on the person. Then we can see right through the paranoid thoughts, the delusions, the disorganized speech and incoherent thinking, that there is always a longing for contact and an acknowledgement of the other person. Because of their illness this contact is at risk. But even in the worst psychotic episodes there is the possibility of contact and acknowledgement and even care for the other.

> We had agreed to change his medication because his life was completely controlled by orders from the secret service. He had to dry his cutlery 30 times and was not allowed to watch television anymore. During the medication change he became even more psychotic. He was isolated. He no longer trusted anyone. Secret service people

> were on the ward and came to execute him. His mother had poisoned the oranges that she had brought him. I visited him in his room. There was dangerous, radioactive radiation everywhere. Even his clothes gave off radiation. After five minutes he said to me: 'You'd better leave, it is far too dangerous for you to be here.'

CONCLUSION

With respect to a person-centered approach to schizophrenia I call for an acknowledgement of the illness. Instead of burdening a person with a psychological diagnosis — a presupposed incongruence between self and experience or an 'autistic' way of relating to the world, we would do better to give the person a proper medical diagnosis. Discussion is possible on whether the diagnosis of schizophrenia reflects adequately the disease process it is supposed to describe. But there can be no doubt that there is such a thing as mental illness that influences a person's functioning much more than can be understood in psychological terms.

The person-centered approach has been developed in an optimistic era, the 'high time' of the 'so-called humanistic position' (Schmid, 2003, p. 111). This resulted in a neglect of the *conditio humana*, 'the partial lack of freedom, physical illness, transience, suffering and grief' (Schmid, 2003, p. 111). Only when we are willing to give the illness its proper place in persons with schizophrenia, will we be able to see the interrelatedness between illness and person. We have to leave behind the current metaphor in present-day psychiatry where the person is fighting the disease. In case of severe mental illness the person cannot be separated from the illness.

A person-centered approach to schizophrenia can learn a lot from the work of Davidson and Strauss (1992, 1995) who regard the person as the crucial factor in the process of recovery. But there is more to learn. Anthropological research into the nature of schizophrenia has resulted in findings that concern the heart of the person-centered approach. The independent, self-reliant person is not synonymous with a healthy human being as once was taught in the humanistic tradition. With respect to vulnerable individuals, which is what persons with a mental illness are, the relational side of persons must be emphasized. In the egocentric settings of Western society 'even those without significant disability may find themselves isolated, alienated and alone' (Lin & Kleinman, 1988, p. 561). There is much to be said for the *dialogic position* that Schmid (2003) regards as essential for the person-centered approach.

People with schizophrenia are not at odds with the society in which they live, as once was thought. Like any other person in a given society, they try to live a life that embodies the values of the culture in which they are raised. Facing the difficulties persons with schizophrenia have to endure in our society, we can question the evidence of values such as independence, self-reliance and autonomous functioning.

The long-term course of schizophrenia seems to be influenced favorably in 'a context of stable and unlimited continuity of care' (McGlashan, 1988, p. 538). Therefore a person-centered approach to schizophrenia requires a long-term care. 'The most important element in psychotherapy with schizophrenic patients is the active establishment and maintenance of

a reliable interpersonal relationship for an extended period of time' (Berghofer, 1996, p. 492). Furthermore, this care must take place in a context other than the weekly appointment with the therapist. 'The therapeutic context is a crucial variable in work with the psychotic client' (Lambers, 2003, p. 115). Berghofer (1996) made daily visits to the apartments of her patients. There is still little variety in supported housing projects for people with a severe mental disorder. Either clients are forced to live in a group or they are living independently in an isolated context. 'Unfortunately, in our culture there is little variety of holding environments on offer beyond hospitals' (Lambers, 2003, p. 115).

Within the contemporary person-centered approach there are openings for the care of people with schizophrenia. I would not prefer a person-centered approach parallel to conventional treatment as Sommerbeck (2003) proposes with her dualistic approach or *complementarity principle*. Discussion about diagnosis, contact with relatives, the prescription of medicines, hospitalization (involuntary or not), nursing and care in a supportive environment, all are important elements in the treatment of people with schizophrenia. It is not because the patient is prescribed medication or is committed to a hospital involuntarily that the approach cannot be person-centered. I hope to have demonstrated in the foregoing that within regular psychiatry there are enough openings to be found for a person-centered approach. In the person-centered literature there is invariably a mentioning of the 'medical model'. This might be useful to carry on a controversy with present-day psychiatry but it is not a good starting point to open up a dialogue. The current diverse thinking in psychiatry cannot be reduced to one 'medical model'.

The person-centered approach can do invaluable work in psychiatry, by establishing a personal relationship with the client, in which the client can find a valued self — not the old self, before the outburst of the illness, but a new self — as a person with a severe mental illness *and* as a person who can recover from this illness with a new perspective on life.

REFERENCES

Berghofer, G. (1996). Dealing with schizophrenia — a person-centered approach providing care to long-term patients in a supported residential service in Vienna. In R. Hutterer, G. Pawlowsky, P. F. Schmid & R. Stipsits (Eds.), *Client-centered and experiential psychotherapy: A paradigm in motion* (pp. 481–493). Frankfurt am Main: Peter Lang.

Binder, U. (1998). Empathy and empathy development with psychotic clients. In B. Thorne & E. Lambers (Eds.), *Person-centred therapy: A European perspective* (pp. 216–230). London: Sage.

Binder, U. & Binder, J. (1991). *Studien zu einer störungsspezifischen klientenzentrierten Psychotherapie —— schizophrene Ordung, psychosomatisches Erleben, depressives Leiden*. Eschborn: Dietmar Klotz.

Birchwood, M. (2000). The critical period for early intervention. In M. Birchwood, D. Fowler & C. Jackson (Eds.), *Early intervention in psychosis* (pp. 28–63). Chichester: Wiley.

Blankenburg, W. (1980). Phenomenology and psychopathology. *Journal of Phenomenological Psychology, 11*, 50–78.

Bleuer, E. (1908). Die Prognose der Dementia praecox (Schizophreniegruppe). *Allgemeine Zeitschrift für Psychiatrie, 65*, 436–464.

Bleuer, M. (1972). *Die schizophrenen Geistesstörungen im Lichte langjähriger Kranken- und Familiengeschichten*. Stuttgart: Thieme.

Bleuer, M. (1978). *The schizophrenic disorders: Long term patient and family studies* (S. Clement translator). New Haven: Yale University Press.

Carpenter, W. T., Strauss, J. S. & Bartko, J. J. (1981). Beyond diagnosis: The phenomenology of schizophrenia. *The American Journal of Psychiatry, 138*, 948–953.

Ciompi, L. & Müller, C. (1976). *Lebensweg und Alter der Schizophrenen Eine katamnestische Langzeitstudie bis ins Senium*. Berlin – Heidelberg – New York: Springer.

Corin, E. (1990). Facts and meaning in psychiatry. An anthropological approach to the lifeworld of schizophrenics. *Culture, Medicine and Psychiatry, 14*, 153–188.

Corin, E. (1998). The thickness of being: Intentional worlds, strategies of identity and experience among schizophrenics. *Psychiatry, 61*, 133–146.

Corin, E. & Lauzon, G. (1992). Positive withdrawal and the quest for meaning: The reconstruction of experience among schizophrenics. *Psychiatry, 55*, 266–278.

Corin, E., Thara, R. & Padmavati, R. (2004). Living through a staggering world: The play of signifiers in early psychosis in South India. In J. Jenkins & R. Barrett (Eds.), *Schizophrenia, culture and subjectivity* (pp. 110–145). Cambridge: Cambridge University Press.

Davidson, L. & Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology, 65*, 131–145.

Davidson, L. & Strauss, J. S. (1995). Beyond the biopsychosocial model: Integrating disorder, health and recovery. *Psychiatry, 58*, 44–55.

Dumont, L. (1986). *Essays on individualism: Modern ideology in anthropological perspective*. Chicago: University of Chicago Press.

Estroff, S. E. (1989). Self, identity, and subjective experience of schizophrenia: In search of the subject. *Schizophrenia Bulletin 15*, 189–196.

Estroff, S. E. (1995). Brokenhearted lifetimes: Ethnography, subjectivity and psychosocial rehabilitation. *International Journal of Mental Health Care, 24*, 82–92.

Estroff, S. E., Lachicotte, W. S., Illingworth, L. C. & Johnston, A. (1991). Everybody's got a little mental illness: Accounts of illness and self among persons with severe, persistent mental illness. *Medical Anthropology Quarterly*, (new series) *5*, 331–369.

Fabrega, H. J. (1989). On the significance of an anthropological approach to schizophrenia. *Psychiatry, 52*, 45– 65.

Gendlin, E. (1966). Research in psychotherapy with schizophrenic patients and the nature of that 'illness.' *American Journal of Psychotherapy, 20*, 4–16.

Greenberg, L.S., Elliott, R. & Lietaer, G. (1994). Research on experiential psychotherapies. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 509–539). New York: John Wiley.

Harding, C. M., Brooks, G. W. Ashikaga, T., Strauss, J. S. & Breier A. (1987a). The Vermont longitudinal study of persons with severe mental illness: I. Methodology, study, sample, and overall status 32 years later. *American Journal of Psychiatry, 144*, 718–726.

Harding, C. M., Brooks, G. W. Ashikaga, T., Strauss, J. S. & Breier A. (1987b). The Vermont longitudinal study of persons with severe mental illness: II. Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. *American Journal of Psychiatry, 144*, 727–735.

Hell, D. (2001). Eugen Bleuers Herkunft, Kindheit und Jugend — Hintergrund für seine Lehre. In

D. Hell, Ch. Scharfetter & A. Möller (Eds.), *Eugen Beuler — Leben und Werk* (pp. 19–27). Bern: Hans Huber.

Hopper, K. (2004). Interrogating the meaning of 'culture' in the WHO international studies of schizophrenia. In J. Jenkins & R. Barrett (Eds.), *Schizophrenia, culture and subjectivity* (pp. 62–86). Cambridge: Cambridge University Press.

Hopper, K. & Wanderling, J. (2000). Revisiting the developed versus developing country distinction in course and outcome in schizophrenia. *Schizophrenia Bulletin, 26*, 835–846.

Huber, G., Gross, G. & Schüttler, R. (1979). *Schizophrenie. Verlaufs- und sozialpsychiatrische Langzeituntersuchungen an den 1945–1959 in Bonn hospitalisierten schizophrenen Kranken.* Heidelberg – New York: Springer.

Huber, G,. Gross, G., Schüttler, R. & Linz, M. (1980). Longitudinal studies of schizophrenic patients. *Schizophrenia Bulletin, 6*, 592–605.

Jablensky, A., Sartorius, N., Ernberg, G., Anker, M., Korten, A., Cooper, J. E., Day, R. & Bertelsen, A. (1992). Schizophrenia: Manifestations, incidence and course in different cultures. A World Health Organisation ten-country study. *Psychological Medicine, Monograph Supplement 20.*

Jaspers, K. (1912a). Die phänomenologische Forschungsrichtung in der Psychopathologie. *Z. Neur. u. Psych 9*, 391–408.

Jaspers, K. (1912b). Kausale und ‚verständliche' Zusammenhänge zwischen Schicksal und Psychose bei der Dementia praecox (Schizophrenie). *Z. Neur. u. Psych. 14*, 158–263.

Jaspers, K. (1969). The phenomenological approach in psychopathology. *British Journal of Psychiatry, 114*, 1313–1323.

Jaspers, K. (1973). *Allgemeine Psychopathologie.* Berlin: Springer. (First edition: 1913.)

Jaspers, K. (1974). Causal and meaningful connexions between life history and psychosis. In S.R. Hirsch & M. Shepherd (Eds.), *Themes and variations in European psychiatry* (pp. 81–93). Bristol: John Wright and Sons Ltd.

Jaspers, K. (1997). *General psychopathology. Vol. I and Vol. II.* Translated by J. Hoenig & M. H. Hamilton; with a new foreword by P. R. McHugh. Baltimore: Johns Hopkins University Press.

Kirmayer, L. J., Corin, E. & Jarvis, G. E. (2004). Inside knowledge: cultural constructions of insight in psychosis. In X. Amador & A. David (Eds.), *Insight and psychosis* (pp. 197–229). Oxford: Oxford University Press.

Kirschenbaum, H (1980). *On becoming Carl Rogers.* New York: Delta.

Kleinman, A. (1991). *Rethinking psychiatry.* New York: Free Press.

Kleinman, A. & Kleinman, J. (1991). Suffering and its professional transformation: Toward an ethnography of interpersonal experience. *Culture, Medicine & Psychiatry, 15*, 275–301.

Kraepelin, E. (1999). *Psychiatrie. Ein Lehrbuch für Studirende und Aerzte, I. Band und II. Band.* Sechste Auflage, 1899. Nijmegen: Arts & Boeve.

Kua, J., Wong, K. E., Kua, E. H. & Tsoi, W. F. (2003). A 20-year follow-up study on schizophrenia in Singapore. *Acta Psychiatrica Scandinavica, 108*, 118–125.

Kusters, W. (2004). *Pure waanzin.* Amsterdam: Nieuwezijds.

Lambers, E. (2003). Psychosis. In D. Mearns *Developing person-centred counselling* (pp. 113–116). London: Sage.

Lin, K.-M. & Kleinman, A. (1988). Psychopathology and clinical course of schizophrenia: A cross-cultural perspective. *Schizophrenia Bulletin, 14*, 555–567.

McGlashan, T. H. (1988). A selective review of North American long-term follow-up studies of

schizophrenia. *Schizophrenia Bulletin, 14*, 515–542.

McGrath, J. J. (2005). Myths and plain truths about schizophrenia epidemiology — The NAPE lecture 2004. *Acta Psychiatrica Scandinavica 2005, 111*, 4–11.

Mearns, D. (2003). *Developing person-centred counselling.* London: Sage.

Prouty, G. F. (1976). Pre-Therapy, a method of treating pre-expressive psychotic and retarded patients. *Psychotherapy: Theory, Research and Practice, 13*, 290–295.

Prouty, G. (1994). *Theoretical evolutions in person-centered/experiential psychotherapy: Applications to schizophrenic and retarded psychoses.* Westport, CT: Praeger.

Prouty, G. (2002). Humanistic psychotherapy for people with schizophrenia. In D. Cain & J. Seeman (Eds.), *Humanistic psychotherapies. Handbook of research and practice* (pp. 579–601). Washington: American Psychological Association.

Prouty, G., Pörtner, M. & Van Werde, D. (1998). *Prä-Therapie.* Stuttgart: Klett-Cota. (English edition: *Pre-Therapy — Reaching contact-impaired clients.* Ross-on-Wye: PCCS Books, 2002.)

Rasmussen, J. (2001). De betekenis van het lijden in de psychiatrie. *Maandblad Geestelijke volksgezondheid, 56*, 833–841.

Robinson, D., Woerner, M., Alvir, J., Bilder, R. et al. (1999). Predictors of relapse following response from a first episode of schizophrenia. *Archives of General Psychiatry, 56*, 241–247.

Rogers, C. (1951). *Client-centered therapy.* Boston: Houghton Mifflin.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95–103.

Rogers, C. (1959). A theory of therapy, personality, and interpersonal relationship as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of science. Vol. 3, Formulations of the person and the social context* (pp. 184–256). New York: McGraw-Hill.

Rogers, C. (Ed.) (1967a). *The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics.* Madison: University of Wisconsin Press.

Rogers, C. (1967b). The findings in brief. In C. Rogers (Ed.), *The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics* (pp. 73–93). Madison: University of Wisconsin Press.

Rogers, C. (1967c). Introduction. In C. Rogers (Ed.), *The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics* (pp. xv–xix). Madison: University of Wisconsin Press.

Rogers, C. (1967d). Some learnings from a study of psychotherapy with schizophrenics. In C. Rogers & B. Stevens, *Person to person: The problem of being human* (pp. 181–192). Moab, UT: Real People Press.

Rogers, C. & Russell, D. (2002). *Carl Rogers: The quiet revolutionary.* Roseville: Penmarin Books.

Sanders, P. (2005). Principled and strategic opposition to the medicalisation of distress and all of its apparatus. In S. Joseph & R. Worsley (Eds.), *Person-centred psychopathology* (pp. 21–42). Ross-on-Wye: PCCS Books.

Schmid, P. (2003). The characteristics of a person-centered approach to therapy and counseling: Criteria for identity and coherence. *Person-Centered and Experiential Psychotherapies, 2*, 104–120.

Shepherd, M., Watt, D., Falloon, I. & Smeeton, N. (1989). The natural history of schizophrenia: A five-year follow-up in a representative sample of schizophrenics. *Psychological Medicine, Monograph Supplement 15.*

Shorter, E. (1997). *A history of psychiatry.* New York: John Wiley.

Sommerbeck, L. (2003). *The client-centred therapist in psychiatric contexts: A therapists' guide to the*

psychiatric landscape and its inhabitants. Ross-on-Wye: PCCS Books.

Sommerbeck, L. (2005). The complementarity between client-centred therapy and psychiatry: The theory and the practice. In S. Joseph & R. Worsley (Eds.), *Person-centred psychopathology* (pp. 110–127). Ross-on-Wye: PCCS Books.

Strauss, J. S. (2005). Diagnosis and reality: A noun is a terrible thing to waste. *Psychopathology, 38*, 189–191.

Teusch, L. (1990). Positive effects and limitations of client-centered therapy with schizophrenic patients. In G. Lietaer, J. Rombauts & R. Van Balen (Eds.), *Client-centered and experiential psychotherapy in the nineties* (pp. 637–644). Leuven: Leuven University Press.

Trotha, T. von, (1995). Über die Unmöglichkeit, eine 'Psychose' zu erfahren. In T. Bock, D. Buck, J. Gross, E. Mass, E. Sorel & E. Wolpert (Eds.), *Abschied von Babylon* (pp. 183–187). Bonn: Psychiatrie-Verlag.

Van Werde, D. (1998). Anchorage as a core concept in working with psychotic people. In B. Thorne & E. Lambers (Eds.), *Person-centred therapy: A European perspective* (pp. 195–205). London: Sage.

Van Werde, D. (2005). Facing psychotic functioning: Person-centred contact work in residential psychiatric care. In S. Joseph & R. Worsley (Eds.), *Person-centred psychopathology* (pp. 158–168). Ross-on-Wye: PCCS Books.

Vlaminck, P. (2002). De 'schizofrenie' ontmanteld. *Maandblad Geestelijke volksgezondheid, 57*, 342–363.

Warner, M. (2002). Luke's Dilemmas: A client-centered/experiential model of processing with a schizophrenic thought disorder. In J. Watson, R. Goldman, & M. Warner (Eds.), *Client-centered and experiential psychotherapy in the 21st century* (pp. 459–472). Ross-on-Wye: PCCS Books.

Warner, M. (2005). A person-centred view of human nature, wellness, and psychopathology. In S. Joseph & R. Worsley (Eds.), *Person-centred psychopathology* (pp. 91–109). Ross-on-Wye: PCCS Books.