Person-centredness: Conceptual and historical perspectives

ALAIN LEPLEGÉ¹, FABRICE GZILI², MICHELE CAMMELLI¹, CELINE LEFEVE¹, BERNARD PACHAUD³ & ISABELLE VILLE⁴

¹REHSEIS (UMR 7596, CNRS-U. Paris7) and Université Paris Diderot - Paris7, Paris, ²IHPST (UMR 8590, CNRS-U. Paris1) and Université Paris Diderot-Paris7, Paris, ³CREA, Centre de recherches en épistémologie appliquée, École Polytechnique and Université Paris Diderot-Paris7, Paris, and ⁴CERMES, Centre de recherche médecine, science, santé et société (CNRS UMR 8169 - EHESS - INSERM U750), Villejuif, France

Abstract

Purpose. The definition and aims of rehabilitation are both topics of frequent debate. Recently several authors have suggested defining rehabilitation and its goals in terms of ‘person-centredness’. However such attempts to define rehabilitation in this way have not occurred without running into their own difficulties and criticisms. Consequently, one may question whether person-centredness is a good candidate to characterize and define rehabilitation. The purpose of this article is to reflect upon the historical background and conceptual underpinnings of this term and their relevance for understanding contemporary person-centred rehabilitation.

Method. We conducted a conceptual and historical analysis of the notion of person-centredness in relation to rehabilitation. We ask first whether person-centredness has a consistent and fixed definition and meaning? Secondly, where does person-centredness come from, what is its conceptual history and does an historical approach enable us to identify a unique source for person-centredness?

Results. In the context of rehabilitation, we have identified four main understandings or interpretations of the term person-centredness, each of which denotes several ideas that can be, in turn, interpreted in quite different ways. Thus the concept of person-centredness in rehabilitation has multiple meanings. The conceptual history indicates that person-centredness has diverse meanings and that it has been used in a variety of contexts somewhat unrelated to disability and rehabilitation. Moreover, there does not seem to be any strict relationship between person-centredness as it is used in the context of rehabilitation and these prior uses and meanings.

Conclusion. Person-centredness has an ancient pedigree, but its application in the field of rehabilitation raises both practical and theoretical difficulties. It may be that rehabilitation might get a better sense of what it should be and should do by focusing less on the rhetoric of person-centredness and by putting more emphasis on the investigation and operationalization of its key conceptual components.

Keywords: Person-centred, disability models, rehabilitation, ICF, concepts

Introduction

Person-centredness seems to be a widely-used and somewhat fashionable topic lately, whether it is being used in the corporate world (client-centredness), in public services (user-centredness), or generally in hospitals and health settings (patient-centredness). Why is it a particularly important issue in the area of rehabilitation? Why are rehabilitation specialists so interested in person-centredness? Why do they want to know what it means and where it comes from?

For professional caregivers, rehabilitation has been almost but not quite a synonym for re-adaptation or re-education. As for person-centredness, they have found it to be a leitmotiv in official recommendations although it may have seemed that the more this injunction was repeated, the less clear its meaning...
became… and the less ‘person-centred’ the interventions were. Let us take as one example Clare’s definition of rehabilitation:

Cognitive rehabilitation is an individualized approach to helping people with cognitive impairments in which those affected, and their families, work together with health care professionals to identify personally-relevant goals and devise strategies for addressing these. This emphasis is not on enhancing performance on cognitive tasks as such, but on improving functioning in the everyday context. [...] Cognitive rehabilitation interventions aim to tackle directly those difficulties considered more relevant by the person with dementia and his or her family members or supporters, and target everyday situations in the real-life context, since there is no implicit assumption that changes instituted in one setting would necessarily generalize to another. Goals for intervention are selected collaboratively, and interventions are usually conducted on an individual basis. This approach is likely to be accompanied by provisions of information aimed at facilitating an understanding of cognitive strengths and difficulties and by supportive discussion relating to the individual emotional reactions or other needs, and where appropriate links are made with other possible sources of support. Elements of cognitive rehabilitation have also been incorporated in broader psychosocial early intervention programs [1, pp. 2–3].

This quote summarizes in both a clear and succinct way the concept of person-centredness. It also illustrates quite clearly the ambiguity of the concept of person-centredness, with the person being alternately the object and the agent of the action. It also suggests some kind of identity between rehabilitation and person-centredness – or at least that rehabilitation should evolve in the direction of increased person-centredness. This tends to suggest that, eventually, the degree of person-centredness would allow one to distinguish rehabilitation from its ‘false friends’ re-education and re-adaptation. As a matter of fact in the Clare et al. review article, it was the concept of person-centredness [1] that made it possible to distinguish cognitive rehabilitation from cognitive training. From this perspective, since person-centredness seems a central concept of rehabilitation, it is only natural that researchers and practitioners in the field should be willing to understand the problems, opportunities and contexts related to person-centredness in rehabilitation.

In this article we attempt a conceptual and historical analysis of person-centredness. In the first section, we will consider what exactly the term means, and whether it possesses a specific meaning. In the second section, we will examine the origins of person-centredness and determine how far its genealogy can be traced back. Finally, we will consider whether the notion of person-centredness is a good criterion to specify or define rehabilitation. More specifically, we will ask whether rehabilitation could do just as well without it.

Conceptual analysis

In this section, we conduct a conceptual analysis of the notion of person-centredness within the area of rehabilitation. By conceptual analysis we do not mean a semantic analysis. Rather, our goal is to unpack the conceptual extensions of this notion beyond the various terms which have been used to express it and the variety of speakers who have used them.

To express the idea of person-centredness, a variety of terms have been used interchangeably (patient-, client-, person-, individual-/centre, -oriented, -focused, -directed). Various studies have documented what professionals, institutions, disabled persons, families and ‘experts’ (e.g., disability sociologist) mean by the term person-centred rehabilitation (see for example [2]). Our goal here is to make as exhaustive an inventory as possible of the various meanings attached to this notion. An extensive search within the relevant literature shows that not only is the term given diverse meanings, it relates to at least four major ideas or dimensions, each one of which can be specified in several ways. As we shall see, this variety of meanings entails some unresolved tensions and even contradictions. On the surface the concept of person-centredness seems unequivocal, lexically speaking, but it is in fact quite equivocal as soon as one attempts to use it as a comprehensive and unified concept. These four different conceptual pictures are each explored below.

(a) Person-centredness means addressing the person’s specific and holistic properties

The first portrayal of person-centredness is that an individualized and holistic approach (biological-psychological-social) must be adopted. In this normative sense, it is opposed to the classical analytic medical focus on specific organs or functions and prescribes what one must or should do instead.

This first approach nominates that individuals are unique and different from one another. Therefore, one should understand the uniqueness of people as opposed to: (i) The assumption that all people with one kind of disability will automatically have similar needs, and therefore benefit from the same type of interventions, and (ii) prejudging outcome on the basis of the diagnosis alone. To the contrary, the same medical labels (diagnosis, symptom) are often attached to quite different situations. For example, brain injury is not going to be the same for every
person. Its effects and implications will vary according to the severity of injury, the standard of medical care at the time and following injury, the person’s premorbid cognitive abilities and level of functioning, the age at which the injury occurs, the person’s available social support, and so on. Consequently an individual assessment of each patient is needed. A person-centred approach is an individualized, tailored approach and not a routine or standardized group approach. Since there is also some intra-individual variability, and because a person’s needs and strengths can evolve, it is necessary to have some flexibility and the capacity to adjust to their changing needs rather than a systemic adherence to a rigid policy. In that sense, person-centredness means: to tailor interventions for specific individual and evolving needs versus ‘one size fits all’ programs [2, p. 1419].

Another aspect of this approach is that disabilities have an impact on people’s lives and identities. Thus, one should see disability through the person’s eyes, recognise emotional needs and concerns, and learn how to manage and deal with the emotional challenges related to a chronic condition. Furthermore, people with impairment do not all react to their impairment or to interventions in the same way. For instance, ‘even if two people with dementia are both thought to be showing agitation because of a high level of internal arousal, what helps one may be quite different from what helps the other. One person’s relaxing and warming hand-massage may be another’s invasion of personal space and confinement’ [3, p. 279]. Thus, one should listen to the person with empathy, pay attention to the person’s thoughts and enter into the person’s world. Finally, diseases should not be reduced to just their more visible symptoms. For example, in the case of dementia associated with Alzheimer’s disease, the subject not only requires treatment for cognitive decline but also for anxiety and depression, which means that interventions should target both cognition and emotion. In that sense, person-centredness means that the individual’s subjective experience, personal history and emotions should all be taken into account (versus relying solely on objective data).

Lastly: Individuals are social beings. Therefore, the entire context of the rehabilitation process and the person’s unique environment must be taken into account: so it is important then to register the interdependence between the person and his or her friends and family, to understand the importance of peer support, to provide family members with emotional support, to give them information about the client’s condition and treatment, to offer ongoing help with care giving; and to involve families in goal setting and decision-making [2, p. 1420]. Furthermore, ‘problems and solutions are embedded in a cultural and political context’, e.g., inaccessible public buildings which impede cultural activities, education and employment [4, p. 1003]. These non-medical aspects of disability should be acknowledged and acted on. In that sense, person-centredness means: to adopt an ecological view as opposed to the more focused point of view of a clinical caregiver (see also Siegert et al. [5] in this issue).

(b) Person-centredness means addressing the person’s difficulties in everyday life

Disabilities often imply a negative impact on daily tasks and some disadvantages encountered in various life situations. A goal of rehabilitation is arguably helping prepare people with impairment for community living (versus living in a hospital), e.g., learning how to ask for help and interact with others in order to survive within the community. Furthermore, it may be that there is a greater need for more practical support than for ‘technical’ interventions. For instance, going to school or having a job, which both require regular attendance, may mean someone requires considerable help with personal hygiene, dressing and eating, in order to reduce the time taken for those activities and to preserve their energy for other demanding activities [6, p. 976]. Moreover, when discharged, people often feel isolated and abandoned, they do not always know where to find help and how to gain access to services: As a result, there seems to be a need for better transitions between rehabilitation programs and the community [2, p. 1416]. More generally, a given intervention must not only prove its efficiency in controlled situations (i.e., efficacy), it has to be efficiently applied in less-controlled situations (i.e. effectiveness) and be widely spread within healthcare services. In that sense, person-centredness surely means that interventions should focus on daily-living activities and address real-life difficulties.

Quite often what happens in reality is that disabled persons receive interventions, which while they involve a great deal of technical know-how, seem largely devoid of relevance. For instance, reality orientation interventions might arguably have little relevance when a person (e.g., a person with dementia) is having difficulty eating by his/herself. Although interventions are sometimes evaluated according to their benefit for third party individuals (e.g., decrease of the burden on the helper in the Alzheimer’s disease), person-centredness means that interventions should first and foremost reflect the person’s needs (versus third party interests). Finally, disabilities involve social and environmental factors. Therefore, instead of stigmatizing disabled persons, it is sometimes necessary to modify the environment rather than ‘adapt’ people to an
abnormal environment. In the case of Alzheimer’s disease, for instance, instead of trying to reduce the so-called ‘behavioural symptoms’, one should sometimes try to prevent the development of negative interactions within the family and the social environment: ‘The problem (e.g., wandering) lies in part with our reaction to the behaviour, which itself may not present a problem to the person with dementia. Thus, rather than prescribing a “therapy”, some of our interventions have to involve changes in attributions, attitudes and interactions of family carers and paid care-workers’ [3]. In that sense, person-centredness signifies acknowledging the environmental origin of difficulties (versus stigmatizing the persons).

(c) Person-centredness means the person as an expert: Participation and empowerment

Interventions are often chosen according to which outcomes third parties consider to be the most important. For this reason, they often merely address the physical issues of the person’s condition and their basic care needs.

However, this third meaning of person-centredness embodies the notion that disabled persons should not be passive recipients of interventions which are decided upon, implemented, and evaluated by others. In this perspective, disabled persons should not be left in a situation of passivity and ignorance. One should therefore inform them about their condition, give them the means to optimise their own abilities and allow them to choose implicit training over explicit training. Persons should also be informed about the availability of alternative treatments. In this sense, person-centredness means: Disabled persons should be active participants in the rehabilitation process (versus objects of care).

According to this notion of person-centredness, a disabling illness may diminish executional autonomy but not decisional autonomy. One should therefore avoid directiveness (which occurs when professionals define and determine what is in the patient’s best interest). The basic concerns of a person with a disability are arguably the same as those of a person without a disability: to live a good or meaningful life and to participate in the social and occupational activities of their choice. In this sense, person-centredness signifies improving participation in social relationships, home life, education, work and economic life (versus only addressing impairments and activity limitations) [2, p. 1419] (see also Patston in this issue [7]). The patient-professional encounter should be a dialogue through which an individual’s values and preferences are discovered [2, p. 1415]. In addition, this conceptual definition underlines the fact that the improvement of functional performance is not always highly correlated with subjective and social improvements. For example, relearning how to write or to play with a grand-child might be far more important to an individual than learning how to dress independently [8, p. 973]. In that sense, person-centredness means that: Interventions should have a subjectively perceived significance and be evaluated by appropriate instruments (i.e., meaningful and relevant to the client) versus outcomes based on measures of isolated impairments and disabilities. Thus, a successful intervention must not only prove a specific benefit in a standardized environment but also globally and durably improve the individuals’ actual quality of life. In this regard, one should improve personal participation in the goal formulation process. Persons should be actively involved in defining their needs, important goals and outcomes, and setting priorities. In this sense, person-centredness means: respect of patients’ values, preferences and expressed needs (versus paternalism). Patients should participate in determining the weights assigned to various outcomes, since there is no theoretical reason why disabled persons cannot establish their own weights, based on personal preferences [8, p. 973]. In conclusion, disabled persons are experts about their own situation and needs and are often capable of evaluating their own quality of life and whether they benefit from the interventions by themselves. Their competence and expertise must be acknowledged. At the heart of this conceptual definition is recognition of the personhood of disabled people.

(d) Person-centredness means respect the person ‘behind’ the impairment or the disease

The fourth meaning that we discerned in the literature is that disabled persons should be treated, as any other person, with respect and dignity, whatever their impairment or disability may be. Disabled persons are sometimes regarded with pity or condescension and even stigmatized (Patston’s paper in this issue explores this issue in depth [7]). It is therefore important to remind ourselves that disability is a ‘normal’ part of life (i.e., the person’s condition is not necessarily tragic), that disabled persons remain interlocutors and fully-fledged citizens who retain every right to moral respect and to participate in democracy, and also that interdependence is a natural thing in a society. Disabled people should not be considered as a burden on society, they are not necessarily more dependent on others than people without disability [9, p. 985].

People often possess strengths and capabilities, which are not suspected or recognized by health professionals. Their goals are often also much more ambitious than we might assume. For instance,
Doolittle’s study [10], stroke patients viewed recovery as returning to previously valued activities, health care whilst professionals viewed recovery in terms of isolated and discrete components of recovery of mobility. There is a need for maintaining hope about the future (versus “that’s beyond your capacity”). More generally, one should recognize that disabled people can have worthwhile and rewarding lives [11, p. 1247]. In that sense, person-centredness means the need for a more positive perspective from disability to abilities and from handicaps to participation (versus defectology).

Comments on the conceptual analysis of person-centredness

This conceptual analysis calls for several comments:

Implicit in all the definitions we have identified is the idea that person-centredness is an important condition for a successful rehabilitation. If the rehabilitation process is to succeed one should, if the above arguments are sustainable, take into account the person’s particularities, their environment, their needs, their strengths or their preferences. Moreover, person-centredness is also presented as the condition of a morally legitimate intervention. It is a normative notion, which indicates what rehabilitation should be (and should not be) and prescribes a certain way to consider disabilities. Naturally, there are some kind of contradictions between this set of norms and recommendations addressed to professionals and the idea that the person should be at the centre of the decision-making process, i.e., that she or he should be the one who decides and acts upon his or her own preferences and values.

From a general standpoint, the notion of person-centredness represents anti-reductionism. It asserts that disabled persons should not be reduced to their disabilities alone, but rather that their particularities, their subjectivity, their integration within a given environment, their strengths, their future plans and their rights should also be taken into account. It affirms that disabilities should not be reduced to impairments, nor should impairments be reduced to diseases, nor diseases to their more visible symptoms. Thus: when affirming a disabled person’s individuality, subjectivity, rights and preferences, needs and competence should be acknowledged. When prescribing that they should not be reduced to a label, to their pathology or deficits, when pointing out that their environment should be taken into account, the notion of person-centredness disqualifies certain behaviours and conceptions. In particular, it criticizes an approach towards disability and disabled persons, which tends to be: Too uniform; too analytical; too theoretical; too negative; and too directive.

This notion of person-centredness does not simply imply some degree of anti-reductionism in discussing rehabilitation, but rather it is itself strongly anti-reductionist in that it cannot be reduced to one specific idea. Thus, person-centredness encompasses multiple meanings that cannot be summed up under one notion. In other words, it is a multi-dimensional concept.

What is more, person-centredness not only covers several ideas, each of these ideas can be (and has been) interpreted in a variety of ways: (i) For some authors [12], mostly in North America, considering the political and social dimension of disabilities consists of taking its consequences into account (e.g., limitations to social participation) and trying to minimize them, whether by enabling persons with certain skills, or by claiming the implementation of a universal design. In this case, responding to difficulties the person encounters in his/her life implies that rehabilitation programs should prepare the person for life in the real world; (ii) For others (mostly the British disability studies writers), it implies a need to act on the social environment and to tackle the social oppression disabled persons suffer from (i.e., the social model of disability). This implies that this latter approach is not really concerned with this discussion of person-centredness since their main focus is on the environment. This means that there is a time for care and a time for life and that rehabilitation should not be incumbent upon health professionals, but upon others such as social workers, and that the main question concerns social policies and the adaptation of the environment. This would seem inevitably to lead to tension about the scope (or extension to) rehabilitation and the way to implement it correctly. The idea that disabled persons are entitled to the same respect as non-disabled persons has given rise to two types of claim, within disabled persons’ movements [13]. On the one hand, a tendency, which could be described as separatist or culturally distinct, can be observed. It claims the right to difference, and even to an identity as a minority group, with a ‘disability pride’ (there has for instance been such a movement in the deaf community). On the other hand, there is a tendency which could be qualified as ‘universalist’, which asserts that we all are temporarily able-bodied or not yet disabled, and which is based on Human Rights universality and refuses particularism [12]. This latter perspective is not literally person-centred since it considers the whole of humanity as a set of diversities (see Patston in this issue [7]). Here the disagreement concerns the definition of a ‘disabled person’ as a subject and the way to increase his or her standing.

Finally, for some, the notion of participation and empowerment means that disabled persons
should be allowed to make choices freely and independently, and to shape their life into a meaningful existence which expresses individuality. This idea (client-driven practice) corresponds to the individualistic-liberal view on autonomy, which stresses autonomy of choice and action (decisional autonomy). Others understand the notion of participation and empowerment in terms of patient-focused care and community integration. They intend to increase executional autonomy by organizing routines which are close to the patient and by cross-training staff in order to decrease the number of people the patient must interact with. For these, the goal of person-centred rehabilitation consists of maximizing disabled persons’ participation in society [14]. Here again, the disagreement concerns the definition of participation and empowerment and how to increase the person’s standing.

In conclusion, not only does person-centredness cover different ideas but each of the ideas it expresses can give rise to a large variety of interpretations. No consensus can be found, whether about its meaning or about its implication. Where does this confusion come from? Why does it seem so difficult to reach a consensus on the meaning and the implications of person-centredness? One hypothesis is that the manifest difficulty for it to become a consistent, unified and comprehensive concept may be related to the heterogeneity of its origins which we shall explore now.

**Historical analysis**

In this section, we shall try to trace the origins of the different ideas we distinguished earlier. On the one hand we shall see how the emergence of the notion of person-centredness takes place in a more general historical transformation of the status of medical activity and the relation between patient and treatment. On the other, we shall see that the notion of person-centredness has been just one of the possible responses to this general change. Despite the fact that this enquiry initially takes us away from rehabilitation, we propose that it will enable us to understand this notion better and to find some eventual way forward.

**(a) (re)Emergence of the notion of person in the history of medicine**

The current importance of person-centredness within the field of rehabilitation – and more particularly the idea that a disabled person must be considered in an holistic way and as an individual – can, firstly, be correlated with the new status patients have generally had since the 1950s.

Ever since the 1950s, the medical viewpoint has (arguably) been enhanced with a reflection based on the patient’s point of view. This increased attention on the patient’s subjective experience and new-found emphasis on considering the person as a whole – currently known as ‘holistic’ medicine – is supposed to take part in a mutual medical experience. According to Carricaburu and Menoret [15, p. 76], the clinical point of view on a passive body is being replaced by a new paradigm: a patient-centred medicine. Pain medicine is part of this view and constitutes a relevant example that testifies to such a movement. Historically, there has been a shift away from a model in which the patient is the somewhat passive, target of medical intervention to another model a more contractual arrangement in which the patient takes an active part in his or her care and the decision-making process. This historical and cultural trend has made the experience of the patient a reference point, a central value for medical care. In this context, person-centredness, and more specifically the components of participation and empowerment, can be related to movement in favour of patients’ responsibility observed throughout medicine since the second half of the 20th century. It is no accident that, as this movement develops, we refer more and more to the notion of person. As a matter of fact, the notion of the person is a crucial notion in legal matters. By person, one means a subject who is legally responsible for his own acts and behaviours. One uses the concept of person in order to give somebody responsibility vis-à-vis a situation which concerns him or her. In this context the therapeutic relationship has become much more contractual: physicians inform their patients much more than they used to. They tend to discuss therapeutic options and seek agreement and patients’ free and informed consent before taking action. This evolution towards patients’ decisional autonomy (in bio-medical research, and later in clinical medicine) has come along with an increasing recognition of patients’ competence: i.e., their capacity to understand medical data, to provide therapeutic goals, to make consequent decisions, and also to evaluate their own quality of life and appreciate a treatment’s efficiency. Furthermore, whereas the initial bio-ethical literature (e.g., Helsinki Declaration [16], Belmont Report [17]) were establishing a clear distinction between competent persons with a capacity to understand and decide, and non-competent persons who need protection, the current tendency is to recognise that an increasing number of patients have an increasing numbers of skills. For instance, it is now accepted, that persons suffering from a psychiatric disease or suffering from cognitive disorders are often able to understand their diagnosis and prognosis, and that they can take part in the decisions affecting them and
evaluate the efficiency of the treatments they undergo [18].

More recently, this movement in favour of patients’ autonomy has developed into one emphasizing patient education and active involvement in their own treatment. Persons are regarded more and more as experts on their own condition. Nowadays, patients are not only recognized as competent to be informed about their condition and included in decision-making, they are also being considered competent enough to provide relevant information, and to perform, by themselves, some types of actions which only a few years ago would have been regarded as medical actions. This evolution goes beyond a mere transformation of paternalism into contractualism. It deeply modifies the assignment of roles and responsibilities in medical care. Patients are no longer simply asked to ‘give their consent to medical acts’, there clearly is an effort to get them involved in care and to take responsibility for oneself (see for example the Expert Patient initiative in the UK [19]).

As one can see, the emergence of the notion of person-centredness has been made possible by two powerful historical trends. On the one hand the subjective experience of the patient has become a new reference point for medical care and on the other hand, what has become normative and normal is the involvement and participation of the patient in medical decisions and activities, treatments and health services. As a matter of fact, person-centredness is one of many possible responses to the historical and cultural movements we have just described. However, it is not obvious that person-centredness can respond in a comprehensive, consistent and efficient way to this novel valorization of the subjective experience of the patient and their participation in the definition of the aims of medicine. The mere notion of person points in the direction of an individualized response when many other directions could have been followed. The individualist response to the challenge of taking into account the subjective experience of the patient and their participation in medical decisions is precisely the road which has been followed by the father of a person-centred approach: Carl Rogers.

(b) Carl Rogers’ person-centred approach

The current notion of person-centredness – and more particularly the idea that one should adopt a positive view about disabled persons, that one should be pragmatic and empathetic – seems to derive at least in part from the person-centred approach developed by the American psychologist Carl Rogers (1902–1987) from the 1940s onwards in an intellectual context where the dominant paradigm, in psychology and psychiatry, was the psychoanalytic approach with its origin in medicine and the Freudian tradition.

Even though Rogers eventually extended his ideas to a variety of areas, such as education, work and family [20], the fields of psychotherapy and counseling were the ones in which he originally articulated his theory [20–23]. The principles of this theory (initially named the ‘client-centred approach’) can be summarized as follows: Each individual possesses considerable qualities by him/herself. He/she can draw strength from his/her own resources and find a remedy to his/her difficulties by his/herself, provided they are ensured a facilitating environment. Rogers speaks about the ‘person’ or ‘client’ (rather than ‘the patient’) to avoid reducing individuals to their difficulties and thus minimizing their autonomy. Although they may be experiencing difficulties, according to Rogers, individuals should not be treated as objects. The ‘person-centred approach’ aims to turn the individual into the subjects of their own therapy. It claims that the client has a better knowledge of what they suffer from than the therapist does, they know what is important and in which direction to search. They are also able to set their own goals by themselves.

This approach is founded on the idea that every organism is characterized by a tendency towards organization and growth, a tendency to develop its own capacities to the fullest and that each individual possesses within him/herself a natural tendency to actualize all his/her possibilities defined as the ‘actualizing tendency’ [23, p. 196]. Once this tendency is set free, the individual can solve his/her difficulties by him/herself. Rather than acting as an expert who understands the problem better and decides in which way it must be resolved, the therapist must therefore merely limit him/herself to helping the individual fulfil this tendency towards actualization. The therapist must limit his or her role to creating the right conditions necessary to facilitate its development. In Rogers’ mind, this approach is opposed to both behaviourism and psychoanalysis.

Rogers also reproaches the Freudian psychoanalytic school for its tendency to be too interpretative, too theoretical and too directive. Rogers’ approach aims to be resolutely empirical and distrusts all form of theorization or intellectualism [23, p. 186]. For Rogers the therapist’s task is not to provide symptom interpretation or to try to understand the client’s personality, because the analytic interpretation will introduce a relation of domination and impose outside norms on to the individual.

Rogers values attitudes over techniques. In his views, the therapist should limit their role to accompanying the restoration of the patient’s full health by considering him/her with unconditional positive regard [23, pp. 208–209], by adopting a
non-judgmental attitude, altogether attentive, understanding, open and tolerant. He/she must let the client ‘be’ the feelings he/she experiences, whatever those feelings might be. On the therapist’s part, he/she should show the patient unconditional esteem, value his/her feelings, opinions and persona. This benevolent (and not possessive) attitude should allow the client to regain full self-confidence. The therapist must show sensitivity and empathy, he/she must do his/her best to perceive another person’s subjective world as if he/she were this other person, for instance by feeling the other person’s pleasure or sorrow the way this person feels it and by perceiving its cause the way this person perceives it (without forgetting they still are someone else’s experience and perceptions). Finally, Rogers insists on the idea of ‘congruency’ and authenticity: in order to help the client develop in a constructive way, the therapist must be genuine and establish a person-to-person relationship, a direct relationship without trying to hide behind a façade (his profession, for instance). He/she must be open to the feelings and attitudes that ‘flow upon him’ at the time, he/she must succeed in unifying the emotional experience he/she is feeling, the awareness of this experience and what is being expressed towards the client.

Carl Rogers approach is not only individualistic but it is also individualizing since the cure aims at reinforcing the autonomy of the subject. In technical terms, this practice has a performative effect: It produces an individuation of the subject and a centring on the person, which is supposed to be at its foundation.

(c) Types of person-centredness in psychiatry and psychopathology

In psychiatry and psychopathology, the notion of person-centredness gets a peculiar meaning since, in a sense, the object of these disciplines is and has always been the person. However, some aspects of the concepts are not included in the literature of academic psychopathology, as for example, some ethical aspects like the idea of decisional autonomy. The analysis of such cases may help us to understand further some of the perspectives and ways of thinking opened up or initiated by the current focus on person-centredness.

As anyone knows, there exists in the European psychopathology tradition a so-called clinical approach (Jaspers [24]), which advocates paying specific attention to the person, both as a whole (holistic perspective) but also as a singularity, that is to say with a singular history, a singular problem, a singular existential context and subjective experience (as opposed to merely be seen as member of a group of subjects). In this sense, this approach, which encounters some epistemological difficulties to maintain both its validity as a corpus of general knowledge and its faithfulness to the singularity of the subjects, is person centred and satisfies some of the requirements of person-centredness. However, as we have already said, some ethical aspects of person-centredness are not included in the clinical approach, where the aim remains primarily to acquire knowledge, and in which the aims of the cure and the means to reach them remain the clinician’s responsibility. In this way, this approach does not depart from the biomedical paradigm and is still characterized by a dissymmetry between the practitioner and the patient. A good illustration of the gap between psychiatric practice and psychopathology on the one hand and person-centredness on the other hand may be found in the current development of psychosocial rehabilitation in psychiatry. This strand, which is remarkably close to person-centredness in terms of definitions, principles and objectives, claims its differences from the medical approach and presents itself as a complementary approach.

Psychosocial rehabilitation was defined in 1985 by the International Association of Psychosocial Rehabilitation Services as:

...the process of facilitating an individual’s restoration to an optimal level of independent functioning in the community [...] Psychosocial rehabilitation invariably encourages people to participate actively with others in the attainment of mental health and social competence goals. In many settings, participants are called members. The process emphasises the wholeness and wellness of the individual and seeks a comprehensive approach to the provision of vocational residential, social/recreational, educational and personal adjustment services’ [25, p. 61].

Cnaan et al. state that psychosocial rehabilitation is based on two essential assumptions: People are motivated by a need for mastery and competence in areas, which allow them to feel more independent and self-confident; new behaviour can be learned and people are capable of adapting their behaviour to meet their basic needs. They extracted fifteen principles (principles 14 and 15 were added in a second version [26]). The 15 U.S. Principles were:

1. Under-utilization of full human capacity;
2. Equipping people with skills (social, vocational, educational, interpersonal and others);
3. People have the right and responsibility for self-determination;
4. Services should be provided in as normalized environment as possible;
5. Differential needs and care;
6. Commitment from staff members;
(7) Care is provided in an intimate environment without professional, authoritative shield and barriers;  

(8) Early intervention;  

(9) Environmental approach;  

(10) Changing the environment;  

(11) No limits on participation;  

(12) Work-centred process;  

(13) Emphasis on a social rather than a medical model of care;  

(14) Emphasis is put on the client’s strengths rather than on pathologies;  

(15) Emphasis is put on the ‘here and now’ rather than on problems from/originated in the past.

Three particularly relevant elements can be found in this list. The first is that the 15 principles express the entire set of ideas historically attached to the notion of person-centredness (including staff commitment and deprofessionalization of service). The second one is that, in that list, the actual term ‘person-centred’ is conspicuously absent. Cnaan et al. developed every idea which this term usually encompasses and yet avoid using it. It almost seems as if Cnaan et al. had considered the expression itself to be useless – perhaps even harmful – in order to express their ideas in an accessible language. The third observation that can be made is that, although they avoid naming the notion, Cnaan et al. explicitly separate their approach of psychosocial rehabilitation from the ‘medical model of care’, and relate it to the ‘social model of care’ (principle 13).

This movement, which aims at promoting the rehabilitation and the support of people with psychiatric disabilities, is developing with some differences depending on the countries involved. For example in France, it departs slightly from the initial Anglo-American concept, since it is seen as an extension or a complement of the classical psychiatric approach, without discontinuity [27–29]. Such an example may contribute to the discussion of whether in order to be truly person-centred an approach should distance itself from the traditional medical approach.

(d) Disability studies

When disability studies, at least in their American interpretation, responded to the same challenge as person-centredness (i.e., value the subjective experience of patients and patient participation), the line of response was quite different. For disability studies, disabled persons should be regarded as individuals and citizens with full rights, without losing track of the cultural, social and political dimension of disability.

Disability studies have emerged as an academic discipline, following on from the disabled persons’ social and political activism of the 1970s, when people with disabilities in Europe and North America became organized as an active minority (minority group) and as a consumers’ movement. Disabled persons brought numerous claims to public debate, based on Human Rights, respect of human dignity and, more particularly, rights to an autonomous life. (Independent living movement) [30,31]. Initiated in the UK (Chronically Sick and Disabled Persons Act, 1970) and in the USA (Rehabilitation Act 1973), the movement rapidly grew to worldwide scale and gave birth in 1981, in Winnipeg, to the World Disabled People Organization [32]. Disabled persons organizations did not limit themselves just to the political claim for the recognition of their rights. They also militated more broadly in favour of social and moral rehabilitation of a society which, until then, had been suffering from collective contempt for disability. They tried to give rise to a social transformation of medicine and a new ‘person centred’ approach on disability.

While, in the USA, this movement had primarily emphasized the notion of universal design (i.e., elimination of physical and social barriers which hindered the integration of disabled persons) (White House Conference on Handicapped Individuals 1977), the British movement championed the social model of disability. This social model asserts that disability must be thought of as a broader social issue rather than simply as being about an individual being entitled to certain rights. The social model of disability argues that disability does not result from an individual’s characteristics but from the obstacles that society places before put him/her. Hence the goal for rehabilitation is not so much to find a remedy for each individual person’s disability as it is to modify behaviours and social structures which produce oppression, exclusion or stigmatization [33,34].

Comments on the conceptual history of person-centredness

Several concluding remarks can be made from this sketch of a person-centredness genealogy.

Firstly, it can be seen person-centredness, as currently used in the rehabilitation field, has multiple and diverse meanings or definitions that also stem from a number of disparate historical movements. Consequently a true genealogy of this notion (or these ideas) may be impossible and this notion may not be a distinct or discrete concept as such. This complexity of meaning or multidimensionality explains, to a certain extent, the tensions and eventual contradictions we have noted in the foregoing conceptual analysis.
Secondly, person-centredness did not originate within the rehabilitation or disabilities field, but in the medical field on the one hand and in the psychotherapy/counselling field on the other. Only at a later stage was it used within rehabilitation. One may question then, what exactly in the way person-centredness was conceptualized derives from these origins, and how it would have been conceptualized differently if it had originated in the disability and rehabilitation field.

Thirdly, it is important to point out that, for the time being, only some of the ideas historically attached to the notion of person-centredness have been ‘transferred’ to the how it is currently used in rehabilitation. In particular, in the rehabilitation literature, we rarely encountered discussion of how one’s role and image as a professional should be managed/abandoned in order to establish a ‘genuine’ relationship with the client (see also MacLeod and McPherson in this issue [35]). Again, the question arises whether supportive care should be developed independently from the medical influence and be based on separate principles.

Fourthly, we observed that the modern notion of ‘rehabilitation’ that underpins for example, ‘rehabilitation medicine’, seems to have been coined at the same time as the notion of person-centredness was captured by the disabled persons’ movements (The 1973 Rehabilitation Act [36]).

**Conclusion**

In order to contribute to the general clarification of the goals and aims of modern rehabilitation, we have conducted a conceptual and historical analysis of one of its key notions namely that of person-centredness.

We have identified at least four principal meanings associated with the concept of person-centredness: (i) To address the person’s specific and holistic properties, (ii) to address the person’s difficulties in everyday life, (iii) to consider the person as an expert on their own condition and put the emphasis on participation and empowerment, and (iv) to respect the person ‘behind’ the impairment or the disease. Each of these four different uses can be, and has been, interpreted in a variety of ways. Thus, it appears that person-centredness is a highly diverse and multidimensional concept. No consensus can be found either on its meaning or on its implications for rehabilitation. In addition, there does not seem to be any strict relationship between person-centredness as it is used in the context of rehabilitation and these four varied uses and meanings. We noted also that the notion is both descriptive and normative. As a descriptive concept, person-centredness is anti-reductionist and puts the emphasis on the person as a whole. As a normative concept, it indicates what rehabilitation should be (and should not be) and prescribes a certain way to consider disabilities. We noted a contradiction between this set of recommendations as addressed to health professionals and the idea that the person should be at the centre of the decision-making process.

The manifest difficulty for person-centredness to become a consistent unified and comprehensive concept may be related to the heterogeneity of its origins. Its origin does not lie in rehabilitation and prior to its use in this field, the notion was used in a variety of other contexts somewhat unrelated to disability and rehabilitation. The emergence of the notion of person-centredness has been made possible by a two parallel historical movements that initiated in the 1950s: The subjective experience of the patient has become a new reference point for medical care and the involvement and participation of the patient in medical decisions and activities, treatments and health services has become a norm. The individualist response to the challenge of taking into account the subjective experience of the patients and their participation in medical decisions has been promoted by an influential American psychologist, Carl Rogers, who first coined the expression a ‘person centred approach’. The current psychosocial rehabilitation movement in psychiatry, which is remarkably close to person-centredness in terms of definitions, principles and objectives, claims its own differences from the traditional medical approach and presents itself as a complementary approach. In this context, Cnaan et al. state identified 15 principles that express the entire set of ideas historically attached to the notion of person-centredness, which they relate to the social model of care. However, they never use the term person-centredness, and it is almost as if they had considered that this expression is useless – or even harmful – in expressing their ideas in an accessible language. Finally, for the field of disability studies, disabled persons should be regarded as individuals and full-right citizens, without losing track of the cultural, social and political dimension of disability. For example, the social model of disability claims that the goal is not so much to find a remedy for disability, as it is to modify those behaviours and social structures which produce oppression, exclusion or stigmatization of people with a disability. From this historical review, it is clear that person-centredness has multiple and diverse meanings, which have their roots in different academic ideologies and socio-political movements.

This diversity does help to explain some of the tensions and contradictions we identified in the foregoing conceptual analysis. We considered that examining the example of Psychosocial Rehabilitation in some depth might be of heuristic value since the experience with person-centredness is relatively...
more established in this field than in other areas of RH. Moreover, in light of this example, we suggest that rehabilitation might paradoxically get a better sense of what it should be and should do, by incorporating an operational list of the key features of person-centredness — but at the same time refraining from using the term person-centredness.

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