**An example of paradigm change:**

**From illness to health, well-being and empowerment**

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 The Person-Centered Approach was founded by Carl Ransom Rogers, a clinical psychologist. It is a systemic, holistic approach that focuses on health rather than illness; empowering rather than curing. It promotes the development of potentialities of individuals, groups and organizations through the process of freeing people to be responsible for what they do, rather than encouraging passivity and dependency. The central hypothesis of the Person-Centered Approach is that individuals have within themselves innate capacities for self-understanding and self-regulation. These resources can be tapped best in a psychological climate that has facilitating qualities. The helping relationship found in such a climate is characterized by acceptance, empathy and authenticity/congruence. This type of relationship promotes self-understanding and allows for the relationship with oneself, others and the world to change in a positive direction.

 The Person-Centered Approach sees and leaves the locus of responsibility for change with the client. It is important for both the client and the professional helper to recognize that the client, the person with the problem, must be the one entrusted to create change. Leaving the locus of responsibility, evaluation and control with the client reduces the likelihood of passive, rebellious or victim-like behavior, and sets up a process wherein the client develops an increasing sense of response-ability for the problem, willingness to explore possible solutions to the problem, and willingness to initiate actions to solve the problem for him/herself. The Person-Centered Approach recognizes the person as being in charge of her own life and problems, and as being the one with the most data about her personal situation. It recognizes that the role of the professional is that of a facilitator of change, providing an environment that fosters growth and empowerment, thus enabling the client to explore and find solutions to his/her problems.

 Research shows that the therapeutic alliance is the strongest predictive variable for success in psychotherapy. The therapeutic alliance is comprised of Rogers’ formulation of the necessary and sufficient conditions (1959), with the additional elements of client and therapist agreement regarding therapy goals and their capacity to repair ruptures in the therapeutic alliance (Norcross, 2002). The impact of the therapeutic alliance appears to be evident in pharmacotherapyoutcomes, including placebo responses (Krupnick et al. 1996).

 Carl Rogers has been described eloquently by his colleague and friend, Richard Farson (1974), as a quiet revolutionary. This is a very fitting description of Carl’s life and work. He brought a dramatic change to the fields of psychotherapy and human relations. His ideas still are considered fundamental. Practitioners and researchers agree on his impact in this regard. A survey conducted by *American Psychologist* (1982) found Carl Rogers to be the most influential psychologist. In 2006, 26 years later, a survey conducted by Joan Cook at Columbia University, through a grant from the National Institute of Mental Health (NIMH), reached the same conclusion regarding Rogers’ influence (Psychotherapy Networker, 2007).

 Rogers adopted a strikingly different viewpoint from his colleagues - instead of a mechanistic, reductionistic perspective he assumed a holistic-systemic frame of reference. His vision was ahead of his time. In the 1980’s, the World Health Organization manifesto on health promotion, the Ottawa Charter -- (1986, page 1), seems to echo some of Rogers’ tenets:

*Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being*.

In order to fully appreciate the impact of Rogers’ revolutionary work, this paper considers broader contexts, including aspects of the history and sociology of science, shifts in scientific paradigms, the sociology of knowledge, and the effects many years later of Rogers’ original formulations in the field of health .

**A scientific paradigm shift**

For Thomas Kuhn, a scientific paradigm is considered valid as long as it is able to function adequately in exploring that aspect of nature its use is intended to investigate. When evidence emerges of phenomena that cannot be understood or problems that cannot be explained by the current paradigm, this leads to intense research and scientific speculation. This leads eventually to the formulation of a new paradigm that is able to explain the new data better. It also leads to the creation of an array of more powerful tools and modes of intervention.

According to Kuhn, for paradigms to become accepted they must be innovative and open in ways that attract a sufficient part of the scientific community. The science produced by the new paradigm is not for the sake of change per se. Rather, its aim is the resolution of problems, extending the knowledge of key elements of the paradigm and providing experimental confirmation.

*Normal research* *is cumulative and owes its success to the capacity of scientists to choose problems that can be solved with conceptual and instrumental techniques that are closely connected with those already in existence.* (Kuhn 1962).

For this reason, it is evident that any focus on scientific problems without recognition of how the related research is dependant upon and oriented by the paradigm upon which it is based can be, paradoxically, a barrier to scientific development.

Kuhn sees scientific progress as proceeding not according to the successive accumulation of knowledge, but through scientific revolution. Such a revolution is heralded by a growing awareness that an existing paradigm has ceased to function adequately in the exploration of an aspect of nature for which the paradigm had previously been adequate. This awareness is felt first by only a small sector of the scientific community. “Revolution” constitutes an exceptional moment with respect to what Kuhn (1962)calls *normal science*; i.e.,the relatively routine work of scientists  within a paradigm, slowly accumulating detail in accord with broadly established theory, and not actually challenging or attempting to test the underlying assumptions of that theory. Kuhn also tells us

*The success of a paradigm is at the start largely a promise of success discoverable in selected and still incomplete examples. Normal science consists in the actualization of that promise, an actualization achieved by extending the knowledge of those facts that the paradigm displays as particularly revealing, by increasing the extent of the match between those facts and the paradigm’s predictions, and by further articulation of the paradigm itself.* (1962, page 23-24).

In the 18th century, light was considered to be composed of material particles. This was the understanding held within the field of optics, an important and integral part of Newtonian physics. Scientists of the time were convinced they understood the fundamental principles of nature: Atoms were the bricks from which the natural world was built; motion was explained by Newton’s laws; and the majority of physics problems seemed resolved. The Newtonian explanation of light held until the beginning of the 21st century, when Einstein’s and Planck’s experiments contradicted certainties upon which Newtonian physics was based. A new theory emerged that light has a dual nature - both wave and particle. This theory was formalized under the new paradigm of Quantum Mechanics.

**A brief summary of quantum mechanics and General System Theory**

Albert Einstein’s Theory of Relativity along with Quantum Mechanics constitute one of the fundamental paradigms of contemporary physics. Einstein introduced the concept of time as a fourth dimension, along with the three spatial dimensions, specifying that the description of physical phenomena needs to be represented in four dimensional space. The theory presented by Einstein in 1905 was not accepted immediately because of its revolutionary impact on the accepted scientific formulations of Newton and Galileo. Yet, the stunning advances in the scientific understanding of reality springing from his Theory of Relativity were supported by new instruments of observation such as electron microscopes and better telescopes that enabled physicists and astronomers to explore smaller realms and farther reaches of the universe. What they found were phenomena such as subatomic particles and black holes whose actions and characteristics bore little resemblance to those described by Newtonian mechanics or the Cartesian notion of reducing matter to understandable building blocks. Scientists such as Neils Bohr and Werner Heisenberg struggled with interpreting the seemingly chaotic and decidedly counter-intuitive phenomena found in the subatomic realm, and called their area of investigation quantum theory – “quanta” meaning the smallest possible quantity.

Gradually, scientists began to perceive order in the seemingly random and unpredictable behaviors of subatomic particles. Discoveries unfolded to generate a new, integrated view of the universe based on relationships. For example, physicist David Bohm discovered that every particle is part of a pair, mutually and instantly influencing each other instantly even when separated by vast distances. The world appeared as an interacting, mutually influencing system made up of subsystems ranging from galaxies, to human beings, to the atom. More importantly scientists achieved a new breakthrough in awareness regarding the creation of scientific knowledge. This is illustrated by the Heisenberg’ principle: the observer and the instruments he/she uses for observation interact with the phenomenon observed and co-construct it. This concept derived from the “hard” science of physics helps us understand how Rogers’ criticism of Freud’s and Skinner’s visions of human nature, as well as the dangers of psychopathological labeling, actually is grounded in a paradigm that had been known to top physicists and biologists since the 1930’s.

Another significant paradigm shift tackled the concept of wholeness. This is the Systems paradigm. Biologist Ludwig von Bertalanffy, author of the fundamental text, *General System Theory*, intended to furnish an integrated structure for all scientific activities. Such theory allows for an integrative framework for scientific activity; eg., viewing the biosphere as a whole. Rogers’ work, within an integrative, organismic and relational framework carries similarly profound implications.

Systems theory, as developed by Bertalanffy and later by others, is “*based on awareness of the essential interrelatedness of all phenomena—physical, biological, psychological, social and cultura*l.” (Capra, 1996, page 265). It can be seen as a ***total ecology model*** wherein the human organism is best understood as a system that is part of a bigger system (e.g., one’s family of origin, community, socio-economic status, profession, culture, the environment, etc.). The human organism is also made up of smaller systems (e.g., one’s genetic blueprint, cardiovascular system, lymphatic system, skeletal system, immune system, personality, emotional and cognitive systems). This ecological, systemic view has relevant implications for the understanding of the health of individuals and society.

 Since Systems theory sees all living structures as comprised of extensive subsystems that are in constant interaction with each other, any impact on society affects the family, the individual, and vice versa. The figure below illustrates this concept.

###### MACROSYSTEM

(Culture, Shared beliefs, Social expectations, Laws, etc.)

**EXOSYSTEM**

(Government agencies, Economic system, Religious organizations, etc.)

**MESOSYSTEM**

(All the systems of daily life interacting with each other)

**MICROSYSTEM**

(Family, friends, Workplace, etc.)

**PERSON**

(The various bodily systems: skeletal, Immune, Cardio-circulatory Respiratory, Cognitive, Emotional, etc.)

Adapted from Egan and Cowan, 1979 in

The following example illustrates the interconnectedness within a whole system:

 If there is a shared cultural belief that women are inferior to men, legislation likely will reflect this will not grant the same rights to all citizens based on gender. Women may lack even the right to elect their representatives in public elections, may not receive equal pay for equal work, and will be unlikely to receive equal treatment within society and within their own families. In such a scenario, women may even accept the cultural belief that they are inferior to men. This, in turn, will impact on their emotional and cognitive experiences, and their potentialities likely will not be actualized fully. This will have far reaching consequences for women and the entire society within which they live. This leads us to consider another idea: the social construction of reality.

**The social construction of reality**

What is perceived as real varies from society to society and is produced, transmitted and conserved through social processes. In other words, our perception of reality is largely modeled from beliefs and a conceptual assumption that is typical of the society and culture in which we belong. What we know, what we consider true and right, the behaviors we adopt, all are influenced profoundly by the social/cultural environment in which we live. This process happens through the internalization of a “reality” that occurs during the socialization process (by parents or other significant persons).  This occurs largely without an awareness that **“**The world of everyday life is not only taken for granted as reality by ordinary members of society in the subjectively meaningful conduct of their lives. It is a world originated in their  thought and  actions, and is maintained as real by these.”(Berger & Luckmann, 1966, page 19).

Our reality is largely determined by the roles that are played by the people who interact with us, by the roles that they give us, and from the ways in which we relate with ourselves, others, and society at large. The social environment influences individual behavior through the imposition or communication of societal norms and through individual adherence to and respect for the social model of control. The concept of health, for example, is a *social* construct in the sense that it is closely correlated with the dominant culture.

In every society the majority of people live their lives with experiences that have meanings that are socially shared, and where daily behavior is familiar and predictable. The social construction of reality is not perceived as socially constructed by the majority. Therefore, it is not easily criticized or modified when aspects of it are dysfunctional and not allowing for awareness of basic needs or their fulfillment. A consequence is the persistence of dysfunctional attitudes and behaviors—both in individuals and society. The influence of such unexamined beliefs and behaviors on an individual can be significant, as suggested in the following scenario:

When I was a child my mother (influenced by background and culture) served (as most mothers did) tasty, fat-filled food. She was worried if I looked “skinny” and urged me to be a “good boy” and eat more even if I was not hungry. My peers urged me to smoke and drink “as real men do” as we saw Humphrey Bogart and all of the glamorous stars doing in the movies. I learned the social expectation of being a passive patient at the doctor’s office and I was led to believe that health simply meant not being sick. All of these influences helped build my perception of “reality”. These social experiences had real health consequences for my life, just as the accepted standard practice for better insulation that resulted in asbestos being put in my school building had real health consequences for many.

Another example: If a shared cultural belief is that gays, lesbians, and bisexuals are deviant and sick people, and their loving relationships are seen as sinful, we might see this pathologizing view mirrored in the diagnostic frameworks used by health professionals in that culture.[[1]](#footnote-1) Such a social construction of reality, reinforced by health processionals, easily would be considered the truth by the majority of people in that culture. Even large proportions of gay, lesbian, and bisexual citizens would adopt this belief. This would create untold suffering and lead to wasted human potentials for individuals and society. This scenario is in fact played out in many cultures in countless ways. This same process could be visualized for the impact of social constructs in discrimination towards racial or ethnic groups, women, older people or the “mentally ill,” among other groups of people.

Carl Rogers challenged his colleagues to ask themselves if they were aware of the social construction they were creating actively with their patients or clients.

His work contained the implicit challenging question: As helping professionals, are we part of the solution or are we part of the problem? It was a stunning contribution during his time. His work affirmed that labeling people who were asking for help as “patients,” and framing them with psychopathological labels, would contribute to their problems, not to solutions. He recognized that such socially constructed labels automatically would put people in a passive, dependent role, and would risk the creation of self fulfilling prophecies.

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**Paradigm change in the health sciences**

As has happened in other fields, public health and medicine are experiencing a paradigm shift over the last 30 years. The mechanistic, reductionistic medical paradigm has survived for many years. However, it is seen now as less likely to offer effective answers to emerging health problems. A new paradigm, grounded in the systemic approach, has emerged. This new framework takes every aspect of life into consideration, from individual awareness and lifestyles to the society and natural environment in which people live. This new vision of health, understood as a system composed of sub-systems, hierarchically inclusive and functionally interdependent, allows us to better understand and impact health at every level: personal, familial, work, community and beyond. This new frame of reference is defined a biopsychosocial model. It enables the integration of all the interdependent relationships that determine health: biological, psychological and social. Its dynamic field of action is called Health Promotion, and it is understood as a process of empowering individuals, groups, communities and institutions for the purpose of fostering maximal health.

The essential premise of this new paradigm is the concept that health and illness are determined by numerous interrelated biological, psychological and social factors. It is therefore necessary to design and take actions that help people to assume a proactive role in the protection and promotion of their health and wellbeing. Mental health is an important variable in this new paradigm. As such, professionals who work in the health sector need to acquire a new view of their professions—one that encompasses seeing themselves as *agents for social change*. It necessitates a view of themselves as people who assist individuals, communities and institutions in weaning themselves from passivity and dependency; in other words, as people who become protagonists in the promotion of health and wellbeing.

The biopsychosocial model recognizes that health is socially constructed within the context of human behavior and relationships.

*Health is created and lived by people within the settings of their everyday life: where they learn, work, play and love. Health is created by caring for oneself, and others, by being able to take decisions and have control over one’s life circumstances and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.*

*Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.* (WHO, Ottawa Charter for Health Promotion ,1986, pages 3 and 4)

This view of health and its determinants is a radical departure from the mechanistic biomedical approach. While this new approach certainly will continue to include medical doctors treating people with illnesses, it also will require that health professionals go beyond the focus on illness or the bio-medical model. Health professionals must foster a significant change in the way people understand how health is created and promoted. They also must help people and their institutions become aware of some key concepts:

* Health is created by behaviors and actions that to a large extent are determined by human choices.
* These choices are important to individuals’ lives, the lives of their loved ones, and to their communities.
* Decisions and actions that affect the environment have important consequences for health.
* The world of work must recognize that virtually every action taken will promote or damage health.
* Government leaders must support programs and regulations that benefit human health.
* Health and wellbeing must be a priority for society.

To help others become aware of these concepts, health professionals must adjust their perspectives and relinquish much of their expert status over those whom they serve. Health professionals must become practitioners of learning and empowerment. For the health promoter in this new paradigm, the focus on health includes individuals, the health system, the workplace, governmental agencies, communities and society in general.

 **The biomedical paradigm and the costs of a mechanistic, reductionistic approach**

The biomedical paradigm imposes limitations that are too costly to ignore. It is a mechanistic, reductionistic model that overlooks too many opportunities and entails too many dangers to remain acceptable. A systemic approach to health recognizes that human life is embedded in a constellation of biopsychosocial systems that work as a whole to impact the health of individuals, and helps us move beyond the costly limitations of the biomedical model.

After World War II, the development of pesticides and chemical fertilizers was seen as a scientific breakthrough for feeding humanity and building a better and more prosperous world. The unlimited use of these chemicals fit the prevailing expectation of scientific progress for the betterment of society. Unfortunately, this mechanistic, reductionistic view did not take into account the complex interrelationships of the world in which we live. The massive use of pesticides and chemical fertilizers initially expanded the production of food. However, success encouraged one-crop cultivation that soon impoverished the soil, necessitating an ever greater use of chemicals. This created a downward spiral of increasing chemical usage and decreasing soil vitality. Moreover, after boosting crop production and killing unwanted pests and weeds, it became apparent that the pesticides had a long period of continued action on the environment. They continued to affect the cohesiveness of the soil’s organic matter, creating topsoil run-off and pollution of drinking water. This negatively impacted the whole food chain. For example, traces of DDT have been found in human breast milk and in the livers of penguins in the Arctic, sites far removed from their original targets. The end result is the immeasurable, unanticipated degradation of the environment, as well as ongoing threats to human health and the whole food chain. It is now evident that our simplistic approach to the use of chemicals for the improvement of food production was tragically flawed. Our eyes are opening now to the costs of ignoring the complex web of relationships involved in growing our food.

Heart bypass surgery is another example of well-intentioned myopia generated by the biomedical model. “Patients” often see this surgery as a miracle cure, a new lease on life. However, this procedure does nothing to improve the factors that create the problem - patients’ arteries will eventually re-occlude if bypass surgery remains the only intervention. An ecological or systemic approach would promote awareness of interconnectedness and encourage changes in attitudes and lifestyle; eg., a diet low in saturated fat and cholesterol, abstinence from tobacco use, undertaking appropriate exercise, and improving stress management. Such an approach has been shown to reverse the build up of arterial plaque without surgical intervention, (Pelletier, 1994). It allows the patient/client to understand and cope more effectively with his health problems and produce better long-term results. (Ornish, 1990).

**A paradigm shift in psychotherapy**

Can we build a *psychological* science or a *behavioural* science which grows out

of the problems encountered in the study of the whole man in his subjective and

objective being? or must we feel that our science can only be a copy of Newtonian

science- a model already outdated in its own field? ( Rogers 1968, page 69)

When Rogers started to propose a new holistic/systemic approach to psychotherapy, the health fields were dominated already by the Biomedical Model, the traditional approach of western medicine for 150 years. The biomedical model is a disease-based paradigm, founded upon a mechanistic, reductionistic view of biological systems. Illness is seen as arising from biological changes beyond individual control, either from outside the body, or as internal, involuntary physical changes caused by factors such as chemical imbalances, bacteria, viruses, or genetic predisposition. Treatments in this model involve medication, surgery, chemotherapy, vaccination and other interventions aimed at changing the physical state of the body. The mind and body are viewed as functioning independently from each other, with the mind incapable of influencing physical matters. Responsibility for treatment is seen as lying with the medical profession. The field of mental health was characterized by a mechanistic psychiatric model based on diagnosis and cure, solidly within the biomedical paradigm.

Even though there is still some resistance, our present day paradigm is the Biopsychosocial Model. This model is a systemic paradigm recognizing that health is determined by a multiplicity of biological, psychological and social factors, all of which mutually interact. Health is promoted by empowering individuals as responsible for and capable of taking steps that support their own health. The mind and body are viewed as one, each strongly influencing the other. Illness is seen as the result of a combination of biological, psychological, social, lifestyle and environmental factors, over many of which each person has significant control. Individuals are seen as largely responsible (being *able to respond*) for their own health, with health professionals serving them as a valuable resource in their ability to respond (in their response-ability). Treatment is given to the whole person, not just the physical symptoms associated with an illness. Treatment is provided with strategies of empowerment, and may include facilitation of awareness, attitudes, behavior and lifestyle changes, coping strategies, social and emotional support, and better compliance with medical recommendations.

Carl Rogers’ work was revolutionary, moving the focus from illness to health and wellbeing. Rogers’ formulation of an approach to psychotherapy and human relations is within a holistic-systemic paradigm. His view of the human being is as a unified organism, with somatic and psychic aspects. The mind-body separation typical of reductionistic paradigms as well the notion of intrapsychic problems found in Freud were gone. For Rogers human nature is trustworthy, and the origin of individual problems is environmental (extrapsychic).

Rogers’ actualizing tendency axiom was a natural articulation of his holistic viewpoint. Self-understanding, self regulation, agency and free will flow from this model. Rogers’ notion that the quality of the relationship was the principal variable promoting change is also within this holistic framework. Healthy change is a process in which a person becomes free by removing the obstacles to the development of her/his potentialities so that normal growth and development can proceed and independence and self-direction is achieved.

**The politics of psychotherapy**

Rogers was aware that every organism is a complex system continuously interacting with other systems and affecting and being affected by them. He recognized that human beings may formulate self-fulfilling prophecies, and are highly susceptible to the influence of others in this regard. This made him wary of the way he was taught in the biomedical model to manage his relationships with patients. Clinical experience taught him that there was a need for a more democratic, more optimistic, respectful, authentic and effective approach.

The Epistemology of Carl Rogers is grounded in trust of human nature. He viewed congruence as an essential sources of knowledge, and emphasized the ultimate reliability of a congruent human organism’s self-experience.

*…not as a scientist to an object of study, but as a person to a person. He feels this client to be a person of self-worth; of value no matter what his condition, his behavior or his feelings. He respects him for what he is, and accepts him as he is, with his potentialities.* (Rogers, 1965, p.22)

Rogers tells us that organisms know what is good for them. Since self-regulation is adaptive for every living organism, why would it not be so for human beings?

Every approach to health based on a view of human nature. If we compare an anatomic table based on allopathic medicine with one based on traditional Chinese medicine the different underlying views of human nature are clear. Likewise, every approach in the helping professions is based on a specific vision of human nature, which in turn is based on values. Those values determine the politics of the helping relationship and influence outcomes. To be trained generally in the biomedical reductionistic model, or to be trained specifically as a psychiatrist, Freudian Analyst, behaviorist or person centered psychotherapist, is to enter into and belong to a construed world of values, to take on different roles, and to create clinical settings that actively promote different narratives. The definitions of disease, illness and cure, and the roles of therapist and consumer of the service provided are all influenced by differences in therapeutic approach. Different approaches are grounded in different world views, and most importantly, in different values and different politics. Any view of human nature assumes a set of values. That views of psychopathology and theories of therapy descend automatically from views of human nature is still not necessarily accepted by everybody, even among the different “tribes” of Person Centered practitioners and researchers. Perhaps this is one of the reasons it is difficult to find agreement among ourselves when assessing innovations in the Client Centered and Person Centered Approaches.

One of the invited addresses at the 2006 World Conference for Person-Centered and Experiential Psychotherapies and Counseling focused on the promotion of health. The term patient was used consistently – the term client was not used once. For some colleagues this biomedical model terminology apparently is not at odds with the paradigm Rogers created. However, for me, this is entirely incongruous with the basic premises of Client Centered Psychotherapy and the Person Centered Approach.

Research shows us that psychotherapists from any orientation able to create a good working alliance with her/his clients has a good chance of being an effective facilitator of change. This is not surprising, since different cultures are all effective in creating consensus realities. Realities are socially construed, whether in a culture or in a therapy relationship. However, different cultures differentially impact and “mold” people’s roles, differentially define what is good or bad, and differentially favor the introjection of different values and constructs. Different cultures show different kinds of respect or dignity, offer or negate equal opportunities for some of its members. For example, socially, women are defined very differently in different cultures, with different consequences for the women born and raised within these different constructions of cultural reality. In psychotherapy, whether theoreticians or practitioners are aware of it, the same process of social construction of reality is at work. It is an entirely different thing to assign the role of “patient” and to label a service offered as a psychotherapeutic treatment from facilitating clients in their process of change. With all that we know presently, can we really believe that these two approaches or constructions of therapeutic reality will have identical impacts? Perhaps we should be asking such questions as whether psychotherapy is nowadays the best socially constructed concept for reaching our aims, or whether a more appropriate one can be found.

Profound differences and results are created by different narratives of symptom reduction, health promotion and self-realization. As such, the significant variables to be measured should not be limited only to symptom reduction and the usage of health care services. World views rooted in different values, role models and ways of relating create vast differences in terms of impact on individuals. In all democratic societies there is continued negotiation around such issues. The Person Centered community, along with other psychotherapeutic orientations, cannot afford to be unaware in this respect. Lack of attention to the issues of values and relational politics in psychotherapy settings before Rogers’ revolution was a reflection of the level of awareness of the time. When the results of therapist behaviors become apparent, ethical codes and psychotherapy practice must take notice. Nowadays any exploration of psychotherapists’ ethical responsibilities cannot ignore the politics of psychotherapy. Rogers’ refusal to construct the role of “patient” for his clients offered all professionals a profound learning: how we see and how we relate to clients influences them and also influences us. This is the premise of psychotherapy: Some relationships can be debilitating, and other relationships can be healing and health promoting. In this regard, Rogers’ offered this profound political statement,

I object to the process of depersonalization and dehumanization of the individual which I see in our culture. I regret that the behavioral sciences seem to me promoting and reinforcing this trend. (1968, page 59)

**Being a Patient may be dangerous to your health**

In addition to the grim evidence that the health care system in developed nations is both more expensive and less effective than desirable, there is a further, more subtle cost in our way of relating to health care in the industrialized world: The hidden dangers of being a patient. Modern medical practice is structured with the doctor at the top of the ladder, other health care professionals below this, and the patient at the bottom rung. A consequence of this way of shaping reality is the disempowerment of the consumer of health services. This consumer is designated as the patient. There may be no simpler way to shed light on this disempowerment than to review synonyms of the word *patient*: submissive, calm, susceptible, long-suffering, invalid. Indeed, there is an essential invalidation of the person that occurs as a byproduct of our health care practices, including our ways of relating to “patients” that discount their concerns, observations, needs, human dignity, and potential for regaining health.

The invalidation of patients is not just a matter of semantic cleverness. The helpless, passive role expected of patients is, in fact, bad for their health. Social critic Ivan Illich, writing as far back as 1976, saw modern technological medicine as overextending itself and becoming “medical imperialism,” insisting that anything remotely connected with health belonged under the supervision or control of the medical profession. According to Illich (1977. p.3), the disabling impact of professional control already “*reached the proportions of an epidemic*.”However, Illich went even further, seeing the way the medical establishment relates to people as a major threat to health itself.

People have learned to be patient, passive recipients of whatever health-affecting circumstances are meted out to them by the medical system and life in general—whether they be life-enhancing or life-damaging. The by-product of modern medical practice is that the locus of control for health has been handed over to the medical establishment. Most people do not view themselves as the person primarily responsible for their own health. Consciously or unconsciously, they have externalized that responsibility and assigned it to medical professionals, on whom they rely to cure them when they are ill. Typically, people go about their lives until illness arrives, following this each time by another trip to the medical center looking externally for another cure. Whether healthy or ill, most people in industrialized countries do not experience being in charge of their own health. They have fallen into a pattern of “learned helplessness” in regard to their health and well-being.

*People have given their power over to the health care establishment—oftentimes without realizing it. To further compound the damage, people commonly commit an act of self-denial by thinking they do not have the power to create change*. (Zucconi & Howell 2003 page 32 and 33)

**A compass for the person-centered psychotherapist**

**...***at the basis of anything that a scientist undertakes is, first of all, an ethical and moral value judgment that he makes***.**  (Rogers, 1968, page 200)

Relating to persons as patients or as clients brings about very different outcomes. According to the Heisenberg principle in physics, the observer and the instruments he uses for observation interact with the phenomenon observed and co-construct it. Understanding this concept, allows us to appreciate the context and significance of Rogers’ refusal to label people as “patients,” and to avoid subjecting clients to a series of psychological “tests,” as this would have clear consequences. Many authors have emphasized that observing a person through psycho-pathological labels can produce harmful iatrogenic outcomes (Rogers, 1961; Rogers, et al,1967; Kirk & Kutchins, 1992; McNamee & Gergen, 1992; Kutchins & Kirk, 1997; and Neimeyer & Raskin, 2000). Understanding how reality is constructed socially (cf., Berger and Luckman, 1968) enables us to pay attention to messages and metamessages we communicate to our clients.

Grasping the relevance of the *social construction of reality* offers the practitioner a compass – it offers the practitioner a deep understanding of the difference between assuming the role of expert and assuming the role of a promoter of empowerment. Many professional failures begin with a lack of awareness of the politics of psychotherapy and a lack of awareness of the incongruent application of one’s own paradigm. The politics of psychotherapy and the paradigm shift brought about by Carl Rogers necessitate an awareness of whether we are respecting our clients and their rights and empowering them, or unintentionally impeding personal and social change.

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1. The Diagnostic and Statistical Manual of Mental Disorders, created and used widely by psychiatrists and psychologists in the Western world, listed homosexuality as a diagnosable pathology, a mental “illness,” as late as 1973. [↑](#footnote-ref-1)