NOTES ON THE RELATIONSHIP BETWEEN
PERSON-CENTERED THEORY AND THE
EMERGING FIELD OF HEALTH
PSYCHOLOGY: INDICATIONS AND
SUGGESTIONS FOR THEORY, RESEARCH,
AND PRACTICE

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When the original flyer for the annual 1993 meeting of ADPCA arrived last year, I saw the
stated theme, "The Person-Centered Approach in the 90's," as an occasion to place some structure
on my thinking about the relationship between person-centered theory and practice and the
emerging field of health psychology. Developments in health psychology suggest the increasing
relevance of person-centered notions. This new field needs a theoretical foundation, with the
person as the interpreter of everything that happened before the onset of some physical health
problem and as the one who gives meaning subsequent to an illness state. Indeed, to be effective
as a thinker/theorizer, practitioner, and researcher in matters of health and illness seems to require
a person-centered approach. It is my goal to present some of the indications for this position.

DEFINITION OF HEALTH PSYCHOLOGY

Briefly stated, health psychology is the study of behaviors (thoughts, feelings, perceptions,
and lifestyles) that result in immediate and long-term changes in our physiology such that we are
more or less prone to illness states. The germ theory, embedded in a biomedical approach, does
not explain why some of us fall ill and others do not in the known presence of a pathogen. Thinkers
in the emerging field of health psychology believe that a wide array of variables in the host person
may account for greater or lesser proneness to subsequent illness states. The field also is

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concerned with behavioral variables affecting the course of an illness over time and with factors related to effective treatment and therapeutic regimens.

APPEALS FOR RELEVANT MATERIAL

Appeals for articles and research relevant to health psychology have appeared in previous issues of the Person-Centered Review (Cain, 1989; Chickadonz, 1987; Lietaer, 1987). Cain’s (1989) appeal calls for articles giving attention to the mind-body relationship in physical and mental health. Chickadonz’s (1987) interest in the nurse-client relationship called for research that would identify clients’ perspectives about their health situation. Lietaer (1987) specifies as a needed focus for research “the development of a good working alliance with specific types of clients e.g., psychosomatic and borderline clients” (p. 244). Speierer (1990) appeals for a theory of client-centered therapy that is specific to psychosomatic disorders.

Brodley (1988) suggests that applications stemming from the person-centered approach are unlimited and can pertain to any life situation, work, or task. Her list of applications includes some seeming "psycho-technologies" such as meditation, relaxation training, and biofeedback, modalities now often applied in the treatment of illness. Brodley names the fields of medicine and nursing as needing ideas from person-centered theory. Natiello (1987) questions how procedures such as hypnosis, relaxation, and psychodrama can be reconciled with the concept that locus of control remains with the client. Similarly, Graf (1988) sees no advantage to broadening the definition of the person-centered approach to include the various psychotechnologies. He believes that the use of a technique, any technique, "fundamentally involves a power differential, a manipulation" (p. 3). Bower (1989) responds to this issue by reminding us that "Rogers argued for the use of the whole person-therapist," and goes on to suggest that "relaxation techniques are helpful responses to a person who is directly asking for a dimension for his or her life that is missing"(p. 1). Carl Rogers (1980) speaking of his own experience, described the value of altered states of consciousness experienced in individual and group sessions. He says,

I find that when I am closest to my inner, intuitive self, when I am somehow in touch with the unknown in me, when perhaps I am in a slightly altered state of consciousness, then whatever I do seems to be full of healing (emphasis added). (p. 129)

Quite possibly such transcendence beyond the ordinary level of consciousness, enhanced by meditation and relaxation therapies, can be facilitated most completely by the person-centered therapist.

Writing from the field of medicine, Stoeckle (1987) acknowledges Rogers’s contributions in defining acceptance, respect, and empathy as essential in patient-doctor relationships. He further suggests that these qualities significantly affect the patient’s self-care and the long-term maintenance of optimal health. Calling for research, Stoeckle notes that the "measurement of the caring qualities of medical practice has not been regularly undertaken" (p. 384).

In a prescient, now classic, often-quoted article written more than 65 years ago, Peabody (1927) called for a person-centered approach in patient-doctor relations when he proclaimed

... the vital importance of the personal relationship between physician and patient in the practice of medicine. In all your patients whose symptoms are of functional origin, the whole problem of diagnosis and treatment depends on your insight into the patient’s character and personal life, and in every case of organic disease, there are complex interactions between the pathologic processes and the intellectual processes which you must appreciate and con-
MY ROOTS

In my own life, at least since my late teen years, I have been involved in thinking about matters of physical health and illness. In parallel with this interest, I have had a passionate interest in people’s differing thoughts, feelings, and perceptions about the situations in which they are engaged. My curiosity about illness and health which began when I was a preschooler, was governed by the fear and uncertainty of seeing my mother treated for and eventually dying of tuberculosis. At the age of seven, I was left to be raised by a father whose notions of childrearing and behavioral control included being a stern German taskmaster and preaching about my sinfulness when I did something he deemed inappropriate. The life of inner thoughts and feelings was hardly recognized in these practices. Needless to say, my later childhood and adolescent years were filled with considerable amounts of uncertainty about my own worth, ever-present anxiety, and a feeling of being frightfully alone.

Although I was only an average student at the time, I knew I wanted to go on to college. A routine component of the entrance procedure for the nearby state university was a physical examination. In this examination, it was discovered that I had an abnormally high white count in my urine. When the problem did not yield to the best drugs of the day, the advice was to remove one of my kidneys. This operation was performed; a follow-up culture of the tissue showed that the problem was tuberculosis. My only sibling, a brother younger by two years, did not contract T.B. From what is known today, I believe that the prolonged stress of my earlier years compromised my immune system so severely that I could not fend off the tubercle bacilli which were ever-present in our home.

After taking some time off for recuperation, I returned to college and became fascinated by the life of the mind and the wonder of personal survival and growth, no matter how harmful the details of one’s particular beginning. I wished to go on to graduate school, and had the good fortune to be admitted to the psychology department at the University of Chicago.

I was even more fortunate to be at Chicago during the years when Carl Rogers, John Shlien, Gene Gendlin, and others were there. Coming into contact with notions of client-centered therapy and the person-centered approach, I found a solid theoretical foundation for much of my own emerging conceptions of the human person, the value and significance of the inner life, the place of self as an active agent for change, and the reality of incredible potential in each and every person.

My own earlier experiences, and the subsequent loss of a kidney, focused and stimulated my observations and thinking about the connections between mind and body in matters of physical illness and health. In the late 1970’s, when initial indications suggested that a new field in psychology was emerging, I designed a year-long sabbatical and in 1983-1984 was awarded the position of Visiting Scholar in Health Psychology at The Ohio State University. The following year I returned to Denison University and developed an integrated lecture/research course in this new content area. Early in 1993 I published an article on teaching such a combined course in health psychology -- to my knowledge, the first such article.

In my view, the thinking of Rogers and others in the person-centered framework corresponds to many of the current developments in health psychology. Today I attempt to describe some of these developments.
THESIS AND DEFINITIONS

The central thesis of this presentation is that researchers and theoreticians with a strong background in psychophysiology and behavioral change, operating from a person-centered approach, can make important gains in understanding the onset and course of illness, the effects of treatment, and the long-term maintenance of health. Likewise, person-centered practitioners with a strong background in counseling and psychotherapy and in psychophysiology can provide a proper climate for the restoration and maintenance of physical health.

Before turning to a discussion of correspondences between health psychology and the person-centered approach, let's consider what is meant by "health." Stone (1987) suggests that definitions of health fall into two categories: (a) those which portray health as an ideal state and (b) those which portray health as movement in a positive direction. The definition of health cited most often is that of the World Health Organization (WHO, 1964), which states that "health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (p. 1). In declaring health as more than the mere absence of disease and infirmity and in defining health as a state of well-being or as optimal functioning this view suggests the relevance of such concepts as the fully functioning person (Rogers, 1963a; Seeman, 1984), self-actualization (Maslow, 1971, 1987), increasing differentiation and complexity of perceptions, concepts, and functions (Combs, Richards, & Richards, 1988; Kelly, 1955; Rogers, 1963b), organismic integration (Seeman, 1983), and positive health (Seeman, 1989).

By contrast, illness has been viewed in various ways. Jourard (1971), for example, regards illness as the result of "dismalring events," namely transactions in everyday life that produce a sense of helplessness, such as loneliness or a loss of identity and self-esteem. "Dismalring events," on the other hand give a sense of identity, worth, hope, purpose, meaning, and direction in life. In doing so they produce and maintain wellness, even in the face of stress. "People become ill, not just because of germs, viruses, trauma, or stress, but because these assaults fall upon receptive hosts" (Jourard, 1971, pp. 76-77).

Maslow (1971, 1987) suggests that we become ill when our actualization tendency is thwarted -- that is, when our "metaneeds" or "B-values" are unfulfilled. When we are working to satisfy a deficit, we experience considerable tension. Later in this paper we will see how high levels of prolonged, unabated tension can result in stress-related disorders. Maslow’s (1968, 1971, 1987) list of metaneeds (see Table 1) and metapathologies (see Table 2) is a quite remarkable catalog of variables now shown by research to be related to states of illness and health.

Similarly, Rossman (1989), a physician, regards illness as signals for attention or ways of making us aware of needs that are not being met. Thus, if we learn to pay attention to our body’s signals or symptoms in a certain way, we can actually learn something from an illness that helps bring us back into alignment with our potential for wellness. (p. 79)

Carl Rogers (1959) defines maladjustment as follows:

Psychological maladjustment exists when the organism denies to awareness, or distorts in awareness, significant experiences, which consequently are not accurately symbolized and organized into the gestalt of the self-structure, thus creating an incongruence between self and experience. (p. 204)

Anxiety is the emotional response which signals that the self-structure is in danger of being disorganized if the discrepancy between the self and the threatening experience reaches awareness. The anxiety-ridden person dimly perceives that recognition of the threatening experience
### Table 1

**Maslow’s List of Metaneeds or B-Values**

<table>
<thead>
<tr>
<th>Metaneeds</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Wholeness</td>
<td>Unity, integration, tendency to oneness, interconnectedness, simplicity, organization, structure, dichotomy transcendence, order</td>
</tr>
<tr>
<td>2 Perfection</td>
<td>Necessity, must-rightness, just-so-ness, inevitability, suitability, justice, completeness, oughtness</td>
</tr>
<tr>
<td>3 Completion</td>
<td>Ending, finality, justice, “it’s finished,” fulfillment, destiny, fate</td>
</tr>
<tr>
<td>4 Justice</td>
<td>Fairness, orderliness, lawfulness, oughtness</td>
</tr>
<tr>
<td>5 Aliveness</td>
<td>Process, non-deadness, spontaneity, self-regulation, full-functioning</td>
</tr>
<tr>
<td>6 Richness</td>
<td>Differentiation, complexity, intricacy</td>
</tr>
<tr>
<td>7 Simplicity</td>
<td>Honesty, nakedness, essentiality, abstractness, skeletal structure</td>
</tr>
<tr>
<td>8 Beauty</td>
<td>Rightness, form, aliveness, simplicity, richness, wholeness, perfection, completion, uniqueness, honesty</td>
</tr>
<tr>
<td>9 Goodness</td>
<td>Rightness, desirability, oughtness, justice, benevolence, honesty</td>
</tr>
<tr>
<td>10 Uniqueness</td>
<td>Idiosyncrasy, individuality, non-comparability, novelty</td>
</tr>
<tr>
<td>11 Effortlessness</td>
<td>Ease; lack of strain, striving, or difficulty; grace, perfect functioning</td>
</tr>
<tr>
<td>12 Playfulness</td>
<td>Fun, joy, amusement, gaiety, humor, exuberance, effortlessness</td>
</tr>
<tr>
<td>13 Truth, Honesty, Reality</td>
<td>Nakedness, simplicity, richness, oughtness, pure and unadulterated beauty, completeness, essentiality</td>
</tr>
<tr>
<td>14 Self-Sufficiency</td>
<td>Autonomy, independence, not-needing-other-than-itself-in-order-to-be-itself, self-determining, environment transcendence, separateness, living by its own laws</td>
</tr>
</tbody>
</table>


### Table 2

**Examples of Maslow’s Metapathologies**

- Mistrust, cynicism, skepticism
- Hatred, repulsion, disgust, reliance only upon self and for self
- Vulgarity, restlessness, loss of taste, bleakness
- Disintegration
- Loss of feeling of self and individuality, feeling oneself to be interchangeable or anonymous
- Hopelessness, nothing to work for
- Anger, cynicism, lawlessness, total selfishness
- Grimness, depression, cheerlessness, loss of zest in life, paranoid humorlessness
- Responsibility given to others
- Meaninglessness, despair, senselessness of life

will force a drastic change in self-concept. Whatever we may label this state, it is known that a threat to well-being can activate the primal "fight or flight" or physiological stress response.

Drawing from Rogers, Speierer (1990) developed a theory of physical illness and psychosomatic disorders based on the notion of incongruence. He proposes that when incongruence is dimly perceived, thus leaving one vulnerable to anxiety, threat, and disorganization, subjective suffering is experienced. This suffering is accompanied by physical symptoms related to psychosomatic disorders. Consequently, to the degree that client-centered therapy reduces incongruence, suffering and physical symptoms dissipate.

David Rogers (1974), a physician, distinguishes between disease and illness. He views disease as a biologic process;

... illness, on the other hand, is a human event. It is a grouping of discomforts, dysfunctions, anxieties, and changes in feeling state and in the ability to function. [Illness] ... is influenced by the background, life style, and temperament of the individual who is experiencing it ... Thus an illness is ultimately to be understood not in scientific terms, but in human terms. (p. 126)

INCIDENCE

In matters of physical health as affected by threat, anxiety, and behavior, are we concerned about a small number of persons or a large number? According to research conducted on the problems brought to a general practitioner of medicine, as many as 80% of the health disorders seen are due to a significant behavior and/or psychological component. Surveys of the general population have revealed that 50% of the respondents report suffering, in a continuing way, at least one physical symptom with known behavioral precursors -- complaints such as headaches, chronic pain, gastrointestinal disorders, hypertension, tissue or joint inflammation. Peabody (1927), a physician and medical educator, noted that typically among hospital or private practice patients, "approximately half of the patients complained of symptoms for which an adequate organic cause could not be discovered" (p. 889). Today, as a result of the research on the impact of stress and of emotions on the immune system, it is suggested that all physical health problems are related to personal, perceptual, behavioral factors. (The effects of stress on the immune system will be discussed later.) Recent findings show that emotions can stimulate the production of neuropeptides in the central nervous system, resulting in either an enhancement or a reduction of immune competence. These findings suggest that the central nervous system, influenced by emotions and higher mental processes, is literally an apothecary, always at work producing endogenous chemicals for better or worse (Cousins, 1979). Later we will examine what iatrogenic problems are created when the workings of stress and the emotions are not understood sufficiently on behalf of the individual suffering from a worrisome physical symptom.

TRENDS IN HEALTH PSYCHOLOGY AND CONCORDANCES WITH THE PERSON-CENTERED APPROACH

The following findings and trends suggest the increasing viability of the person-centered approach in matters of illness and health.

The Holistic View

One trend is a shift toward looking at matters of health and illness in terms of the whole person and from a living-systems view (Brody, 1973; Schwartz, 1980, 1982, 1983, 1984; Seeman, 1989; Tapp, 1985). Thinking has moved from a predominantly biomedical model to a position known as the biopsychosocial model. This model assumes that any health or illness outcome is
influenced by the interplay of biological factors (e.g., invading microorganisms and the competence of the immune system response), psychological factors (e.g., a person’s thoughts, feelings, perceptions, and behaviors), and social factors (e.g., the influence of others and the environment) G. Engel, 1977, 1980; Jemmott & Locke, 1984; Schwartz, 1982).

Individual Differences

In our most effective work as person-centered therapists we know the richness and uniqueness of individual differences in perceptions and the effect of these differences on behavior. Increasingly appearing in the literature are findings showing that each of us is also unique with respect to anatomy, biochemistry, and physiology (B. Engel, 1960; Engel & Bickford, 1961; Graham, 1962; Lacey, 1959, 1967; R. J. Williams, 1967).

R. J. Williams (1967), a biochemist, presents evidence in support of this assertion. He shows a picture of a "textbook" stomach followed by pictures of stomachs taken from normal, well-functioning individuals (see figure 1). The actual stomachs depicted show the range of individual differences in anatomy. Williams presents similar observations for a number of biochemical and physiological systems. For example, individuals with no known stomach ailment have been shown to exhibit variations in gastric-juice pepsin levels of 1 to 4,300 units. Some normal hearts have been observed to beat more than twice as fast as others; some pumping capacities are at least three times as great as others. As the discoverer of pantothenic acid and

Figure 1
Actual Stomachs and Textbook Stomachs

folic acid (important constituents of the vitamin-B complex) Williams has noted that as much as a fortyfold difference can exist between the biochemical needs of any two persons.

Lacey (1959, 1967) was the first researcher to systematically explore individual differences in patterns of sympathetic nervous system responses. He labeled this phenomenon "individual response stereotypy"; this term refers to the finding that a particular individual will respond to a variety of stimulus situations with a characteristic pattern. Individual response stereotypy may be one key to explaining why a particular stress-related health problem develops in one individual but not in another when these individuals appear to be experiencing a similar stressful situation and follow similar patterns of coping. Other findings that support the need for concern about individual differences show a considerable variation in the size and productivity of endocrine glands and in the balance among various neurotransmitters.

**Phenomenology**

Research increasingly suggests the necessity of understanding an individual's internal frame of reference if we are to learn what factors account for the level of suffering experienced, how much vulnerability to stress-related disorders is present, why certain therapeutic climates and interventions are effective, and what persons need to maintain a healthy lifestyle. For example, the understanding of human stress has shifted from a consideration of "life change units" (Holmes & Rahe, 1967) to the view that a person's interpretation of an event is more important than the event itself (Lazarus & Folkman, 1984; Sarason, Sarason, & Johnson, 1985). Research on the Type A personality as a precursor to coronary heart disease has moved from study of a cluster of behaviors (easily aroused hostility, a sense of time urgency, and competitive striving for achievement) (Friedman & Rosenman, 1974; Rosenman, 1978) to a concern about how persons view their world. According to Redford Williams (1989), persons at risk for coronary heart disease view their world with suspiciousness, resentment, frequent anger, and cynical mistrust of others.

A significant literature is developing, which shows that persons view or define illness on at least two levels: an abstract level of disease labels and a concrete level of symptom experiencing. The level of the meaning of disease labels is concerned with patients' explanations and attributions (Barnard, 1984; Harwood, 1971; Janis & Rodin, 1979; Koslowsky, Kroog, & LaVoie, 1978; Lau, Bernard & Hartman, 1989; Lau & Hartman, 1983; Leventhal, Meyer, & Nerenz, 1980; Leventhal, Nerenz, & Steel, 1984; Meyer, Leventhal & Gutmann, 1985; Mechanic, 1972; Peterson & Seligman, 1984; Roth, 1962; Stoeckle & Barsky, 1981; Turk, Rudy, & Salovey, 1986). Stoeckle and Barsky (1981) describe the importance of health care workers' understanding patients' "illness attributions" when they observe,

Patients are more likely to feel genuinely supported when they sense that the doctor's behavior expresses a concern based on a personal understanding of them than when it only shows authoritative medical competence. Because attribution is a sensitive indicator of the patient's perception, its recognition is one demonstration of that understanding. (p. 225)


King (1962) asserts, "Man's basis for action in health and disease is a component of many things, but one crucial variable is the way that he 'sees' or perceives the situation of disease and
all of the social ramifications that accompany it" (p. 32). Watson (1979), speaking as a nursing theorist on the importance of the patient's personal, subjective experience, states that "the phenomenon of health and the human predicament of coping with illness are perhaps not only best but perhaps only understood from an existential-phenomenological perspective" (p. 214). Jourard (1971) proposes that consideration of the person's phenomenal field (i.e., one's own perception, beliefs, meaning, and self-structure) is the essential variable in yielding accurate diagnoses and in rendering more effective health care. Jourard regards this approach as so essential that he recommends that a patient's phenomenal field--his or her subjective experience--be checked, recorded, and evaluated as routinely as are readings of blood pressure or temperature. Utilizing person-centered theory Chikadonoz et al. (1986) describes the development of a graduate nursing program in which students learn to value the perspective of the client as a valid basis for understanding the clients' needs and health concerns" (p. 207). In this program data for the nursing assessment and diagnosis is derived by having students practice experiencing, communicating, and validating with clients, their perceptions of the phenomenological world of their clients.

Baron (1985), lamenting that disease rather than sick people has become the physician's primary focus, observes that a wide difference exists between the way physicians think about disease and the way patients experience it. To fulfill the human goals of medicine, he suggests development of a medical phenomenology by which physicians can effectively enter the world of illness as experienced by patients.

The Role and Power of the Person: Greater Individual Responsibility

In the traditional medical model, patients are expected to assume a passive or dependent role and to be cured by the physician. Now, with greater emphasis on the whole person and on the body's capacity for self-healing, individuals are encouraged to assume a more active role in the healing process and in maintaining health. Knowles (1977) advocated less reliance on medical treatment of disease and more individual responsibility for disease prevention:

Over 99 percent of us are born healthy and made sick as a result of personal misbehavior and environmental conditions. The solution to the problems of ill health in modern American society involves individual responsibility, in the first instance, and social responsibility through public legislative and private voluntary efforts, in the second instance. (p. 58)

Implicit in this shift is the notion that effective health care necessitates the availability of a climate, between person and health care provider, of respect, open communication, empathic understanding, and the mutual design of programs for treatment and behavioral change. A climate is needed in which greater responsibility for self is achieved and in which education and empowerment result in improved health care practices. William Rogers and David Barnard (1979) propose that professionals in the health care fields need to facilitate a greater sense of "agency" on the part of the patient. By agency they mean the "sense of empowerment, potency, internal force, or confidence in initiating change or control" (p. 26). They suggest that increased agency for healing and health is likely: when patients are given increased access to information about their illness and modes of treatment; when patients are offered a range of treatment settings -- placed where familiar people, objects, schedules, aromas, and vistas may enhance the sense of internal locus of control and the establishment of a co-healer relationship with medical experts; when patients are helped to achieve greater empowerment in significant aspects of their life such as employment, housing, education, personal and social relations, and access to political institutions; when physicians acknowledge and communicate the limits of scientific medicine and deal sensitively with the realities of death and dying; when physicians explore and resolve,
for themselves, such issues as suffering, tragedy, disillusionment, helplessness, and motives for a medical career; when a range of healing teams with differing perspectives is offered to the patient. Cooperative interprofessional healing teams could be established with the patient as the central member (p. 46-48). In the nursing education program described by Chickadonz et al. (1986) the patient (renamed the client) is seen as the healer with the source of healing originating from within the person. Thus one essential nursing role is to facilitate "self-care." Self-care is assisted by fostering the development of "agency" or the power to act in matters of health.

Indicative of the power of the person is research on the role of the so-called "placebo effect." Research findings indicate that the individual's perceptions about a drug can be more powerful than the drug itself. Similarly, it is known that one's personal view can even reverse the effects of known potent-acting drugs. Sir William Osler was convinced that psychological influences such as belief, faith, and positive expectations played the major role in instigating the restorative mechanisms of vis medicatrix naturae -- the healing power of nature, or what is now known more often as self-healing systems. At a minimum we can say that in the early stages of an assault by a pathogen, the power of the person is greater than the power of the germ. One central theme of Cousins's (1979, 1989) writings and of his work as an adjunct professor in the School of Medicine at UCLA is "that every person must accept a certain measure of responsibility for his or her own recovery from disease or disability" (1979, p. 11).

Mind-body Reintegration

The ancients posited an integration of body and mind. Descartes, however, writing in the seventeenth century, proposed that the mind (or soul) and the body operated according to different principles. Because the body was seen to function mechanistically as a discrete, objective, passive entity, the person and his or her mindfulness was removed from treatment. This dualistic viewpoint was accepted more widely during the nineteenth century with the discovery that microorganisms caused certain diseases. Unexamined at that time was the observation that some persons exposed to such microorganisms fell ill, while others remained healthy. Little attention was given to factors in the host person which might account for the ability to resist the harmful effects of an invading organism.

A device used first by the existential psychologist Victor Frankl (1969) and more recently by Bakal (1979) and Suter (1986) illustrates the necessity of taking a broad perspective in comprehending the nature of a human being in matters of illness and health (see Figure 2).

Imagine spotlights, one up above and one off to the right, each casting a shadow of a cylinder onto a translucent screen. Let the cylinder represent a human being, and the two shadows the biological and the psychological aspect of a human being. Picture a stationary observer situated behind each screen, each one trying to understand the cylinder from its shadow. However, the cylinder is neither a circle nor a rectangle, nor is it even a circle plus a rectangle. Similarly, a human being is neither a body, nor a mind, nor a body plus a mind -- nor a machine with a ghost in it. (Suter, 1986, pp. 11-12)

A person and his or her susceptibility to illness and responsiveness to treatment is understood more appropriately in terms of a mind/body integration. If indications are needed to remind us of this interaction, consider the following:

How can someone who suffers from asthma choke and wheeze at the sight of a plastic flower?

How can people warm their hands just by thinking about it?
How can a current embarrassment or even the recollection of a past embar-
assment result in an increased flow of blood to the surface of the skin and face
(as in blushing)?

How can imagery result in increased salivation?

Clearly, if we limit our attention only to the biological or only to the psychological, we are
less likely to affect everything that operates in healing and positive growth.

Pert (1986), reflecting on her research with emotions and neuropeptides, says this about the
mind-body connection:

I can no longer make a strong distinction between the brain and the body . . .
Indeed, the more we know about neuropeptides, the harder it is to think in
the traditional terms of a mind and a body. It makes more and more sense to
speak of a single integrated entity, a "bodymind." (p. 14)
For some years the term psychosomatic was used for bodily disorders thought to be caused by emotional conflicts. McMahan and Hastrup (1980) make the following observation in their account of post-cartesian history:

There gradually emerged . . . an ambiguously defined diagnostic category designed to accommodate what we know today as "psychosomatic" disorders. This category was called "nervous". . .The apparent influence of "emotions of the mind" in such conditions made their etiology an enigma. It was agreed that if a physician had evidence that a patient was "only nervous," he should stop further inquiry. He is then outside the pale of rational medicine. . .According to the prevalent view, that which was caused by a psychological variable could itself be nothing but psychological. Thus the "nervous" condition became dissociated from physiological processes, and a somatic complaint "of nervous origin" was understood as having no physical basis. (p. 206)

In the mid-1970s, biomedical and behavioral researchers became disaffected with the term psychosomatic medicine because they realized that health problems could not be sorted into those which are psychosomatic and those which are not. Researchers working from both the biomedical and the behavioral perspectives were becoming aware that no such phenomenon existed as a purely somatic (organic) health problem.

The reintegration of mind with body requires that the person be the center of concern in facilitating physical health. Let us recall the story of the drunk who looked for his lost key only under the street lamp because that was where the light was falling. Similarly, the biomedical model sheds its light from a germ or pathogen perspective and looks at illness symptoms purely from an external point of view. Psychosomatic thinkers sought solutions only from an emotional, psychological point of view. It is at the person level, however, neither solely biological nor solely psychological, that the individual seeks and gives meaning to all that is happening mentally and physically. Later in this paper, I will show how personal meanings and personal interpretations can greatly affect resistance to disease and movement toward health. I propose that person-centered theorists and therapists are most capable of knowing where the light needs to fall to understand whole-person functioning as it relates to health and illness.

MECHANISMS LINKING BEHAVIOR TO ILLNESS

In this section, I examine from a person-centered perspective the elements which link person to illness. These might be considered under four basic mechanisms: health impairing behaviors and habits, outcomes of stress, reactions to illness, and self-definitions.

Health-Impairing Behaviors and Habits

Considerable research is being conducted on the effects of various behaviors and habits. These include behaviors such as smoking, diet, exercise, substance abuse, use of seat belts, and improper use of antihypertensive medication. Health-impairing behaviors can take a bizarre turn, as in the story, reported some years ago, of a young Floridian who died from an overdose of water:

Some years previous, Tina’s mother died of stomach cancer. Tina soon became convinced that she also had stomach cancer. Doctors told her she did not. But her expectations were more important than the doctor’s diagnoses. She did not cooperate with medical treatment. To cleanse her stomach of cancer, Tina developed a treatment in which she didn’t eat but flooded her body by drinking gallons of water each day. The tremendous amount of fluid intake upset her body’s chemical balance. Furthermore, Tina was drinking so much water that
her kidneys could not keep up with it. Some of the water drained into her lungs and she literally drowned. News reports quote the medical examiner as saying, "It's unbelievable, but it happened." (Reported in Newsweek, March 14, 1977)

Perhaps this behavior was bizarre, but no less so than smoking. We become sick and die from a prolonged overdose of tobacco smoke, either our own or other people's. The health belief model (Becker & Rosenstock, 1984) predicts that a person's likelihood of taking preventive action is determined: (a) by the person's perceived seriousness of the health problem; (b) by how susceptible the person perceives himself or herself to be to that health problem; and (c) by available information giving "cues for action." In matters of health behaviors, such perceptions determine action.

Outcomes of Stress

The causal sequence between stress and illness can involve either of two paths: (a) a direct route resulting from changes that stress produces in the body's physiology or (b) an indirect route affecting health through one's own perception and subsequent behaviors. What is meant by stress? In everyday use we speak of stress as if it were a pressure or some negative force that could explain unusual sensations or behaviors. Sometimes we speak of stress in terms of physiological activity, such as changes in heart function, a dry mouth, or sweating.

In understanding stress we must consider two interrelated concepts: stressors and physiological processes. The notion of stress, properly considered, is the interrelationship between: (a) the processes by which a person perceives something in the environment or about the self as potentially harmful to a sense of well-being and (b) the physiological processes by which that person responds to this threat. Both elements are involved in the concept of stress.

The perceived environmental event is called a stressor. When such an event is perceived as threatening to well-being, a cluster of physiological responses is activated. We may label these responses variously as dread, fear, anxiety, threat, or anger, depending on the setting. Therefore, these labels can be regarded as cognitive side effects of the more basic process of perceiving a threat to well-being. As person-centered therapists we make a direct contribution to an individual's health and resistance to illness when we help persons to identify threats to self-structure and offer a climate for developing alternative perceptions and modes of coping.

We now must consider two questions: What physiological actions are set in motion by the perception of threat to well-being? How do these physiological reactions result later in illness? When a person perceives something as harmful to well-being, the entire sympathetic nervous system is activated. This is known as the "fight or flight" response, and it prepares the body for emergency action (Cannon, 1929, 1930).

The following actions belong to the "fight or flight" or stress response. These occur in a ganged way -- that is, all together. Here I include only a few of these physiological responses; I later show that if these actions are not read with sufficient empathy and understanding, secondary and unnecessary iatrogenic problems are created for the person experiencing stress. These responses include:

Increase in rate and strength of cardiac contraction. (Our heart speeds up and forces blood to places where it is needed for emergency action.)

Constriction of blood vessels in the skin and extremities. (Our hands grow cold because blood is flowing to more central locations, where it is needed.)

Decrease in gastrointestinal activity.
Increase in respiration. (Our breathing is faster and more shallow; we may read these sensations as anxiety.)

Stimulation of the sweat glands. (We experience sweaty palms and a sweaty brow.)

Increased muscle activity or tenseness.

Actions such as these may or may not be recognized. Even when they are, their meaning is not often interpreted accurately.

Also occurring, seemingly out of the conscious realm, is another "hard-wired" action of the sympathetic nervous system. During the stress response, the adrenal glands are stimulated to release certain hormones into the bloodstream. These hormones are helpful in the short term to sustain "fight or flight" behaviors, but are harmful if the stress response continues unabated over a long time. Two of these hormones are epinephrine and cortisol. When they continue to be released over time, they affect the competency of the immune system to carry out its usual function of fending off the everyday pathogens in our environment. In relation to the immune system, epinephrine appears to increase suppressor T-cells and to decrease helper T-cells. Cortisol inhibits the functioning of phagocytes, macrophages (important immune system scavengers), and lymphocytes (Jemmott & Locke, 1984; Schleifer, Scott, Stein, & Keller, 1986). A lowering of immune competence explains why some people fall ill and others do not in the known presence of pathogens. Findings suggest that changes in the immune balance need be only slight in order to dramatically increase a person's susceptibility to pathogens generally present in the body or the environment.

Marianne Frankenhaeuser (1986) has shown a wide range of psychological events that can elicit the physiological response of secretion of catecholamines and corticosteroids. Her list of stressors includes: urban commuting, job dissatisfaction, loss of the sense of control over something important to one's life, bereavement, conflict, (and perhaps not surprisingly) even boredom.

Snygg (1953) defines humankind's basic need as a "need for adequacy," a term used to include a need for self-actualization, self-fulfillment, or self-regulation. Snygg sees this need as a "biologically grounded force in each of us by which we are continually seeking to make ourselves ever more adequate to cope with life" (p. 37). Combs et al. (1988) state that "each person seeks not only the maintenance of a self, but the development of an adequate self, a self capable of dealing effectively and efficiently with the exigencies of life, both now and in the future" (p. 56). When individuals feel unable to cope with personal stressors, a vicious cycle of events can result. A recognized absence of effective coping modes, however dimly perceived, prolongs the stress response and eventually can result in helplessness, giving up, and fatalism. These feelings -- these perceptions -- can effectively shut down the search for alternative modes of action and for meaning; the result is a "sickness of spirit" (Jourard, 1971), a "sickness unto death" (Kierkegaard, 1954).

Selye (1974, 1976) distinguishes between bad stress and good stress. Good stress, which he called "eustress," refers to the stress of a challenge. In a related manner, Combs et al. (1988) distinguish between threat and challenge. We are threatened by situations with which we feel unable to cope. We are challenged by "situations in which we feel fairly adequate, but in which we also see some opportunities for testing and enhancing our adequacy" (p. 246). Interestingly, research suggests that the physiological activity accompanying threat is different from that accompanying challenge (Holroyd & Lazarus, 1982). Threat is associated with elevation in catecholamine and cortisol levels; challenge is associated only with elevations in catecholamine levels, while cortisol levels remain normal or even lowered (Frankenhaeuser, 1980; Rose, 1980).
By way of review, the evidence suggests that higher mental processes (cognition, perception, "states of mind") via the mechanisms of appraising a stressor as threatening to oneself and one's well-being, followed by ineffective and/or harmful modes of coping over an extended time, can alter bodily functions in ways which leave an individual more vulnerable to an array of physical problems.

All of this may seem to be a curious turn of events in our own evolution as a species: that we are unknowingly placing ourselves in jeopardy by our perceptions or "states of mind." How did this come about? It has been suggested that in earlier times a stressor situation (the necessity for finding food before returning to one's cave at nightfall, the sight of an oncoming bear, fighting a saber-toothed tiger) set in motion, quite appropriately, the physiological changes which would enhance one's ability to engage in "fight or flight." The behaviors of "fight or flight," once engaged in, could result in a rather short time, in a reduction of these survival-serving excitations. As civilization developed, however, we ceased to condone these behaviors as proper modes of coping in most situations. Perhaps another way of expressing this idea is that in our modern day, we have not yet evolved sufficient alternatives to the "fight or flight" options, which can yield resolution such that we need not suffer prolonged physiological excitation. Instead, indicators of stress reactivity often accumulate beyond our awareness. Why might this be so?

For whatever reason, in our time it seems we have come to desensitize and dissociate ourselves from the various physiological indicators of threat or stress in our bodies. Sometimes this is a conscious decision, but more often it is due to the likelihood that we do not comprehend the meaning of these signals within ourselves. When normal and vitally important reactions to perceived threat do not reach our full awareness, we may interpret them, only dimly perceived, as something abnormal and as signs of disease -- if we believe the TV ads that bombard us daily. For example, we may speak of "indigestion" as an affliction when it is likely that apprehensiveness about something is killing our appetite (there is a pill for this); we may regard "insomnia" as a problem when in fact it is fright, anger, or an exciting personal challenge that keeps us awake at night (there is another pill for this); an increase in heart rate becomes "palpitation"; we refer to the sudden elimination of waste matter as "diarrhea"; the clenching of our back muscles in former times was called "lumbago," when prolonged we call it "lower back pain"; anxiety is known as "bad nerves"; and so on, with a pill for each ailment.

Ironically, medication may mask and prolong the stress response and obscure the meaning of the threat. More often, effective modes of coping are needed and each of these physical signs can provide useful cues. Of course, each of these physiological responses could indicate an array of possible problems. The point is that all possible meanings of these responses must be addressed if the person eventually is to function well again.

When an individual or a member of the health care professions systematically misreads or mislabels such information and provides only a palliative -- whether in the form of a pill or some other type of dismissal -- this action only further obscures the total picture, thus permitting the underlying causes to further accumulate beyond awareness, until a more clearly recognizable and more serious physical symptom is manifested. By this time, the body's capacity to respond may have been damaged beyond repair.

A. J. Scott (1977), a faculty member of the University of Auckland School of Medicine, suggests that physicians' accuracy in diagnoses could be much improved if there existed a category of "non-disease." He believes that proper diagnoses must be based on a richer clinical phenomenology. Scott recognizes that patients consult a physician because they are concerned and fearful about the meaning of the symptoms they experience. Thus, when tests have ruled out the presence of disease, he believes that a diagnosis of "non-disease" should be communicated. Should concerns and fears about the sign value of symptoms continue, then staff members trained in clinical phenomenology and operating from a person-centered perspective could be consulted.
Peabody (1927), wrote the now often-quoted article "The Care of the Patient" while he was seriously ill with liposarcoma of the stomach. He observed that a large number of persons who are admitted to hospitals and who see their private physicians are characterized by symptoms that cannot be explained by organic disease, and that these persons often are told that they have "nothing the matter" with them. Instead Peabody suggested that

. . . Henry Jones, lying awake nights while he worries about his wife and children, represents a problem that is much more complex than the pathologic physiology of mitral stenosis, and he is apt to improve very slowly unless a discerning intern happens to discover why it is that even large doses of digitalis fail to slow his heart rate. Henry happens to have heart disease, but he is not disturbed so much by dyspnea as he is by anxiety for the future. (p. 879)

Peabody concluded with the admonition that in many patients "it is not the disease but the man or the woman who needs to be treated" (p. 880). Needed are teams of researchers and health care providers who can assist persons in awareness (of one's own experiences), meaning (clarification of the meaning of felt symptoms), and coping (development of alternate modes). Researchers and practitioners operating from a person-centered perspective are well positioned to provide this kind of assistance.

Reactions to Illness: Attributions and Explanations

The third mechanism linking the person to an illness state pertains to a person's reactions to an illness. Lipowski (1970) gives an account of the kinds of personal meanings people give to their illness, injury, or disability, as follows:

*Illness as punishment.* Illness can be seen as unjust or just punishment. If viewed as unjust, anger and/or depression may result. If viewed as just, the person may remain passive to the point of not seeking help.

*Illness as enemy.* Sickness can be viewed as an invasion by some harmful agent or force over which the person has little potential power.

*Illness as relief.* Being ill can be seen as a welcomed relief from a life filled with overwhelming demands, conflicts, or problems.

*Illness as weakness.* Illness can be viewed as a clear sign of failure: one's inadequate body confirms that control over events is no longer possible. Because resources now seem to be insufficient, it becomes foolish to attempt a restoration of health.

*Illness as irreparable loss or damage.* Illness may mean that the person no longer feels he or she can be worthy as a whole person. Physical loss can become a symbol of being incomplete and as less worthwhile than others.

*Illness as strategy.* Illness can be used as a strategy for securing attention, support, and compliance from others.

*Illness as challenge.* Illness can be viewed with the attitude "Here is but another life situation with particular tasks to be mastered."
Illness as value. The person may conceive that illness or suffering has value and may lead to a richer spiritual life and a greater appreciation of aesthetic and intellectual pursuits. The notion can be that sickness, by contrast, makes one appreciate health more fully.

Various reactions obviously would have different implications for the progression over time of a disorder, and would have considerable implications for an effective individualized treatment program. For example, some "reactions" would diminish the willingness even to report symptoms and seek medical attention. Even if help is sought, other reactions might interfere with the following of a prescribed treatment regimen. Awareness and clarification of such meanings might result in greater self-responsibility.

This particular mechanism linking person to illness is significant because that which maintains an illness state often may be quite different from that which precipitated it. That is, the person may have recovered from the disease or injury but now is (for example) passive, anxious, worried, or reluctant to exercise because of continuing beliefs and perceptions operating beyond awareness. To miss these subsequent and lingering meanings and their impact on behavior is to fall far short of assisting a return to full functioning. According to Stoeckle (1979), encouraging the patient's full expression of his attributions and meanings is essential if the physician is to carry out the "tasks of care" -- diagnosis and treatment, information and education about illness, personal support, and planning for prevention and the long-term maintenance of health.

Eisenberg (1981) portrays the importance of the physician's understanding the search for meaning in each patient:

The patient who consults a doctor because he has experienced discomfort or dysfunction seeks more than remission of his symptoms; his quest is for relief from the fears aroused by the disruption in the continuity of his accustomed self. Beset by distress, he searches for an interpretation of the meaning of the misfortune which has befallen him. (p. 239)

Self-Definitions

Seeman (1988), reviewing the concept of self and its rediscovery in American psychology, observes:

One of the most dominant themes in health psychology has been the central role of self-definition and personal disposition as correlates of health status. (p. 159)

Bandura (1986) views "self-efficacy" as the belief that one can be successful at carrying out a particular set of behaviors. The belief that one can negotiate adverse events or their consequences appears to be correlated with a sense of control and well-being. Persons with feelings of self-efficacy are less likely to be depressed; when they experience threat, their sense of adequacy moderates the harmful effects of the stress hormones on the immune system (Bandura, 1986). The view of self as efficacious in carrying out particular health behaviors could explain the success of a particular program of behavior change. Research has shown that self-efficacy affects health behaviors as diverse as abstinence from smoking (Prohaska & DiClemente, 1984), weight control (Strecher, DeVellis, Becker, & Rosenstock, 1985), and reduction of arthritis pain (Gravelle, 1985).

On the assumption that everyone necessarily experiences stress, perhaps one significant difference between those who are at risk for later health problems and those who remain healthy may be the rate of recovery of various components of the response clusters in the sympathetic
nervous system after a stressor situation. Johansson and Frankenhaeuser (1973) found that in a sample of healthy male subjects, those who had a more positive notion of themselves (a lower neuroticism score) experienced a more rapid decrease of epinephrine after a complex-reaction task. Richard’s (1971) findings were similar. He divided subjects into high and low groups on the basis of the Tennessee Self-Concept Scale (Fitts, 1964) and presented each person with a series of mild arousal situations. Continuous monitoring of heart rate, peripheral skin temperature, and galvanic skin response showed that the subjects high in positive self-concept displayed lower levels of physical arousal, an indication of less stress reactivity.

Using a case study approach, Martin, Alcorn, and Stevens-Steward, (1987) suggested that self-concept is an important factor in proper dental plaque control. They noted that patients with a low self-concept tend to neglect their bodies and health, and that this fact has a significant relationship to chronic periodontal disease (periodontitis).

Brown and McGill (1989) proposed an "identity disruption model," which states that the "more a life event changes the way a person thinks about the self, the greater the person's risk for developing illness" (p. 1103). These researchers wished to learn why positive life events might produce negative health consequences. The identity disruption model suggests that persons with low self-esteem find it difficult to accept good things that happen to them because these events are outside their sense of identity. By contrast, when good things happen to persons with high esteem, these persons experience no variance from their own self-concept. This research showed that college students with high self-esteem enjoyed good health after positive life events, whereas those with low self-esteem suffered more symptoms of illness after reporting positive life events.

I suggest that in addition to promoting gains in health for our clients, we may enjoy significant healthful outcomes for ourselves as person-centered practitioners. Carl Rogers describes the therapeutic relationship as an encounter of two persons, each with potential for enhanced awareness, healing, and growth.

The root of the word heal is the Anglo-Saxon word haelen, which means to be or to become whole. Acknowledging Carl Rogers’s notion of unconditional positive regard, Rachel Naomi Remen (1989), medical director of the Commonweal Cancer Help program, describes the healing relationship as one which allows wholeness to emerge. She believes that one person does not heal another; instead we invite another person into a healing relationship. Effective healing occurs when people heal together.


When people help other people they often experience a "helper’s high" -- a sudden rush of warmth, good feelings, and increased energy followed by a longer-lasting sense of calm, emotional well-being, and increased self-worth. Those who experience this "healthy-helping syndrome" report better overall health -- less pain, fewer colds -- and appear better able to cope with chronic diseases and stress-related disorders. (Newton, 1993, p. 2)

As practitioners employing a person-centered approach, we may be significantly affecting our own health and well-being.

I suggest that the person-centered approach has much to say about physical health and illness. To the extent that persons experience threat (an incongruence between self-concept and experience), they are more likely to bring about activation of the sympathetic nervous system cluster of stress responses. Prolonged and unabated activation of the stress response results in a wide range of physical disorders and leaves one with a weakened immune system, less able to fend off ordinary, ever-present pathogens. Furthermore, when concepts of self and/or modes of coping are ineffective, persons continue to be at risk, carry out fewer and fewer health behaviors, and
eventually may give up. Person-centered therapists and researchers, however, informed by an understanding of psychophysiology and focusing on the perceptions and meanings of persons, can have a major impact on the individual’s restoration to health. Current trends in the emerging field of health psychology suggest that theorists, therapists, and researchers using the person-centered approach can contribute a great deal to the pursuit of physical health and well-being.

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Indications and Suggestions


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