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THE METAPHORICAL USE OF DIAGNOSIS AS A RELATIONAL RESOURCE: BETWEEN LISTENING, CARE AND BELONGING POLICIES

[1]Roberto Ricardi Costard

1 Universidade São Judas Tadeu - USJT. E-mail: beto_costard@hotmail.com

ABSTRACT

This article proposes a critical reflection on the use of diagnosis in clinical and institutional practice, understanding it not as an objective truth, but as a relational language and symbolic construction that can open or close possibilities for listening, care and belonging. Far from being just a technical tool, diagnosis operates as a discourse that communicates norms, regulates access and shapes identities. Based on a theoretical-reflexive approach, the text articulates contributions from the Person-Centered Approach, the anthropology of health and critical perspectives on normativity, stigma and institutional culture, such as those of Carl Rogers, Eugene Gendlin, Mary Jane Spink, Georges Canguilhem and François Laplantine.

The actualizing tendency, a central concept of the Person-Centered Approach, is mobilized as a key to rethinking the role of diagnosis as a language of recognition — and not as a means of capturing identity. It also discusses how certain forms of selective listening, permeated by cultural and institutional norms, can transform diagnosis into a tool of exclusion, reinforcing historical inequalities and illnesses. On the other hand, when co-constructed with sensitivity, ethical listening and relational implication, the diagnosis can become a resource for recognition, bonding, guaranteeing rights and social belonging.

Keywords: Diagnosis; Listening; Person-Centered Approach; Actualizing Tendency; Normativity; Belonging; Care; Public Policies.

O USO METAFÓRICO DO DIAGNÓSTICO COMO RECURSO RELACIONAL:

ENTRE ESCUTA, CUIDADO E POLÍTICAS DE PERTENCIMENTO

RESUMO

Este artigo propõe uma reflexão crítica sobre o uso do diagnóstico na prática clínica e institucional, compreendendo-o não como verdade objetiva, mas como linguagem relacional e construção simbólica que pode abrir ou fechar possibilidades de escuta, cuidado e pertencimento. Longe de ser apenas uma ferramenta técnica, o diagnóstico opera como discurso que comunica normas, regula acessos e molda identidades. A partir de uma abordagem teórico-reflexiva, o texto articula contribuições da Abordagem Centrada na Pessoa, da antropologia da saúde e de perspectivas críticas sobre normatividade, estigma e cultura institucional, como as de Carl Rogers, Eugene Gendlin, Mary Jane Spink, Georges Canguilhem e François Laplantine.

A tendência atualizante, conceito central da Abordagem Centrada na Pessoa, é mobilizada como chave para repensar o papel do diagnóstico como linguagem de reconhecimento — e não como captura da identidade. Também se discute como determinadas formas de escuta seletiva, atravessadas por normas culturais e institucionais, podem transformar o diagnóstico em ferramenta de exclusão, reforçando desigualdades históricas e adoecimentos. Por outro lado, quando co-construído com sensibilidade, escuta ética e implicação relacional, o diagnóstico pode se tornar um recurso de reconhecimento, vínculo, garantia de direitos e pertencimento social.

Palavras-chave: Diagnóstico; Escuta; Abordagem Centrada na Pessoa; Tendência Atualizante; Normatividade; Pertencimento; Cuidado; Políticas Públicas.

INTRODUCTION

This article proposes a reflection on diagnosis as a language and as a practice that produces effects — subjective, relational and social. When used as a rigid classification, it tends to reduce the complexity of human experience, potentially blocking spontaneous movements of growth and making it difficult to listen to the person in their entirety. However, when regarded as a relational metaphor, constructed with sensitivity and ethics, diagnosis can become a powerful resource for recognition, listening and belonging.

Diagnosis, as it circulates in clinical, school, family and media spaces, is not just a technical instrument: it is also a language that communicates values, defines social places and organizes expectations. In institutional contexts, it is often used as an eligibility criterion for access — be it treatments, benefits, adaptations or even listening. In affective contexts, it can produce relief or anguish, depending on how it is presented. And on a symbolic level, it carries with it cultural stories about what it means to be "normal", "capable", "autonomous", "intelligent", "adjusted".

The proposal for this work arises from listening to these tensions: between the diagnosis that recognizes and that which labels, between what opens paths and what crystallizes identities. These are tensions that permeate both clinical practice and broader social discourses on mental health, inclusion, productivity, and difference. In this sense, I am interested in reflecting on how diagnosis, when guided by normative logic and selective listening, can make people sick — erasing the individual's uniqueness and reinforcing historical inequalities. Diagnosing, in this case, is less about listening and more about framing.

In contrast to this logic, I propose here an approach that values diagnosis as a situated, relational, and context-sensitive construction. A construction that is based on genuine listening and ethical implication, inspired by the principles of the Person-Centered Approach (PCA), formulated by Carl Rogers. This perspective understands care as a relational field, supported by empathy, authenticity and unconditional positive regard — elements also explored in depth by Eugene Gendlin in his proposal of Focusing as a way of ethically listening to lived experience — in which each person's actualizing tendency can emerge and be reorganized.

The reflection developed here is also anchored in authors such as Humberto Maturana and Francisco Varela [1], Georges Canguilhem [2], François Laplantine [3,4], Erving Goffman [5] and Mary Jane Spink [6], whose contributions help to understand diagnosis in its historical, symbolic, institutional and political dimension. From Maturana and Varela, we especially take up the notion that language is not a neutral instrument of representation, but a relational phenomenon, constituted in the interaction between living beings — an idea that reinforces the need to consider diagnosis as a situated construction. Spink, on the other hand, proposes understanding discursive practices as forms of action and production of meanings that directly influence the possibilities of care, listening and recognition. Along with these perspectives, we seek to understand how the ways of naming human suffering affect the way we relate to the people we serve — and how these namings participate in the production or blocking of belonging.

More than a critique of the diagnosis itself, this text proposes an ethical listening to its use. It is about seeking forms of language that respect the complexity of human suffering, promote more authentic encounters and favor the construction of policies of belonging — those that not only recognize differences, but also guarantee conditions so that they can exist with dignity.

METHODOLOGICAL PROCEDURES

This article is a theoretical-reflective essay, based on the articulation between Humanistic Psychology — with an emphasis on the Person-Centered Approach (PCA) — and critical references from the human and social sciences. It starts from the understanding that discourses on diagnosis are not neutral, but constitute situated relational practices, with concrete effects on the possibilities of listening, care and belonging.

The reflection was constructed from a selective bibliographic review, guided by ethical-conceptual affinities with authors such as Carl Rogers, Eugene Gendlin, Georges Canguilhem, François Laplantine, Erving Goffman, Mary Jane Spink, Humberto Maturana and Francisco Varela. These authors contribute to the understanding of diagnosis not as an objective truth, but as language — historically constructed, culturally mediated and politically implicated.

More than describing or applying a traditional empirical methodology, this path is guided by the construction of an implicated perspective, capable of challenging normativities and proposing a more sensitive clinical listening, committed to the ethical recognition of singularities. Writing, therefore, constitutes a political and epistemological gesture, in which care emerges as a relational practice, rooted in unconditional positive regard, empathy and congruence as foundations of the encounter.

LISTENING: DIAGNOSIS AS LANGUAGE

In the Person-Centered Approach (PCA), listening is not just hearing sounds or recording speech — it is a posture of genuine presence and availability. Listening is welcoming the other person’s experience without prior judgment, without trying to adjust what is said to ready-made categories or normative expectations. For Carl Rogers, listening is one of the pillars of the therapeutic relationship, as it creates the safe space necessary for the *self* to emerge authentically. When I truly listen to someone, I am placing myself alongside that person on their journey, and not ahead of them with a ready-made diagnosis [6,7].

Understanding diagnosis as language is recognizing that it is not just a technical tool, but a relational gesture. Every act of naming carries values, feelings, and implications that go beyond the objective description of a state or condition. When diagnosing, we establish a way of relating to the person’s experience. This language can bring people closer or further away, open or close, recognize or exclude. Therefore, diagnosis needs to be thought of as a form of listening — not just a technical code, but an expression that we co-construct with the other person based on the bond.

From the perspective of Humberto Maturana and Francisco Varela, I understand that language is not an objective representation of reality, but a relational action that creates possible worlds among those who live together [1]. Diagnosis, in this sense, does not just describe something: it acts on what it describes, shaping perceptions, relationships and possibilities. Diagnosing is, therefore, also a creative act — which must be guided by ethical responsibility and care with the impact that this language can produce.

However, it is necessary to recognize that listening often becomes selective, filtered by institutional, cultural or professional biases. Listening shaped by norms of productivity, performance, gender, class, race, disability or language pattern tends to capture only fragments of experience — precisely those that confirm already established knowledge. In this scenario, diagnosis ceases to be an open language and becomes a form of forced fitting, in which suffering is adjusted to models and protocols, and not the other way around.

This selective listening is not necessarily intentional, but it is structured by systems of power that operate even with the best intentions. A school that only listens to deviant behaviors and not to a student's living conditions; a Psychosocial Care Center that only listens to the risk and not the context of vulnerability; a health institution that only listens to the symptom and not the biography. In all these cases, listening is already marked by a logic of exclusion that silences other possibilities of understanding suffering.

In contrast, listening according to PCA invites full presence. It does not seek to adapt the person's speech to a technical language, but is willing to inhabit the person's language, even if it is fragmented, silent or non-verbal. This listening is relational and non-hierarchical. It suspends automatic filters and allows the experience to reveal itself in its complexity, without the rush to be translated.

According to Rogers, for a therapeutic process of change to occur, certain conditions need to be present in the relationship. These include: the client being in a state of incongruence and emotionally disturbed; the therapist being in psychological contact with the client; the therapist being congruent and aware of his or her own feelings; offering unconditional positive regard and empathetically understanding the client, communicating this understanding effectively. When these conditions are offered authentically, they become fertile ground for the reorganization of the *self* and for the updating of internal experiences, which are often fragmented or unnamed [6].

In this context, empathic understanding — that is, the therapist's ability to enter the client's frame of reference and communicate this experience to them — is one of the most transformative aspects of relational language. Rogers states that when the client realizes that the therapist genuinely understands their experience, even if they themselves do not yet have the words to say it, a new symbolic space opens up. Diagnosis, when inserted into this type of listening, can cease to be an external framework and become a provisional and co-constructed language that supports the naming of experience, rather than its reduction.

Diagnosis, in this context, is not about applying a label, but about supporting a language that makes sense in the context of an encounter. It is more than classifying: it is listening. It is less about defining what the other has, and more about understanding with the other what is being experienced. Thus, diagnosis becomes a gesture of recognition — a way of sustaining the other's existence as legitimate, even when it escapes the norms.

This understanding is in line with the clinical stance of the Person-Centered Approach, especially when Rogers proposes a form of listening that does not seek ready-made answers, but rather accompanies the other person's process in its singularity. In resonance, Eugene Gendlin proposes that the therapist should not fixate on interpretations, but rather support the continuity of the experiential process through open listening, which favors micro-understandings — "micro-diagnoses" that emerge in the relational movement itself, rather than being applied from outside [8].

Therefore, I propose that the diagnosis, when necessary, be the result of a process of shared listening, and not of a unilateral analysis. That it can function as a provisional language, open to revision, sensitive to the person's time. And that it should always be accompanied by a fundamental question: does this language bring closer or distance? Does it expand or reduce? Does it listen or silence?

DIAGNOSIS AND CONTEXT: CULTURE, TIME AND BELONGING POLICIES

Diagnostic categories are not fixed truths about human nature, but rather historical and cultural constructions that reflect the values, beliefs, and interests of a given era. The emergence of certain classifications is linked to broad social processes: sometimes to the medicalization of childhood and emotions, sometimes to the logic of productivity and autonomy, sometimes to demands for institutional control. Thus, to diagnose is also to participate in the symbolic production of a time—it is to name according to the criteria of the present, and not merely to describe something timeless and universal.

Georges Canguilhem invites us to understand that the notions of “normal” and “pathological” are not rooted in nature, but are shaped by historical and political values [2]. What is considered healthy in one period may be classified as a deviation in another. And, in the same way, what is diagnosed as a disorder today may express, in other contexts, legitimate ways of existing. The diagnosis, in this sense, carries a normative load: it not only describes, but regulates — who belongs, who needs to be adjusted, who will be listened to.

François Laplantine, in criticizing the rigidity of dichotomous categories in Western thought, broadens this discussion by showing how suffering is always permeated by symbolic, social and cultural dimensions [3,4]. The separation between normal and abnormal, reason and emotion, mind and body — present in many diagnostic manuals — tends to capture only part of the experience, erasing nuances and complexities that resist simplistic naming.

When the diagnosis is anchored in this logic of normalization, it runs the risk of becoming ill. It makes listening ill, by limiting the person's language to what is institutionally recognized as a symptom. It makes the bond ill, by transforming the relationship into an evaluative and hierarchical process. It makes the person themselves ill, by reducing their existence to a label that determines their possibilities of being, living together and imagining other paths. Normativity, in this sense, does not operate only as a technical criterion, but as a symbolic force that defines what is acceptable to feel, desire, express — and what should be silenced or corrected.

This is why diagnosis also requires critical listening to the norms that support the act of diagnosis itself. After all, it is not uncommon for suffering to be more an effect of the context than a trait of the person. Environments of oppression, exclusion, violence or institutional abandonment sickens people — and it is often this illness that reaches clinics as an individual complaint. As Spink [13] proposes, psychological suffering can express the effects of social inequality and the precariousness of care networks, rather than an individual pathology. When diagnosis ignores this contextual and political dimension, it contributes to perpetuating the invisibility of the structures that generate suffering.

In this scenario, we need to ask: who do diagnoses serve? What experiences do they legitimize — and which do they leave out? Clinical categories are not neutral: they shape public policies, organize care offerings, and produce social places. And that is why they also need to be analyzed from the perspective of belonging policies.

This is about belonging policies as practices — explicit or implicit — that regulate who is seen as a subject with full rights, who is listened to in their legitimacy, and whose existence is recognized as worthy of care. Diagnosis, by offering institutional visibility to certain forms of suffering, can operate as a tool for belonging: it can be what allows a person to access resources, to be understood in their difference, and not need to “perform normality” in order to exist. But diagnosis can also be, paradoxically, what fixes, labels, and excludes — especially when constructed in a decontextualized way.

At this point, Erving Goffman’s reflections on stigma become especially useful. Diagnosis can be both an opening and a risk: it can provide language to organize an experience, but it can also become a deteriorated identity that overshadows all other dimensions of the person [5]. When society defines someone solely based on a diagnosis, it is not listening: it is framing.

Therefore, diagnosing requires awareness of the contextual and institutional effects of this practice. It requires situated listening, sensitivity to the culture of the other and care with the social markers that permeate the experience: class, race, gender, disability, neurodivergence, among others. It also requires ethical responsibility: knowing that naming is often about distributing places of belonging — and that this must be done with caution, implication and commitment to justice.

WHEN THE DIAGNOSIS IS ALLIANCE: PUBLIC POLICIES AND THE RIGHT TO CARE

Given the many possible criticisms of the use of diagnoses, it would be tempting to imagine that the best course of action would be to simply abandon them. However, I understand that this attitude runs the risk of disregarding an essential dimension: the diagnosis, despite all its limitations, can be an important tool in the fight for recognition, access to rights and in the formulation of public policies. Therefore, I believe that the problem does not lie in the diagnosis itself, but in the way it is handled and the intentions that guide its use.

There are contexts in which the diagnosis is the only possible way to guarantee specialized care, school inclusion, curricular adaptation, access to legal benefits, psychosocial support or even protection against institutional negligence. Without it, many lives remain invisible — or, worse, invalidated. In this sense, the diagnosis acts as a mediator between subjective experience and social rights: it is through it that someone's suffering gains public intelligibility and comes to be recognized as legitimate, deserving of care.

Furthermore, it is based on diagnoses that statistics, technical guidelines, legislation and intersectoral care strategies are constructed. It not only names individual experiences, but also organizes collectives, justifies investments and underpins public policies. Ignoring or rejecting it completely would also be neglecting its function as an instrument of citizenship — especially in contexts marked by inequality.

The power of the diagnosis is also revealed when it becomes a bridge between different policies and care territories. In services such as Psychosocial Care Centers (CAPS), public schools, Social Assistance Reference Centers (CRAS) and units of the Unified Health System (SUS), the diagnosis is often the common language that allows for coordination between professionals and actions. When well managed, it functions as a resource that organizes care in a broader way, respecting social intersections, local vulnerabilities and community ties. In these instances, the diagnosis can function as a collective listening device, which connects individual suffering to public support and intervention networks.

However, for this to happen, the diagnosis needs to be built along with the person, and not just about them. It needs to be supported by a relationship of trust and sensitive listening. When imposed without dialogue, it becomes a sentence; when carefully elaborated, it can become a language of support: a starting point for subjective reorganizations and access to policies of belonging.

It is at this point that I return to Carl Rogers' criticism of the diagnosis in his time. His positioning took place in a clinical context in which the diagnosis was often used as an instrument of labeling and hierarchy, more at the service of institutions than of the person in distress. Rogers argued that genuine listening, connection and trust in the actualizing tendency of each human being should be at the center of therapeutic practice. Even though the scenario has changed, I believe he would maintain his critical sense regarding the risk of the diagnosis blocking this tendency — especially when presented in an imposing way. But I also believe he would recognize the value of the diagnosis as a relational and political resource, when it favors autonomy, growth and the right to exist [6].

This concept is expanded upon by Rogers and colleagues when they propose PCA as an ethical stance with the potential for social and institutional transformation [11]. Thus, I understand that we are not talking here about a diagnosis in its essential form, but rather about a relational diagnostic model, guided by listening and collaboration. It would be inappropriate to separate diagnosis and use, as if there were a pure diagnostic act free of ethical and political implications. Every diagnosis has always been a way of using language and of situating the other in the world. Therefore, when the diagnosis is offered as a language built along with the other — and not about the other —, it ceases to be an instrument of control and becomes a device for expanded care. And it is in this sense that it can operate as an alliance: between the person and their experience, between services and rights, between listening and belonging.

CARE AS AN ETHICAL METAPHOR

In the Person-Centered Approach (PCA), caring is not about intervening on someone, but about creating a space where that person can recognize themselves and transform themselves based on their own experience. Caring, in this context, is about being present in an authentic, empathetic and unconditionally welcoming way — values that support what Carl Rogers proposed as a facilitating therapeutic relationship. This centrality of the person as the ethical subject of the relationship is also reinforced in the work co-authored with Rachel Rosenberg, when highlighting that listening is a path to affirming the existence and value of each individual [10].

This understanding leads us to see care as something that transcends technique: it is a form of presence that recognizes the other as legitimate. It is a relational disposition that allows the subject to perceive, reorganize and assert themselves with greater freedom. It is in this line of thought that I understand care as an ethical metaphor: a way of being with the other that welcomes their difference without needing to neutralize it, and that sustains the time and rhythm of their own growth movements.

The centrality of the actualizing tendency in PCA reinforces this conception. According to Rogers, every human being carries within them a vital drive toward growth, the construction of meaning, and the fulfillment of their potential [6]. This force does not eliminate conflicts, but allows them to be reorganized from a reliable relational space. It is up to the therapist not to direct this process, but to create an environment in which the person feels safe to follow their own path — even if that path does not fit external expectations.

This formulation, although profoundly original, was inspired by ideas from holistic biology, especially the work of Kurt Goldstein, whose understanding of the human organism as a self-regulating system directly influenced Rogers' thinking. From this basis, combined with his clinical listening and ethical sensitivity, Rogers developed the notion of the actualizing tendency as a force inherent to the human being — present whenever external conditions favor its expression [6,8,11].

Congruence, in this scenario, is more than emotional transparency: it is the ground on which trust is built. When the therapist is in touch with his or her own feelings and acts authentically, he or she communicates to the person being treated that there is a safe space there — not just for listening, but for real presence. For Rogers, this stance on the part of the therapist is one of the fundamental facilitating conditions for change, as it breaks with the logic of evaluation and creates the necessary field for the emergence of new ways of being [6,7,10].

Incongruence, in turn, appears as a legitimate human condition — not as a flaw or deficit. It describes the state in which there is a misalignment between the lived experience and the internalized self-image, often shaped by rigid social norms or idealized standards of acceptance. In many cases, incongruence arises from the distance between the lived experience and the so-called ideal *self* — that is, the internalized image of who the person believes he or she should be in order to be accepted, recognized, or loved. This ideal *self*, often shaped by exclusionary social norms, can become a source of chronic suffering. However, incongruence can also arise from other sources, such as blocks to accessing one's own experience, traumatic or fragmented experiences, or even internal conflicts that are not limited to comparison with an ideal, but to the difficulty of integrating aspects of oneself. Care, in this sense, does not seek to adjust the person to a model of identity, but to help them reconnect with their authentic experience. Listening with empathy also means listening to these conflicts — whether with the ideal *self* or with other layers of the experience — and offering a space where the *self* can reorganize itself with more freedom and less submission to imposed demands.

When the diagnosis is offered in an empathetic and non-judgmental way, it can help the person recognize that they are not failing because they do not correspond to their ideal *self* — but that this ideal is often the result of external demands that are incompatible with their real experience. In this context, the diagnosis is not a sentence, but an opportunity to name internal conflicts and reorganize the *self* with more kindness. It can be an invitation to free ourselves from the norms that make us sick, and to cultivate a way of being that is closer to what is experienced than to what is expected.

This view is reinforced by Rogers' own formulations about the human being as a self-regulated organism that tends toward wholeness and integration even in the midst of suffering. Based on his clinical listening and observation of processes of change, Rogers identifies that, when there is an environment of safety, listening, and respect, the actualizing tendency can reorganize fragmented experiences and restore personal meanings [6,8,11]. Care, in this sense, is the relational field that favors this vital movement.

Among the central elements of the therapeutic relationship, empathic understanding is perhaps one of the most transformative. It is an active and sensitive effort to inhabit the other's world as if it were one's own — but without losing one's anchoring in oneself. Rogers states that the therapist needs to have an empathic understanding of the client and their internal frame of reference, and communicate this understanding to the client [6]. This symbolic communication of “I see you” is what transforms listening into presence, and presence into the possibility of reorganization. Diagnosis, in this context, can participate in this language — as long as it serves the person's experience, and not the external framework.

This empathetic listening is supported by an even more fundamental value: unconditional positive regard. For Rogers, considering someone without judgment, even in their moments of conflict or pain, is one of the most profound forms of care. This attitude communicates to the person that they do not need to be different to be worthy of affection and respect. In *Freedom to Learn*, Rogers states that when someone finds themselves in an environment where they are accepted, valued, and free to be, they "will develop in creative and constructive ways" [8]. This freedom is the basis for growth — and it is in this space that the diagnosis, if necessary, can be understood not as a sentence, but as an invitation.

Caring, in this context, also means getting involved. Getting involved in the construction of bonds that support growth processes. Engage in criticism of exclusionary norms. Engage in the construction of policies of belonging that recognize the diversity of human experience. Therefore, more than just a technical aspect, care is an ethical and political gesture — and it must always be attentive to the way in which our languages, including diagnoses, support or deny the possibility of someone feeling at home in the world.

FINAL REFLECTIONS

Throughout this text, I have proposed a broader understanding of the diagnosis — not as a label or sentence, but as a language that can sustain or hinder bonds, listening, and belonging. I have reflected on the risks of a diagnosis that operates as an instrument of control and on the possibilities that emerge when it is understood as a relational, symbolic, and ethical gesture. Instead of capturing a person's identity, the diagnosis can contribute to their expression, their reorganization, and their dignity — as long as it is supported by genuine listening and ethical care.

From the perspective of Maturana and Varela, I understood language as a form of action that constructs shared realities [3]. With Canguilhem and Laplantine, I recognized that diagnostic categories are not neutral: they reflect social norms, historical interests, and cultural constructions [1,2]. With Goffman, I understood the effects of stigma when the diagnosis is used as an exclusionary marker [4]. And with Rogers, I reinforced the value of listening, of the actualizing tendency and of care as an expression of radical trust in the power of the human being [6–11].

These references helped me to maintain that listening, diagnosing and caring are not separate actions. They are interconnected dimensions of the same process: the encounter. An encounter that, when sustained with presence, empathy and authenticity, can favor not only the relief of suffering, but also the expansion of belonging, autonomy and freedom of being.

But this encounter becomes impossible when listening is subject to the logic of normalization. When we diagnose in order to correct, to adjust, to silence that which escapes the norm, we lose the opportunity to learn from difference. The diagnosis, then, makes sick: not only the other, but also the bond and the possibility of care. The language that could sustain becomes a language that separates. And what could be an alliance becomes an obstacle.

On the other hand, when the diagnosis is handled with care and openness, it can name experiences that, for a long time, could not be spoken. It can organize suffering, give it meaning and legitimacy. It can allow a person to understand that what they feel is not a failure, deviation or inadequacy — but a legitimate way of being in the world. It can connect subjectivity to citizenship, to the right to exist with dignity.

These reflections do not intend to offer definitive truths. They are invitations. Invitations to ethical listening, to the critique of normativities, to the construction of policies of belonging and to the constant updating of care. May we diagnose not to adjust, but to understand. Care not to correct, but to support. Listen not to classify, but to recognize. And may the diagnosis be more of a bridge than a wall between listening and care, more of a gesture of encounter than an instrument of control.

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