

SCIENTIFIC PARADIGMS AND HEALTH SCIENCES: COMPLEMENTARY AND INTEGRATIVE PRACTICES AND THE SELF-CONSCIOUSNESS RESEARCH

Fernanda Cabral Schweitzer

Mariana Cabral Schweitzer

ABSTRACT. In this paper we present the different scientific paradigms and their relationship with Health Sciences, considering different conceptions of health and health care, and formats of scientific research. In particular, we approach integrative and complementary practices and their potential to comprehend self-consciousness in research, based on an understanding of different medical rationalities, the individualization of health care, and the energetic dimension. Finally, we present both difficulties and potentialities to perform research on complementary and integrative practices, evidencing their approximation to Conscientiological researches, and discuss tools that may help in the study of self-consciousness.

KEY-WORDS: Scientific paradigms, Complementary therapies, Self-consciousness, Consciential health, Conscientiology.

INTRODUCTION

In the health field, different scientific paradigms interfere in self-consciousness research. The strengthening of method and reason as the dominant scientific rationality during modern times has driven research away from subjectivity. The great development of statistic techniques at the end of the 1940's has relegated those scientific methods that seemed too under the influence of one's own psyche (QUEIROZ, 1987).

Nonetheless, there are divergences concerning world conceptions. Whereas realists sustain a material world existing independently of observers, idealists claim that the world fundamentally exists within our minds. These different ways of perceiving the world influence the selection of research methods: quantitative, in the first case, and, in the second, qualitative. Awareness about this epistemological relationship allows for the understanding of the philosophical problem that arises whenever someone tries to combine realism/positivism with constructivism/interpretivism (ROLFE, 2006).

A similar phenomenon occurs between the different scientific health paradigms and the selection of quantitative and qualitative research designs. In this context, complementary and integrative practices (CIP) and the consensual paradigm can contribute with important elements to self-consciousness research, as well as to rethinking paradigms.

The purposes of this paper are to discuss the scientific paradigms in the health area; present difficulties and potentialities to do research on complementary and integrative practices; evidence their approximation to Consentiological research; and demonstrate how helpful some tools can be in the assessment of self-consciousness.

1. SCIENTIFIC PARADIGMS AND HEALTH SCIENCES

The discussion about scientific paradigms and health sciences opens with Descartes and his search for truth by means of reason. The author presented in his book *Discourse on Method* the possibility of reaching a doubtless knowledge that could be collectively reproduced without dogmas, being instead free and methodic. The author has thus demonstrated an experience of truth in the method, supporting that form of making science a liberating activity, able to free society from reputed eternal truths (ROSENFELD, 2005).

This is the direction the modern era has taken, recognizing method and reason as the dominant scientific rationality. Lawn (2006) sustains that such fixation could eventually overshadow alternative truth-seeking forms; furthermore, it could influence, within the sphere of human sciences, a view where man would appear as a purely rational (and material) being.

Gadamer, like many other 20th century philosophers, has also criticized the rationalism of science, since one cannot think about truth by only considering reason (LAWN, 2006). Language's communicative direction can also become a way to seek truth. Through language, one can try to retrieve how people understand the world or their own state of health. For Gadamer, language is one of the most powerful means to put one human being in contact with another, leading them to recognize themselves each and every time (AYRES, 2008).

Reason can also look for validity in speech; the truth within language. Making language circulate allows the subject a greater emancipation, thus making society rethink its role in the world. That way, one can think that no method or concept can guarantee the truth, which is only to be found through dialogue. Truth, therefore, is a form of relationship with oneself and between subjects. That is why looking for mechanisms favoring the use of language in dialogue can become a truth-seeking process (PINZANI, 2009; AYRES, 2001).

The purpose is not to terminate reason, but to rescue praxis within the life sciences in order to improve the relationships between the people involved, since objective reason will always be a form of subordinating the subjects to one single way of seeing the world (PINZANI, 2009). It is understandable, however, that there are strategic moments where reason's instrumental paroxysm should be applied (cause-effect relationship), especially to control disease, whether in symptoms, pathogenesis, infection or epidemics. But that use is insufficient when considering all areas of health, since it is not possible to limit the lifeworld through today's dominant, Cartesian, systemic rationality (PINZANI, 2009; AYRES, 2001).

In the opposite direction, Habermas (1984) proposes a language that actually includes the subjects in the seek of truth from a phenomenon, through dialogue, performing a communicative action to overreach instrumental reason, characteristic of the materialistic, Cartesian-Newtonian paradigm. That way, the trinomial reason-language-phenomenon can orient research in the health area to seek truth, starting from different quantitative and qualitative research designs.

In health practices, dialogical construction of reason must be sought within a less normative-mechanistic investigative practice; but rather one focused, instead, on care, valuing experiences that allow for the understanding of man's complexity, an understanding arising from dialogue, integrality, self-research, bioenergies, parapsychism, multidimensionality, holosomaticity, and evolutiology (GUIMARÃES, 2013).

Care can be understood as a human trait, a moral imperative, a therapeutic intervention characterized by interpersonal sensitivity (FINFGELD-CONNET, 2007). Whenever considering the triangle *Episteme-Techne-Praxis*¹, one must try to integrate all parts of the care process. It is necessary to rethink the normative reference proposed in the first two fields as sufficient, as well as to consider *Praxis* another determinant for a real action in the health field, that simultaneously demands technical and practical successes.

In this process, intervention focuses on the object of care, within the user-professional relationship, by means of a dialogical relationship respecting the different kinds of knowledge of those involved and without the normative criterion as a synonym of success in health practices (AYRES, 2001).

Science's present search for truths separate from practice can lead away from the object of care. Therefore, question and answer dialectics are defended to handle the world. In this way, science that seeks to understand the processes of the other and society is also supported, a science arising from different methods and without any exclusivity.

1 In the trinomial *Episteme-Techne-Praxis*, the epistemological plan corresponds to the field of theory, of knowledge. The technique encompasses production of instruments as well as talents and attitudes. Praxis, or practical wisdom, looks for values and ways that are to provide a more satisfying human co-existence. Aristotle admitted that theory nears practical wisdom, but without joining it altogether (AYRES, 2008).

An exclusively quantitative knowledge production can impair the capacity to apprehend the nature of the world of the user and the nature of their care: whence the commitment proposed is to prepare professionals to construct knowledge out of different methodological approaches approximating them to their object of investigation. Thus, making the advancement of clinical practice possible (PRADO, 2008).

That way, one of the biggest research advancements recently attained is the insight that qualitative research allows exploration in health care practices, enriching the construction of disciplines and challenging the positivistic-research dogma with arguments (MALVAREZ *et. al.*, 2006).

For Minayo & Sanchez (1993), from an epistemological viewpoint, none of the two approaches is more scientific than the other, because scientific knowledge always articulates a theory with an empirical reality, and the method underlies that connection. The scientific approach shall thus be considered a highly abstract regulating idea, and not a synonym of rigid models and norms.

And, by bringing the qualitative debate to the health field, Minayo (2004) stresses that, with regard to the methodological and theoretical problematics, as soon as they extend their conceptual Foundations, the health sciences do not become less scientific. On the contrary, they approach the assessed phenomena and knowledge production with an enhanced clearness.

Since there is no ideal care, but instead a knowledge exchange between the people involved to eventually deliberate together about the best decision to take. From a linguistic reading of the world, able to connect language and action, the more conscious the use of language, the better the relationship between what is spoken and what is realized. Thus, seeking wisdom from praxis and also the acronym *thosene*, which encompasses personal thoughts, sentiments, and energies (GUIMARÃES, 2013).

Whenever one talks about health, one should always question the type of knowledge under discussion, since abandoning a normative reference is always hard for a human being. One should construct concepts that demonstrate the relationship *Episteme-Techne-Praxis*. As language is a form of relating to some subject, with oneself and with others, and this becomes more valid as more dialogue is provoked.

Again, we come back to Gadamer, who proposes to experience the happening of the dialogue, through the use and appropriation of language. Nonetheless, everyone is born in a meaningful world. It is therefore important to stress that language is not always looking for truth, since it is dependent on the human (AYRES, 2008).

The search for truth will depend upon the overcoming of human weaknesses and systematic distortions of communication on behalf of certain interests, that is to say, it depends on the intentionality, along with the subject's strongtraits, missing traits and weaktraits. Therefore, it is worthwhile stressing the rationality of dialogue in practice and in the production of knowledge.

One should understand the convenience of an evidence-based medicine as a form of keeping the structure of science (only in the areas *Episteme-Techne*) as an authority to orient decision-making in health care, while keeping in mind its limitations. Change must be sought in the production of knowledge, including the connection truth-language, while trying to understand health care from the meanings bestowed by humans to that phenomenon. From a multidimensional perspective, abandoning the idea of sickness as a single, monofunctional disease, in order to individualize care and to understand the dynamic balance and self-consciousness as potentialities for life and evolution.

It is thus that the concept of health as proposed by the great Greek philosophers like Aristotle, Plato, and Hypocrates is reassumed, namely: health is understood not simply as something the physician provides, but as something that can only happen by means of a physician helping nature to cure itself. Health seen as a self-restoration of one's balance, where the physician's role is to provide the means necessary to the re-establishment of this state of equilibrium, by itself and from itself (SVENAEUS, 2003).

Health understood as a state of balance and the role of the health care team understood as care facilitators, beyond merely controlling symptoms. According to Ayres (2001), the caring attitude should be expanded to encompass the totality of reflections and interventions in the health care field.

Both the workers and the users are responsible for the edification of care by exchanging, besides signs and symptoms, facts, emotions and feelings. This is a dynamic process, since "to care is to meet someone in order to follow them in the promotion of their health starting from the creation, cultivation, and maintenance of bonds of confidence and closeness" (ZOBOLI, 2009, p. 201).

This way, one understands that in the working process the way the worker understands health influences, among other factors, the form of care provided. Also the control of one's own consciential energies, including sympathetic assimilation and de-assimilation, will be able to influence care outcomes. Some conceptions are more coherent with certain care types, like the complementary and integrative practices toward the conception of integral health, whence the proposition of a holistic care. Multidimensionality, bioenergies, and multiexistentiality, with consciential health grounded in Conscientiology.

2. COMPLEMENTARY AND INTEGRATIVE PRACTICES

Medicine has developed itself in the modern times with basic characteristics that propelled what became the biomedical paradigm. The discovery of several pathogenic organisms and the development of bacteriology and antibiotics have helped consolidate the notion of monocausality of Cartesian science within the medical practice (BARROS, 2008).

Among the characteristics criticized by Barros (2008) in the biomedical model, 3 aspects stand out: low knowledge socialization, both with the population

and other rationalities; asymmetry and authoritarianism, because of unequal relationship with a dominating character justified by professional autonomy and technical competence; patient's subordinated and passive participation, disregarding their knowledge, representations, uses, and popular habits referring to the health-sickness process.

After assimilating Physics' and Biology's mechanism and organicism, Medicine has emerged as a modern science, where all sicknesses and cures began to be observed under those laws without any contaminating interference from sick people's subjectivity. The therapeutic act was exclusively explained by physical or chemical intervention in different parts and structures of the organism to eliminate disease. That concentration of the scientific view in ever smaller parts eventually led to the loss of the approach of the patient as an integrated human being (QUEIROZ, 2006).

Since the second half of the 19th century researchers in Collective Health have proposed models of the natural history of disease and social determinants, propelling changes that included interdisciplinarity and multicausality in the biomedical paradigm. A dialectic that considers how the various determinants of health and disease mutually influence themselves has inaugurated a new possibility for the understanding of man's biopsychosocial complexity (PUTINI, 2010).

Still in the second half of the 20th century strong pressure from counter-culture movements² has taken place in the health area, with projects of complementary and alternative techniques, and rationalities from the non-biomedical paradigm (BARROS, 2008), thus revaluing the individual's natural capacity of self-promotion of health (QUEIROZ, 2006).

The rebirth of "alternative medicines" may be understood as a social phenomenon. Alternative Medicine is understood as rationalities and practices that share a vitalistic perspective centered on the patient's life experience, emphasizing the patient, not the disease; in an integrative and non-interventionist approach (QUEIROZ, 2006).

In a general manner, alternative medicines criticize the reductionism, mechanism, and the primacy of the sickness over the sick in Allopathic Medicine. They promote a treatment based on the commitment with the population, respecting their symbols and views about health and disease, under a necessarily interdisciplinary, systemic and holistic perspective (QUEIROZ, 2006).

Considering the confusion in the terms used to name these practices, one may say that there are presently three main paradigms (analytical macrostructures) in the health field: biomedical or allopathic; non-complementary; and complementary. Each of those paradigms makes the subsistence of standard, alternative or complementary models possible (BARROS, 2008).

² Those movements countered consummation of society, bureaucracy, and modernity at large, while supporting the sustainable development and quality of life (QUEIROZ, 2006).

Today's hegemonic model, the standard model, is the biomedical paradigm, or the materialistic-Newtonian-Cartesian, monocausal, biologicist allopathic model. Whenever this model is associated with "alternative medical systems (homeopathy, ayurvedic medicine, and others); mind-body interventions (meditations, prayers); biological therapies (based on natural, not scientifically recognized products); corporeal manipulation, methods based on the body (massages, physical exercises); and energetic therapies (reiki, ch'i gong, among others), these practices are called complementary" (TESSER & BARROS, 2008, p. 918). When these practices are used instead of a biomedical practice, they are considered alternative.

The non-complementary paradigm prevails in the alternative model, which acknowledges different medical rationalities, like Homeopathy and Acupuncture, as well as complementary and alternative practices, like Iridology and Chromotherapy (BARROS, 2008).

The concept of medical rationalities had been proposed in the 1990's, out of a set of comparative studies of complex medical systems. Every medical rationality includes five complexly structured practical/theoretical dimensions (LUZ, 2006):

1. Human morphology (anatomy, physiology);
2. A medical doctrine conceptualizing disease, treatment, and cure;
3. Diagnostic system;
4. Therapeutic system; and
5. Cosmivision (fundamental basis).

The complex systems analyzed that escaped those dimensions were contemporary Western Medicine or Biomedicine; Homeopathy; Traditional Chinese Medicine and Ayurvedic Medicine. Those distinct rationalities in fact co-exist and interact in contemporary culture (LUZ, 2006).

Since the middle of the 20th century, health started to be recognized as a result of spiritual, social, mental and physical well-being, and not only the absence of disease. Since 1976 the World Health Organization (WHO) recommended the utilization of alternative, non-institutionalized therapeutic practices in health systems, besides recognizing their practitioners as important allies in the organization and implementation of those measures to improve the community's health (QUEIROZ, 2006).

WHO denominates the field of Complementary and Integrative Practices as Complementary/Alternative and Traditional Medicine (CAM/TM). Since the 1970's this organization has stimulated Member-States to formulate and implement public policies for the integrated and rational utilization of CAM/TM in Primary Health Care (PHC) (WHO, 2002-2005).

In Brazil, the legitimization and institutionalization of complementary and integrative practices in health started in the 1980's, continuing after the creation of the Unified Health System (SUS in Portuguese). In 1986 the 8th National Health

Conference deliberated the introduction of complementary and alternative practices into health services. In the 1990's, the 10th Conference approved the incorporation of Phytotherapy, Acupuncture, and Homeopathy into the SUS. In 2000, the 11th Conference recommended the incorporation of those non-conventional practices into PHC (BRAZIL, 2006). The proposal was to provide PHC with soft technologies and to rescue individual responsibility for one's own health, thus challenging the health system's bureaucratic logic, as well as its surrender before both the pharmaceutical and the hospital industry (QUEIROZ, 2006).

In 2006, the Complementary and Integrative Practices National Policy (PNPIC) in the SUS was enforced, presenting rationalities that consider an integral vision about human beings and the process of health-disease. It contemplates several areas, specific to health care, like Medicinal Plants, Phytotherapy, Homeopathy, Traditional Chinese Medicine, Acupuncture, Anthroposophic Medicine, and Thermalism-Crenotherapy (Table 1). These approaches seek to stimulate natural preventative mechanisms against ailments, as well as health promotion by means of safe and efficacious technologies, emphasizing empathic listening, in the development of a therapeutic bond and in the human being's integration with the environment and society (BRAZIL, 2006).

Table 1
Description of PNPIC's Complementary and Integrative Practices

Practice	Description
Traditional Chinese Medicine-Acupuncture	Integral medical system, originated thousands of years ago in China. It symbolizes the laws of nature and valuing the harmonic inter-relationship between the parts aiming at the integrity. Based on the <i>Yin-Yang</i> theory and on the theory of the five elements (wood, fire, earth, metal, water). As its elements it uses the anamnesis, pulse sensing, face and tongue observation in its several treatment modalities (acupuncture, medicinal plants, diet therapy, body/mind practices). Acupuncture comprehends a set of proceedings that precisely stimulate anatomical points through metallic needles for health promotion, maintenance, and recovery, along with ailments and sicknesses prevention.
Homeopathy	Complex, holistic medical system based on the vitalist principle and on the use of the law of similar to that enunciated by Hypocrates in the 4 th century B.C.. Homeopathy has been developed by Samuel Hahnemann in the 18 th century. Grounded on the Law of Similars (<i>Similia similibus curantur</i> : a substance able to cause effects in an organism) can as well cure effects similar to those in a sick organism. It employs homeopathic drugs.

Medicinal Plants and Phytotherapy	Therapeutics characterized by the use of medicinal plants in their different pharmaceutical forms, without the use of active substances isolated, even if those substances are of vegetal origin. The use of medicinal plants for cure is very old, associated to the beginnings of society.
Thermalism – Crenotherapy	The use of mineral waters in health treatments is one of the oldest procedures, coming from the Greek Empire. Described by Herodotus (450 B.C.), author of the first thermal scientific publication. Thermalism comprehends the different uses of mineral water and its application in health treatments, whether to recover or treat health, as well as to preserve it.
Anthroposopic Medicine	Complementary, medical-therapeutic approach, with a vitalist Foundation, whose model of attention is organized in a transdisciplinary manner, seeking the integrality of the health care. Among the resources accompanying the medical approach the use of drugs based on homeopathy, among other resources from the Anthroposopic Medicine are emphasized.

Source: Brazil. Ordinance 971 from May 3rd, 2006. Approves the Complementary and Integrative Practices National Policy (PNPIC) in the Unified Health System (SUS). Brasília, Ministry of Health; 2006, p. 13-24.

Considering the practices described in Table 1, one may say that the PNPIC fits in the non-complementary paradigm described by Barros (2008), as it presents the rationalities of the alternative models – Homeopathy and Traditional Chinese Medicine – besides complementary and alternative practices like Phytotherapy and Thermalism-Crenotherapy.

The increasing demand for alternative practices in health care was concomitant with the difficulty of Biomedicine in focusing its attention on the individual and the therapeutic practice (LUZ, 2005). In alternative practices, care does not have sickness as its object, but the unbalanced individual, who has to be oriented for their recovery, or even improvement of the state of their health (PINHEIRO & LUZ, 1999).

3. RESEARCH ON COMPLEMENTARY AND INTEGRATIVE PRACTICES

Regarding research in the health area, there are constant clashes involving health professionals towards the CIP, since within the parameters of biomedical science it is complex to research different medical rationalities and health practices grounded on other paradigms. Frequently, the methods accepted by the scientific society, especially in the West, are scarcely appropriate to evaluate, and

potential barriers are identified in research on complementary practices, like the different concepts of health and disease, divergent diagnostic criteria, contrasting views between the therapeutic process and different theories about the etiology of diseases.

The mere transference of the Western conception of scientific research, according to some positivistic principles, may be in disagreement with the holistic Foundations of complementary practices. The problems would be rather paradigmatic, the transition from one worldview to another, the challenge to integrate different knowledge, which lacks evidence of the clinical effectiveness of such practices (SALLES, KUREBAYASHI & SILVA, 2011).

Assessments in different realities have already demonstrated that health professionals recommend more easily the CIP services whenever they use or know them, especially when there is scientific evidence about the practice (THIAGO & TESSER, 2011). The increase in undergraduate health courses teaching the CIP is noteworthy, as well as the implantation strategies for those services in the PHC that include the training of those health professionals (CHRISTENSEN & BARROS, 2011). That formation, however, is not lawful yet for health professionals, and health insurance does not cover those practices (SALLES, KUREBAYASHI & SILVA, 2011).

One of the difficulties is the performance of clinical assessments that consider individualization and the subjective factors concerning CIP treatments. Bioscience and its hardest parts have been acknowledged as the only way to produce truths regarding health and disease, thus they monopolize the formation of specialists and also considering the fragmented state of research (TESSER, 2012).

In research on homeopathy, even positive results have not moved the scientific community, who remained negativistic and skeptical about the difficulty of incorporating homeopathic knowledge and practice into the biomedical theoretical corpus (TESSER, 2012).

In phytotherapy, more and more studies have pharmacologic and ethnobotanic objectives. The risk, however, is that the use of plants in non-industrialized forms, which are more fragile, will progressively be replaced by synthetic drugs and industrial phytotherapy, thus discouraging the diffusion of relatively simple and safe knowledge about the professional and popular use of native plants, whether *in natura* or with local, artisanal manipulation, accessible to both PHC professionals and the general population (TESSER, 2012).

A form of researching CIP is to seek legitimization-institutionalization through science, by means of quantitative technologies and laboratory studies. Another form is to construct "social wisdom" in order to value what today is not recognized as science, thus breaking its privilege to define what is or what is

not important, through institutional, social, political action, recognizing truths and efficacies differing from biomedicine, guided by their own criteria, “through a scientific approach that seeks distance and relativization of official medicine” (TESSER, 2012, p. 27).

Analyses of CIP experiences and development of methodologies approximating the CIP’s institutional universe in the PHC, “a kind of research-action or participant evaluation, can contribute to a greater visibility and institutional deployment of research, besides the production of knowledge and its academic circulation” (TESSER, 2012, p. 278).

Researching in CIP demands consideration of the different criteria for disease classification, causes and evolution often differing from biomedicine, sometimes highly artisanal and individualizing, in diagnostics and in treatment (TESSER, 2012).

Clinical tests are valuable regulators of safety and efficacy, although they also silence voices of sick people and health care professionals. Truth relationships, senses, words, gestures, relationships and care taken in contacting the healer should be more valued in health research (TESSER, 2012).

Part of the treatment in CIPs involves individualization of care and empowerment of the patient regarding the state of their health and disease. Therefore, thinking about the placebo effect as a result of the professional-patient relationship (or, in the case of research, researcher - object of study) is to consider that moment of exchange in the consulting room (research space) as relevant to the caring process.

4. SELF-CONSCIOUSNESS RESEARCH

Conventional science generally aims to obtain knowledge about the world around the researcher. However, the most important thing for one’s personal development is self-research (research of oneself). Hetero-inquiry is only the research’s starting point, the most important is the verification of theories in self-experimentation through one’s own developed (KAUATI, 2014).

Self-consciousness is the knowledge one has about oneself, about personal motivations, inner conflicts, and strong, weak and missing traits.

Self-consciousness for Kant is “consciousness about the self as agent of thought and knowledge about the reality”; and for Hegel, “the consciousness obtained about oneself recognizing oneself as an agent of the outer reality, seen as one’s own reflection” (GEIGER, 2012).

Self-consciousness research or objective self-research aims to develop self-awareness, considering multidimensionality and parapsychism in order to reach evolutionary goals, like overcoming weaktraits, obtaining missing traits and potentiating strongtraits (KAUATI, 2014).

Self-researchology is the science applied to the studies or research of one's own consciousness, by the consciousness itself, employing all research instruments available, at the same time, in the conscial microuniverse and in the Cosmos. The science of self-knowledge is Conscientiology's leading theory, seeking to develop self-research through participative personal research, orthothosenity and lucidothosenity; so as to correct one's own self-image, anatomizing intimate conflicts, developing daily conscientiological self-didacticism and one's proexis, or personal existential program (VIEIRA, 2013).

That way, self-consciousness becomes the researcher's constant object. The consciousness researches exhaustively and continuously its own, promoting a pedagogical self-restructuring, a self-reeducation, and potentiating general reeducation through one's own example (VIEIRA, 2013).

Leite (2013) stresses that today the theme consciousness is considered the most important scientific challenge. In Neuroscience the consciousness is a continuous flux only accessible to the individual experimenter. This subjective nature is one of the greatest obstacles to a methodological analysis, this is where the scientific limitation in studying consciousness arises.

Some research formats, especially the qualitative ones, make the assessment of consciousness possible, like phenomenology, which explores the consciousness' essence from itself; the critical theory, because that theory criticizes society, trying to modify it; feminism, questioning social roles (ROLFE, 2006); oral history, trying to understand subjectivity (QUEIROZ, 1987); hermeneutics, proposing the fusion of horizons through means of dialogue (AYRES, 2008); Conscientiology; among others.

The evolution of qualitative research propitiated a wider format for health research. Because researching self-consciousness is complex, CIP and Conscientiology research, when compared with the prevailing paradigm, present five problems or difficulties:

1. Reality's relativization based on one's own experimentation;
2. Strengthening of practices and science considering the dominant paradigm's limitation;
3. The rescuing of systemic view as opposed to the compartmentalization of the soma and holosoma;
4. Approach to the energetic dimension and conscial energies; and
5. Sharing knowledge and the therapeutic decision with the patient.

The epistemological difficulties in CIP research interfere with the possibilities of self-consciousness research *of* the first person (object) and *in* the first person (method) in the health care area. Those difficulties also occur with conscientiological research into health care.

The subject's individualization in health research is a big challenge to be overcome by researchers, firstly in their relationship with the object, a relationship that shall be ethical and cosmoethical; secondly, the method design shall consider

singularity, receptivity, and communication with the object. Therefore, the method cannot follow closed and stagnated research formats, because it tries to respect the object, so that the last becomes the one who is to conduct the investigation.

After discussing the different paradigms, CIP and Conscientiology research, seven items are suggested to promote the study of self-consciousness in the health care area:

1. Recognition of the importance of: self-research; the consciential laboratory; personal notes; self-knowledge and self-conscientiometry; strong, weak and missing traits; and self- and hetero-criticism;
2. Consideration of: ethics, bioethics, and cosmoethics, along with personal and group codes of cosmoethics;
3. Inclusion of consciential energies inter-relations, the influence of holothosenes, and the control of one's own bioenergies, specially the vibrational state (VS) and sympathetic de-assimilation (symdeas);
4. Less rigid research designs arising from qualitative research and mixed methods³, which consider the subjects' singularity, receptivity, communication and empowerment;
5. Search for less invasive health practices that consider the energetic aspect, not only in complementary and integrative practices;
6. Relativization of ideal health considering life's finality and personal purposes for each one's own life;
7. Qualify the subject's intentionality, their orthothosenity, and its impacts in the findings.

Since the last century Biology, Psychology, and even Sociology, have taken possession of the psyche as an object of study, this includes dreams, the unconscious and subjectivity. Although the subjective aspect has been understood as sensations finding no translation, the individual naturally tries to transmit to others what they have understood; whence the necessity of refining every work instrument to be successful. But Queiroz (1987, p. 285) asks if it "is possible to refine mechanisms without at the same time practicing them?"

Dialogue is an important tool in the self-research process, especially self dialogue, aiming at the best expression of thosenes. Among the environments, that exist in Conscientiology and are potentially propitious to self-consciousness researches in health, five stand out:

1. The conscientiotherapeutic setting;
2. Self-research laboratories, specially the Paragenetics Lab;
3. Parapsychic dynamics;

³ *Mixed methods* are the type of research where some researcher or research team combines elements from both qualitative and quantitative approaches (like the use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the general purposes of broadness and deepness of understanding, and corroboration. *Mixed methods* are increasingly associated to the research practice, recognized as the third most used research approach or research paradigm, together with qualitative and quantitative research (JOHNSON, ONWUEGBUZIE & TURNER, 2007).

4. Invisible Colleges;
5. Experiments developed, for example, in Ectolab.

These proposals aim to increase the possibilities for self-consciousness research in health, both *of* the first person (object) and *in* the first person (method). Suggestions should be analyzed by researchers, and this, discussion is under constant renovation, considering the constant evolution of research designs and the complexity of the researcher-object relationship.

The quantitative-qualitative dichotomy proceeds unconcluded, especially concerning the rigor and confidence of qualitative researches. Besides the search for new evaluation criteria, however, one may as well consider each study as unique and individual, and can be judged according to its own merits (ROLFE, 2006; REEVES, 2008).

A reflexive diary can help evaluating the quality of all studies published (REEVES, 2008). Furthermore, scripts can orient narratives and support (self-) reflection or can be used as a memoire aide (SCHRAIBER, 1995).

Designs and tools thus exist in health research that can help modifying the present Cartesian-biomedical paradigm, although changing that paradigm means to sail against the mainstream; and, more than this evidences the need for a mandatory change in posture by researchers and health care professionals, in order to:

Critically reflect about concepts of health and care beyond the normative-ideal, arising from personal experiences, multidimensionality, holosomaticity and evolutiology, with openness to neoconstructs like macrosoma, paragenetics, and paramicrochips; and

Reconsider professional roles and ways of working, analyzing financial interests in the health area, the use of expensive, invasive, cumulative technologies in users of health systems, the growing medicalization of life, the limited empowerment provided to users by the current model, and the lack of therapeutic exemplarism.

In order to enhance the researchers' self-scientificity, Kauati (2014) presents 15 qualifying attributes, like openness, anti-dogmatism, disbelief, neophilia, among others, stressing knowledge about Conscientiology and other sciences, so as to strengthen one's intellectual capacity, discernment, and criticism. The expectation is to prevent the paradox of the neophobic scientist, the religious or mystical scientist, the superstitious scientist, and the idolatric self-scientist.

In order to transform attitudes in the health field it is fundamental that professionals/self-researchers seek to know about and do research beyond their professional practice, even research about themselves, aiming to increase their authority regarding self-consciousness research and thus research into interassistentiality.

Puttini (2014) considers that the co-evolutionary process involves a self-organization both of the individual and of human society, thus generating an intentionality intrinsic to the process, with collective responsibility towards the

species' and the planet's historic and biological evolution. To reach this goal, the bet is on transdisciplinarity as a way to facilitate the realization and identification of multiple determinants of health and disease and their dynamic interactions.

FINAL CONSIDERATIONS

In the health area, the different paradigms interfere in research that approaches self-consciousness. The purpose of this paper was to reflect upon health research and the consciencial paradigm, in order to promote the research of self-consciousness.

Presenting the CIP research and the research on self-consciousness was not intended to identify the best type of care, but to diversify research practices and formats in order to encompass different concepts of health and care, thus contributing to qualify health care work and interassistance. The proposal was, in fact, to reflect about the logic of the process of work that values the different rationalities and understandings about health in order to better care for oneself and others, integrally, within a consciencial paradigm.

Among the contributions of this emphasis was given to the promotion of reflection by professionals and users about their role in health promotion and in self-consciousness research, based on a bioenergetic multidimensional paradigm. Fraternal pondered contributions from other researchers are awaited, as are assessments and methods considering the research of self-consciousness.

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Fernanda Cabral Schweitzer is a Specialist in Occupational Medicine (AMB/ANAMT); M. D. (UFSC). A Conscientiology volunteer since 1999, she volunteers in the Associação Internacional para Expansão da Conscienciologia (AIEC) and in the Associação Internacional de Intercâmbio Conscienciológico (INTERCONS). She has been a Conscientiology instructor since 2001.

Mariana Cabral Schweitzer has a Ph.D in Science (USP-UCP), a Masters in Nursing (UFSC), Acupuncture Specialist (CIEPH-Shandong University), Public Health Specialist (UFSC), graduated in Nursing (UFSC). She has volunteered at the Associação Internacional de Pesquisa Laboratorial de Ectoplasmia e Paracirurgia (ECTOLAB) since 2013.

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