

Section on Conceptual Bases of Person-centered Medicine

Historical perspectives on person-centered medicine and psychiatry

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Introduction

From a historical and actual point of view, the idea of person-centered medicine is not only a question of our basic attitude towards the patient, but also closely connected with any particular concept of illness. WPA drew attention to this central topic already in its founding years and, together with other international medical societies, emphasized it again recently [1].

In general, the term ‘person-centered medicine’ can bear different, though strongly interrelated, meanings:

- Medicine *of* the person: this is the *theoretical* aspect, especially the notion of person itself.
- Medicine *for* the person: this is the *therapeutical* aspect.
- Medicine *by* the person: this is the aspect of the *medical professionals’ role and self-understanding*.
- Medicine *with* the person: this is the *interpersonal* aspect, especially the relationship between patient and doctor.

More specifically, different concepts of illness do have a significant impact on the way person-centered thinking is accepted and integrated into medical practice—or is not. Three examples shall elucidate this. They are taken from the history of ideas in psychiatry, but the arguments involved will be easily applicable to general medicine, as well.

Psychiatry as *pars pro toto*

The diagnostic process in psychiatry has always been a controversial issue. This has to do with particular features of this field: from all medical specialties, psychiatry and psychotherapy are most intensively connected with political, historical and social developments. Psychiatry, as we know and recognize it today, i.e. as a medical discipline closely linked with neurobiological, psychological, sociological and philosophical issues, may with good reasons be regarded a product of the era of enlightenment in the second half of the 18th century [2]. From this time on, the view of mentally ill people as *persons* gained influence, albeit slowly, as persons with indispensable human rights and with a personal autonomy that may be diminished, but not eradicated by whatever illness they might be affected by. Psychiatry began to emerge as a medical discipline, rooted in scientific research and dedicated to the treatment of individual persons.

Since then, three major approaches to the phenomenon of mental illness were developed and adopted in psychiatry: (1) the *realistic*¹ *neurobiological* approach from the middle of the 19th century until now, (2) the *biographical-hermeneutic* approach from the beginning of the 19th century until now and (3) the *nominalistic descriptive-operational* approach practised since the end of the 20th century by ICD 10 and DSM IV [3]. I will now discuss chances and limitations of these three concepts with regard to person-centered medicine.

¹‘Realistic’ in an epistemological sense; i.e. the assumption that the real world is existing fully independently from our conceptualization or our mental acts; Emil Kraepelin’s concept of ‘natural disease entities in psychiatry’ is the example for such a realistic approach to psychiatric nosology [2].

- The *realistic neurobiological* approach regards mental illness similar to, if not identical with, somatic illness: Schizophrenia, for example, will here be regarded an external object, a quantitatively detectable neurobiological disorder, existing independently from the researcher or diagnostician and his or her mental activities. In this case, the process of diagnosing mental illness comes close to taking a photographic picture, because the aim is to objectively depict what is 'real' without interpretation or other subjective influences.
- The second option is the *biographical-hermeneutic* approach. In this case, the focus is not so much on the objective nature of mental illness or on the process of constructing diagnostic terms, but on the understanding and interpreting behaviour and utterances of the patient, given his or her specific biographical and personal background.
- The third option is the *nominalistic descriptive-operational* approach to mental illness. This is what our present operationalized diagnostic manuals as ICD-10 and DSM-IV do. They do not provide us with a definition of what, for example, schizophrenia 'really is', but with practical guidelines how to use the term schizophrenia in a proper scientific way, taking the actual empirical knowledge about this *disorder* (not: disease!) into account. In this case, diagnosis is a theoretical construction and an expert-opinion based convention; it is not, contrary to the realistic definition mentioned above, an objective picture of something completely independent from the person taking this picture.

These considerations are by no means 'only' theoretical, but they do have a significant practical impact on diagnosis, on therapy and on psychiatry's self-understanding. In forensic psychiatry which directly links the notions of mental illness and personal responsibility, the debate became especially controversial and attracted much public interest recently, although the arguments are not fundamentally different from those in the areas of clinical psychiatry and research [4, 5].

The risk of dogmatization

There are often underestimated risks for *any* of the three concepts mentioned above to be used in a reductionistic, not to say dogmatic way, especially with regard to person-centeredness:

- If the realistic definition of mental illness is understood in a extremely narrow sense, as for example eliminative materialism does [6], we will end up with a *naturalistic reductionism* which straightforwardly identifies mental illness with dysfunctional neurobiological processes. This, of course, leaves no space to deal with the issue of subjectivity within a scientific framework. Recently, there are a number of decisive, sometimes even polemical positions in this discussion, e.g. John Bickle's (2003) book on philosophy and neuroscience, subtitled 'A Ruthlessly Reductive Account' [7]. But within the psychiatric and neuroscientific research community itself, many authors nowadays will agree that we need a concept beyond single methodological perspectives which also includes the notion of person. For example, there is a philosophically substantial *and* widely recognized debate on the relationship between evidence- and value-based decision-making in psychiatry. These topics in themselves are, of course, not new for the field, but they attracted remarkable interest and generated fruitful discussions especially since Fulford's (1989) book on 'Moral Theory and Medical Practice' [8].
- Nominalistic definitions as in ICD-10 and DSM-IV bear the risk of becoming dogmatic in the sense of a *formalistic reductionism*. This happens, for example, if the users of operationalized diagnostic algorithms presume that the entire phenomenon of psychosis is covered by or even identical with these operationalized procedures. Special problems will arise in the forensic situation if direct conclusions are drawn from DSM IV- or ICD 10-based diagnoses to such complex issues as criminal responsibility or other legal capacities.
- It must not be forgotten, however, that also the biographical definition may run into dogmatism: if one believes, that the etiology, pathogenesis and clinical symptomatology of a given mental illness may completely be understood, even explained by the process of understanding and interpreting, this will constitute a *heuristic reductionism*. This can become a relevant problem in long-term psychotherapeutic processes by overestimating the explanatory power of a single interpretation, thus underestimating other options. Of course, it is difficult to define where the area of hermeneutical methods ends, and this boundary may vary from one therapeutical situation to the other. Karl Jaspers tackled with that problem in some detail in his famous paper on the differentiation between psychological development and process ('Entwicklung und Prozess') and in his discussion of several types of scientific prejudices in his 'General Psychopathology' [9–11].

In recent years, there has been a tendency to combine classical scientific areas with the suffix 'neuro-' in order to demonstrate the implementation of modern neuroscientific methods and results, e.g. in terms as neuroethics [12]

or, more generally, neurophilosophy [13, 14]. In our present context the question arises if and how person-centered psychiatry could profit by this development. There are two arguments to consider: on the one hand, it is a promising new approach to combine neurobiological techniques like functional brain-imaging or neurophysiological data (e.g. evoked potentials) with more person-oriented areas as social cognition, decision-making or the relationship between affective and cognitive processes. On the other hand, just to combine different techniques or data will not solve the problems of the limitation of each method and the need of a leading principle 'behind' these single approaches. For example, the status of subjectivity or personal autonomy remains a tackling issue no matter which empirical procedure will be chosen.

Psychopathology and personhood

The reason for this is of a principal nature: the basic questions mentioned above cannot be answered by empirical research only, be it biological, psychological or sociological in nature. We do need a basic conceptual framework addressing the notions of personhood and mental illness in general, and diagnosis and therapy in particular. At this crucial point, psychopathology—once named 'basic science of psychiatry' ('Grundlagenwissenschaft der Psychiatrie') by Werner Janzarik (1979) [15]—might again become a relevant point of reference, but only under the following specific circumstances [16].

On the *practical* side, psychopathological notions will have to be continuously developed further (e.g. by not taking any definition of delusion for granted, but to continuously link new empirical data with theoretical considerations). This shall include operational descriptions of psychopathological phenomena (e.g. within the ongoing development of ICD 11 and DSM V) [17] as well as 'open descriptions' (e.g. by scientifically respecting qualitative phenomena like personality traits, interpersonal traits or biographical aspects that are not easily detectable by highly formalized rating scales). And a close linkage, albeit not a merging (!), with neurosciences and social sciences will be essential (e.g. by further developing research designs for the interface between social cognition, empathy or altruism on the one side and brain function on the other side without accepting any naive reductionism or materialism).

On the *theoretical* side, psychopathology will have to acknowledge the chances and limitations of empirical methods (e.g. by the constant awareness of methodological fallacies, be they naturalistic or hermeneutic). It will need to accept subjectivity as a scientific topic of its own and not only as a temporary fill-in, which at some point of time in the future will be replaced by strictly neurobiological data and concepts. And, finally, it will have to actively implement historical knowledge about psychiatric concepts into the actual debate on psychiatry's identity (e.g. by reflecting upon the basic questions that link all the heterogeneous concepts of mental illness at least since the era of enlightenment, especially mind-body-relationship, nosological status of mental illness, status of psychiatric diagnoses, scientific relevance of objective vs. subjective data). But this will also mean for psychopathology to be self-confident enough to leave fundamental issues open (i.e. not to accept premature definitions of mental phenomena in general and of personhood, autonomy and subjectivity in particular, however, practical they may seem to be).

In a broader perspective it is obvious that, on the one hand, the notions of person or personhood are *central issues in practical psychiatry*, but, on the other hand, they necessarily lead us into the center of *philosophical* debate. And not too few psychiatrists, in history and nowadays, were and are decisively sceptical with regard to the benefits of such philosophical arguments for their field. However, if we do not want to reduce the notion of person to just one, usually the prevailing, scientific perspective, we will have to enter the debate on what is or what we call a person and in which way personhood can or cannot be affected by mental illness. One of the radical positions on this issue was developed by transcendental philosophers like Immanuel Kant and Johann Gottlieb Fichte for whom the concept of an irreducibly autonomous and responsible subject within his or her interpersonal relations was not (only) a matter of empirical science, but the prerequisite of any scientific approach to the *conditio humana*. These complex philosophical theories—and many others from the 18th and 19th centuries—have been criticized in recent decades, especially following the linguistic turn in philosophy in the 20th century and its usually underestimated consequences for psychiatry. But nonetheless the issue of personhood and its relationship to diagnosis and treatment of mental illness is far from being settled. So, if person-centeredness shall become *the* essential framework for psychiatry, the philosophical debate needs to be specifically reflected upon and integrated into psychiatry [18, 19].

Conclusion

In conclusion, these brief considerations on the history and present status of person-centeredness and on the future role of psychopathology can be summarized in three theses:

- The debate on the concepts of mental illness may serve as *pars pro toto* for any medical concept since the notion of person is central to psychiatry, but, of course, also relevant for any other medical field.
- The idea of person-centered medicine must be actively supported and worked out separately from single nosological models. These models provide too narrow a framework, thus creating a high-risk of dogmatization.
- Subjectivity and, in general, the nature of the individual person are central topics in psychopathology. They cannot be reduced to a single perspective, not to the neurobiological and not to the hermeneutical one. They create an interface between psychiatry and philosophy that is nothing less than ‘mere theory’ or ‘l’art pour l’art’. It is of utmost importance for psychiatry as a practical medical field and as a research discipline.

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