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ON PERSON-CENTERED INTEGRATIVE DIAGNOSIS

Prof. Juan E. Mezzich
Professor of Psychiatry and Director,
International Center for Mental Health and
Division of Psychiatric Epidemiology,
Mount Sinai School of Medicine, New York University.
President of the World Psychiatric Association

Prof. Ihsan M. Salloum
Professor of Psychiatry and Director,
Addiction Psychiatry and Psychiatric Co morbidity Program,
University of Miami Miller School of Medicine.
Chair, Section on Classification, Diagnostic Assessment and Nomenclature,
World Psychiatric Association

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Abstract

Psychiatry for the Person, is a current major initiative of the World Psychiatric Association (WPA). One of its major endeavors is the development of Person-centered Integrative Diagnosis (PID). This diagnostic model articulates science and humanism to obtain a diagnosis of the person (of the totality of the person's health, both ill and positive aspects), by the person (with clinicians extending themselves as full human beings), for the person (assisting the fulfillment of the person's health aspirations and life project), and with the person (in respectful and empowering relationship with the person who consults). This broader and deeper notion of diagnosis goes beyond the more restricted concepts of nosological and differential diagnoses. The proposed Person-centered Integrative diagnostic model, involving both a formulation and a process, employs all relevant descriptive tools (categorization, dimensions, and narratives), in a possibly multilevel structure, engages the interactive participation of clinicians, patients, and families, and intends to provide the informational basis for person-centered integration of health care.

Considerations of historical concerns and aspirations and of current policy statements and clinical developments in the health field have led to the establishment of a World Psychiatric Association initiative on Psychiatry for the Person and the development of a relevant Person-centered Integrative Diagnostic Model (PID). This paper presents the background for these evolving concepts as well as an outline of the issues involved and the timeline for the design of the theoretical model and the construction, evaluation, and implementation of a resulting practical guide or manual.

Background

Chinese and Ayurvedic medical traditions, among the oldest in the world, promote a broad concept of health and a highly personalized approach to care and health promotion (Patwardhan et al., 2005). Likewise, ancient Greek philosophers and physicians, such as Socrates, Plato and Hippocrates, advocated holism in Medicine (Christodoulou, 1987). In fact, Socrates stated that "if the whole is not well it is impossible for the part to be well." (Plato, edition Papyros, 1975). Those early historical perspectives are echoed in today's world with renewed vigour and scientific substantiation (e.g. Herrman et al, 2005).

The WHO (1999) Director General proclaimed "there is no health without mental health" and several major international statements have cogently argued for paying greater attention to the totality of the person in clinical care and the integration of health and social services (U.S. Presidential Commission on Mental Health, 2003; WHO European Ministerial Conference on Mental Health, 2005).

Converging with the above there are a number of recent clinical developments. Starting in the rehabilitation field and championed by patient/user groups and likely minded clinicians, is the *recovery* movement (Anthony, 1993; Amering & Schmolke, 2007), which attempts to go beyond symptoms removal and functional improvement to promote a flourishing of the whole person and quality of life. Also relevant is the *need-adapted assessment and treatment* approach designed and promoted by Irjo Alanen and colleagues in Finland. Furthermore, the *values-based practice* advocated by Fulford et al (2002) is at the core of a renaissance of applied philosophical research in psychiatry.

WPA's Initiative on Psychiatry for the Person.

In response to the above historical perspectives and recent developments, the WPA's General Assembly established in 2005 an *Institutional Program of Psychiatry for the Person (IPPP).* This proposes the whole person in context as the center and goal of clinical care and public health. In this sense it endorses Ortega y Gasset dictum "*I am I and my circumstance*".

This institutional program is aimed at promoting a psychiatry of the person (of his/her whole health, covering both ill and positive aspects), a psychiatry by the person (with psychiatrists and health professionals extending themselves as total human beings and not merely as healing technicians), a psychiatry for the person (promoting the fulfillment of the person's health aspirations and life project and not merely disease management), and a psychiatry with the person (working respectfully and in an empowering manner with the person who consults).

This initiative seems to represent a conceptual shift in psychiatry and potentially in medicine at large. It is already attracting wide attention throughout WPA and other major international medical and health organizations (Mezzich, 2007).

The IPPP has four components, i.e., conceptual bases, clinical diagnosis, clinical care, and public health. The diagnostic component includes two major tasks: Collaborating with the WHO for the development of the best possible classification of mental disorders and health conditions at large and developing a Person-centered Integrative Diagnosis (PID) (Mezzich & Salloum, 2007). The later includes a theoretical model and its implementation in terms of a practical guide or manual.

Key issues for conceptualizing a Person-centered Integrative Diagnosis.

Feinstein (1967) has noted that diagnosis articulates how clinicians observe, think, remember, and act. In this sense, diagnosis is crucial for both clinical care and public health.

The etymological meanings of diagnosis include, identification of a disorder (from the Greek *dia)*, and understanding a clinical condition and situation (from *diagignoskein)*. Of relevance, the eminent philosopher of medicine Pedro Lain Entralgo (1982) has argued that identification of a disorder can be regarded as *nosological diagnosis* and the differentiation of one disorder from another as *differential diagnosis.* He reserved the true meaning of diagnosis to understanding what is going on in the mind and body of the person presenting for care. This represents a paradigmatic shift in the conceptualization of diagnosis.

Another important analysis would involve the distinction between diagnosis as a formulation and diagnosis as a process (involving interaction among clinician, patient and family). The importance of the latter was highlighted by the conference chair at the final conclusions session of the WPA Thematic Conference on Diagnosis in Psychiatry held in Vienna, June 19-22, 2003. A further elaboration of this process is reflected in the *trialogs* among patient, families and health professionals as documented by Amering (2003).

For constructing a new diagnostic model or schema it is necessary to consider the following points.

First, is the informational domain to be covered. In the more conventional cases, this involves illness or pathology. Additional options include disabilities and other health-related problems. The options may also extend to positive aspects of health (e.g., adaptive functioning, resilience, protective factors, resources, and quality of life) (Cloninger, 2004; Cox et al, 2007; Mezzich, 2005)

Second, are the descriptive tools to be employed, i.e., categorization (classical and even more pertinently, prototypical or probabilistic), dimensions (which also, in a hybrid arrangement, can lead to categorization in reference to particular thresholds), and narratives. Also relevant here is the architecture of the diagnostic schema, i.e. unilevel or multilevel for analysis and formulation.

Third, are the evaluators involved in the diagnostic process. These can include the clinicians as the conventional scientific experts, the patient as the main protagonist as informational source and center of ethical clinical care, and other important participants such as family, carers and pertinent community representatives (e.g., teachers for child diagnosis).

Developmental Resources

As we approach the development of improved diagnostic models, we should note that WPA has an established track record of contributions to the central issue of diagnosis in psychiatry (Mezzich & Ustun, 2002; Banzato, Mezzich, & Berganza, 2005). Also relevant is the publication of WPA's *International Guidelines for Diagnostic Assessment (IGDA)* (WPA, 2003). At the core of the IGDA is a diagnostic model articulating standardized multiaxial and idiographic personalized components. There has been wide acceptance of this model where it has been introduced as illustrated by the Latin American Guide for Psychiatric Diagnosis (APAL, 2004), and the use of this model in different countries in Latin America. Consequently, the IGDA diagnostic model is a significant reference point for the development of envisioned future diagnostic models.

Key participants in the development of the PID model and guide will be members of the IPPP Diagnostic Component. Other relevant resources are WPA scientific sections (particularly the Section on Classification, Diagnostic Assessment and Nomenclature) as well as member societies and their participation in a global network of national classification and diagnosis groups. Available furthermore for consultation will be the members of the IPPP Advisory Council.

Work procedures will include communication through the internet and teleconferences as well as face to face meetings. An internet platform will be established to facilitate information exchanges and storage.

Projected Timeline for the development of Person-centered Integrative Diagnosis

The development of the PID will involve a delineation of its theoretical basis and design, and the construction of its practical guide and application manual. The envisioned timeline and activities leading to the full development of the PID model and guide are the following:

a) The Design of the Person-centered Integrative Diagnostic (PID) Model.

The design of the PID, based on the broad premises discussed earlier, will involve a careful review of crucial demands in the health field, the limitations of current diagnostic systems as well as the key developmental issues noted above. The envisioned time line for this phase would extend to approximately the end of 2007.

b) The Development of the Person-centered Integrative Diagnostic (PID) Guide.

The PID Guide or manual involves the translation of the theoretical model and design for practical use. The development of the PID Guide will include the following steps:

i) Preparation of the PID Guide draft. This draft is expected to be ready by the end of 2008. The PID Guide draft will specify the structure, schemas and procedures of the PID. It will also identify the instruments to be used, and it will describe the procedures to be employed for the assessment of the domains of the PID.

ii) Evaluation of the PID Guide draft. The evaluation of PID draft will involve empirical studies and field trials across different realities and settings. Clinical and epidemiological

studies will be implemented to assess the feasibility, reliability, and validity of the Guide. This task is expected to be completed by the end of 2009.

iii) Preparation and publication of the final version of the PID Guide. Based on the results of the evaluation process discussed above, and on expert discussions and health stakeholders input, the final version of the PID guide will be produced and expected to be published by the end of 2010.

c) Dissemination of the Person-centered Integrative Diagnosis Guide (translations, implementation, and training).

Dissemination of the PID is the final critical task in the development of this model. The PID Guide would first be translated to prominent world languages, followed by the promotion and facilitation of the implementation of the PID Guide across the world. Training curricula will also be developed during this phase. These will involve programs at the graduate, post-graduate and continuing professional education levels. Training programs will target specialty and primary care arenas. The latter category will be the focus of special efforts. Dissemination activities are hoped to take place in 2011 and the years to follow.

Concluding remarks

We hope that the development of the Person-centered Integrative Diagnosis model and guide outlined above will be instrumental for achieving a diagnosis of the person, by the person, for the person, and with the person.

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