EDITORIAL INTRODUCTION

Mental Health in Person Centered Medicine

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Introduction

Person Centered Medicine is fundamentally aimed at promoting the health and well-being of the totality of the person [1]. Here the *person* is the key concept as the center and goal of health care [2]. An important implication is that the focus of contemporary medicine should be shifted from disease to patient to person [3]. In the clinical arena, Iona Heath has spoken critically of "promotion of disease and distortion of medicine" [4] and concerning public health, WHO's definition of health as "a state of complete physical, emotional and social wellbeing and not merely the absence of disease" is compelling [5].

The value of a holistic approach to health and medicine was already argued by the great Hellenic philosophers and physicians, such as Socrates, Plato and Hippocrates. In fact, Socrates taught that "if the whole is not well it is impossible for the part to be well" [6]. He also stated that "everything comes from the psyche, bad things and good things for the body and the whole person" [7]. These considerations illustrate the ancient roots of holism and integrity of the person in medicine, as well as of the particular role of the psyche, i.e. mentation, emotions, and behavior, for health and well-being.

A brief discussion of the place and role of mental health in person centered medicine needs to touch on at least two domains. The first one relates to the various activities and manners through which mental health has contributed to the conceptualization and experience of person centered medicine. The second corresponds to the role that an organized and institutional "psychiatry for the person" has played in the construction of person centered medicine as a collaborative international movement.

Mental Health Perspectives towards Person Centered Medicine

At the 54th World Health Assembly, Gro Brundlandt, former Prime Minister of Norway and then WHO Director General proclaimed "There is no development without health, and no health without mental health" [8]. This summarizes the growing perception of the cruciality of mental health to achieve general health and well-being. The following sections illustrate why this is so, from various angles, particularly with attention to person centered health and person centered medicine.

The importance of behavioral factors for addressing chronic diseases

Chronic non-communicable diseases such as diabetes, cancer, and cardiovascular and respiratory illnesses are responsible for over 70 % of morbidity and mortality across the world. Their prominence as a global epidemic has attracted the urgent attention of the United Nations and the World Health Organization [9].

Addressing chronic disease is particularly pertinent for the International College of Person Centered Medicine given that effective care for such conditions requires indispensably the engagement of persons and their sense of responsibility to undertake actively and creatively required adjustments in life style [10, 11]. Consequently, the International College dedicated its 5th Geneva Conference to *Person Centered Care for Chronic Diseases* and issued its first Geneva Declaration, which was dedicated to this topic [12]. Among its recommendations are to monitor risk and protective factors (intrinsic and extrinsic; biological,

psychological, and social), as well as outcomes for positive health (vitality and resilience despite exposure and adversity).

The World Health Alliance (World Medical Association, International Council of Nurses, International Dental Federation, and International Pharmaceutical Federation) has recently identified through a Health Improvement Card [13] a number of factors to prevent chronic diseases. The majority of such factors have to do with behavior and life style. Among these are: diet, exercise, avoidance of alcohol and other hazardous drugs, stress-control, adequate rest and sleep, and participation in social and creative activities.

Psychological elements in adaptive systems for the promotion of well-being

Keyes and Ryff's research [14] has shown the overlap of physical, mental and social wellbeing, as well as the inadequacy of focusing only on the presence of physical and mental disorders in assessing health. Flourishing involves dynamic interactions between healthy functioning, contributions to health and the experience of health. As argued by Herrman et al [15], in order to develop wellbeing, people must be aware of the causes of both their distress and disability as well as of the paths open to them to develop in health and happiness with community support as well as personal effort.

Cloninger et al [16] have endeavored to explain the dynamic origins of well-being. The causes of wellbeing and ill-being appear to involve a complex adaptive network of components and processes that are being gradually specified, measured and treated according to the principles of person-centered medicine. Some of the key factors promoting well-being seem to be the development of self-awareness, cooperation, and self-transcendence [17].

The importance of subjectivity and inter-subjectivity in person centered care

As noted by Botbol [18], person centered medicine should not be reduced to individualization of care or respect for patients' rights, as it has wider aspirations. These include the recognition of the individual subjectivity of the whole person of the patient beyond what characterizes his or her illness or the status or role of patient. What is of interest here is dealing with the inner world of a patient in his particular situation of suffering and dependence caused by illness, as proposed in Aristotle's Nicomachean Ethics: "Cure of a unique person (not of a generalized nosological case), in a specific situation, within a specific, unrepeatable period of one's life" [19]. What becomes crucial here is the commitment of the mental health professional to approach the patient's subjectivity in such singular vital situation.

In addition to the attention paid to the medico-biological aspects of the person's health status, a person centered assessment needs to give enough consideration to the patient's subjective feelings [20]. Whether or not one suspects a psychic or psychosomatic causality to the disorder that a patient brings to the clinic, it is essential to keep in perspective the factors involved in the patient's health situation. Beyond reasserting this principle, one needs to utterly enhance the methodology for accessing these subjective dimensions among different partners involved in the diagnostic process and the therapeutic relationship. For health professionals, the only way to access these subjective dimensions is through what the patient (and or his/her carers) says in words or shows in acting, as long as these words or acts can trigger in the professionals enough empathy to approach the patient's subjective feelings to which these expressions are related.

Working on a person-centered diagnostic approach has become an important element to meet this methodological goal. This diagnostic model includes, besides the objective elements about the patient and his or her context, the subjective elements reported by the idiographic formulations of the person who is being cared for, their carers and assisting professionals.

This approach appears to lead to a closer examination of the role of the professional's empathy in the methodology to access the subjectivity of the patient, trying to go beyond the general assertions on the importance of this concept in therapeutic relationships and care activities [20].

At first seen as the professional's ability to listen sympathetically to the comments of the patient and to consider his wishes and needs, the notion of empathy has gradually widened to include representations that the physician (or other health professional) makes of the clinical situation in which the person in need of care is involved. In short, these are representations that the professional makes of the health situation of the person suffering through his/her (the professional) own empathy, triggered by the words and the acts of the patients and of their carers. This mechanism is well described by the concept of "metaphorizing-empathy" proposed by Lebovici [21] from his work with babies and their mothers. It is also close to the notion of "narrative empathy" proposed by Jacques Hochmann [22] based on his work with autistic children and on the philosophical ideas brought by Paul Ricoeur in his book "Time and Narrative" [23]. It is also consistent with Kleinman's assumptions [24] on illness narratives. This important development in person centered medicine marks the full recognition of the role of the physician's subjectivity as a diagnostic and treatment tool within the framework of the physician-patient relationship.

Recovery orientation in mental health and its relations to person centered medicine

Recovery-oriented concepts emerged from a coalescence of efforts from both service users and professional groups in the mental health field. On one hand, individuals who suffered and recovered from mental illnesses formed a

recovery movement and a national and international community of activists. For example, Chamberlin [25] and Deegan [26], expressed their criticism against negatively experienced psychiatric treatment and demanded to be considered active protagonists and partners rather than passive recipients of care. On the other hand, well-known experts in the field of psychosocial rehabilitation, such as Anthony [27] welcomed the statements of service users and the need to attend to their subjective experiences, speaking against traditional appeared focused on improving just functioning and adaptation and not on the flourishing of the individual human being. At least since the beginning of the 90's, many professionals in rehabilitation and other fields and various service user groups have started substantial collaboration through joint publications and conferences. Recently, reflecting progress in this regard, Mary Barber [28] has considered recovery as "the new medical model for psychiatry".

Recovery Orientation engages multidisciplinary cooperation, where professionals aim at helping not only to reduce symptoms, disease and disability but also to assist individuals to have a home again, to return to work, and to have friends. Key here is to cultivate a partnership attitude in which the individual can contribute actively based on his/her former illness experience and include family members and friends who know well the patient's needs. Furthermore, peer-support (a recovery oriented development) is becoming frequently complementary to standard treatment in the United States, United Kingdom, and Australia [29].

Patients' participation in treatment planning is being increasingly advocated in mental health [30]. "Shared decision making" was an early contribution of the recovery movement to clinical care, and is becoming gradually a valued tool in person centered medicine. It is considered a promising method of engaging patients in medical decisions and improving health-related outcomes [31, 32]. The concept of "shared decision making" serves as a clinical tool towards enhancing communication and optimizing treatment planning as well as implementing respect for the autonomy, responsibility and dignity of every person involved. It is now a core concept applied in both recovery orientation as well as person-centered care, especially useful for chronic patients. The patient or client, an expert by experience, and the practitioner, an expert by training, are now expected to contribute from their own perspectives and determine collaboratively a course of treatment.

A comparison of the essentials of recovery orientation and person centered care identified unique characteristics for each approach as well as substantial elements of convergence. Recovery orientation is primarily centered within the mental health and psychosocial fields while the person-centered approach covers general medicine and health care at large. Their points of convergence encompass a holistic theoretical perspective, an emphasis on contextualization and establishing a common ground for understanding an action, development of person-centered procedures for clinical care and health promotion, and , last but not least, an ethical commitment [33].

From Psychiatry for the Person to Person Centered Medicine

The organized and institutional development of person centered care in the psychiatry and mental health field has been unfolding in two phases. The first one from 2005 to 2008 took place in the form of an Institutional Program on Psychiatry for the Person within the World Psychiatric Association. The second one, since 2008 to date, evolved from the first one by extending its domain from psychiatry to medicine at large and progressing institutionally through collaboration with a large number of top global institutions in medicine and health.

WPA Institutional Program on Psychiatry for the Person

The Institutional Program on Psychiatry for the Person (IPPP), established by the 2005 General Assembly of the World Psychiatric Association (WPA), involved an organization-wide initiative affirming the *whole person of the patient within his context* as the center and goal of clinical care and health promotion, at both individual and community levels. This was set to involve the articulation of science and humanism to optimize attention to the ill and positive health aspects of the person. As care is basically a partnership experience, the program involved the integration of all relevant health and social services. Furthermore, the program also involved advancing appropriate public health policies.

Historians Garrabe and Hoff [34] have noted that the principles behind psychiatry for the person could be already detected at the very beginnings of the WPA. As a conceptual introduction to the whole Institutional Program, two editorials were published by the first author of the present paper, then WPA president, one broadly focusing on articulating medicine's science and humanism [35] and another on the dialogic basis of the profession [36].

The work of the Institutional Program was organized in four components: Conceptual Bases, Clinical Diagnosis, Clinical Care, and Public Health. These are summarized next.

Conceptual component

This component dealt with analyses and delineations of the conceptual bases of psychiatry for the person. It produced an editorial and a regular article in international journals presenting the objectives of this component [37, 38].

Additionally, a monographic set on the conceptual bases of psychiatry for the person was prepared and eventually published with the following table of contents: Introduction [38], Historical perspectives [34], Philosophy of science perspectives [39], Ethics perspectives [40], Biological perspectives [41], Psychological perspectives [42], Social perspectives [43], Cultural perspectives [44], Spiritual perspectives [45], Users perspectives [46], and Literature and art perspectives [47].

Clinical diagnosis component

There were two work objectives in this component. The first one involved collaborating with WHO towards the development of ICD-11. There was a preliminary background phase in this process during the first half of the preceding decade involving principally the WPA Classification Section and the WHO Classification Office and leading to two monographs [48, 49]. A full development of the ICD-11 Mental Disorders Chapter started in early 2007 under the direction of the WHO Mental Health Department.

The second and main work objective of the IPPP clinical diagnosis component was the development of a person-centered integrative diagnosis (PID) model. At its heart was a concept of diagnosis defined as the description of the positive and negative aspects of health, interactively, within the person's life context. The PID would include the best possible classification of mental and general health disorders (expectedly the ICD-11 classification of diseases and its national and regional adaptations) as well as the description of other health-related problems, and positive aspects of health (adaptive functioning, protective factors, quality of life, etc.), attending to the totality of the person (including his/her dignity, values, and aspirations). The approach would employ categorical, dimensional, and narrative approaches as needed, to be applied interactively by clinicians, patients, and families. A starting point for the development of the PID was the schema combining standardized multiaxial and personalized idiographic formulations at the core of the WPA International Guidelines for Diagnostic Assessment (IGDA) [50].

As an introduction to this IPPP component's work, a broad ranging volume on psychiatric diagnosis: challenges and prospects [51] was prepared. A paper on "Towards innovative international classification and diagnostic systems: ICD-11 and person-centered integrative diagnosis" was published by Mezzich and Salloum as an invited editorial in *Acta Psychiatrica Scandinavica* [52]. Other papers pertinent to this developmental work included an editorial on Clinical Complexity and Person-centered Integrative Diagnosis [53] and On Person-centered Integrative Diagnosis [54].

Clinical care component

The thrust of the work of this component encompassed educational efforts towards achieving person-centered care. The two main developments which were outlined were an approach to person-centered clinical care and a curriculum to carry out training on the above-mentioned approach.

It was noted that the teaching of medicine and that of psychiatry in particular has experienced many changes. There was a time when the core curriculum in psychiatry, written by the WPA together with the World Federation for Medical Education, became a landmark because it did not only define the competencies in psychiatry that every physician should be taught, but mainly because it called attention to prevention of illness and promotion of health.

Public health component

Public health in modern times has a broad scope as the organized global and local effort to promote and protect the health of populations and reduce health inequities. This ranged from the control of communicable diseases to the leadership of intersectoral efforts in health [55]. It was noted that evidence is growing for the value of integrating mental health in general health and public health practice [56, 57]. Despite this, public health programs in many countries around the world have yet to recognize and include mental health and mental illness as areas of relevant action.

Psychiatry for the person is a basis for advocacy that emphasizes the value and dignity of the person as essential starting points for public health action. This includes development of policies and services, and research and evaluation supporting these. Failure to recognize the humanity and dignity of citizens living with mental illness as well as the value of mental health to the individual and community have resulted in abuse and neglect of the former and lost opportunities to improve mental health through population-based and person-based initiatives. The neglect of individual needs and the fragmentation and inadequacies of health and social services undermine policy development [58, 59]. Public health actions to promote mental health prevent illness and provide effective and humane services benefit from and contribute to the development of psychiatry for the person.

IPPP events

1. London Conference on Person-centered Integrative Diagnosis and Psychiatry for the Person: It was organized on October 26–28, 2007 by both the WPA IPPP and the Health Department of the United Kingdom. It represented a path-opening opportunity for synergism between person-centered care and Britain's Shared Vision Project.

2. Paris Conference on Psychiatry for the Person: This was organized on February 6–8, 2008 by the WPA IPPP, the French Member Societies of WPA, and the five WPA European Zonal Representatives. The city and the professional community that served 58 years earlier as the cradle of WPA, offered a special type of conference, focused and interactive, without commercial accompaniments.

3. Philippe Pinel Prize on Psychiatry for the Person: Articulating Medicine's Science and Humanism: In 2007, the WPA Executive Committee established this Prize to honor Philippe Pinel, a pioneer in the systematization of clinical psychiatry and an inspiring humanist who broke the chains of his hospital's mental patients. The awardee was Prof. Yrjo Alanen of Turku, Finland, world-acclaimed for his innovative work on *Need Adaptive Assessment and Treatment* integrating scientifically valid therapeutic techniques with attention to the experience and views of patients with psychotic disorders.

Development of Person Centered Psychiatry within the Framework of Person Centered Medicine

Around 2008, contacts between the leaders of WPA and those of other important organizations such as the the World Medical Association, the World Federation of Neurology, the World Organization of Family Doctors (Wonca), the International Council of Nurses, and the international Alliance of Patients' Organizations, among others, revealed wide interest for placing the person at the center of general medicine and health care. This led to the collaborative organization of the first Geneva Conference on Person Centered Medicine at Geneva University Hospital. This started a process of annual Geneva Conferences. Of note, the World Health Organization joined in formally co-sponsoring the Conferences since its third edition in 2010 to date. From this process emerged the International Network, now International College, of Person Centered Medicine [60].

Within the framework of this broader conceptual scope and wide inter-institutional collaboration, work on person centered psychiatry has continued with greater vigor and reach. Illustrative of these efforts are the following projects.

Development of the Person-centered Integrative Diagnosis (PID) model and practical guides.

This work has involved the publication of a consolidated structural model for Person-centered Integrative Diagnosis (PID), following-up on the work on person-centered clinical diagnosis initiated during the period of the Institutional Program on Psychiatry for the Person mentioned above. Thus, most immediately, this is a model for person-centered psychiatric diagnosis, but potentially extensible to medicine at large.

The PID model [61] articulates science and humanism to obtain a diagnosis *of* the person (of the totality of the person's health, both its ill and positive aspects), *by* the person (with clinicians extending themselves as full human beings, scientifically competent and with high ethical aspirations), *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 presents for evaluation and care). This notion of diagnosis goes beyond the more restricted concepts of nosological and differential diagnoses.

The Person-centered Integrative diagnostic model is defined by three key features: a) broad informational domains, covering both ill health and positive health along three levels: health status, contributors to health, and health experience and values, b) pluralistic descriptive procedures (categories, dimensions and narratives), and c) evaluation partnerships among clinicians, patients and families. Evolving research on the PID includes a conceptual validation of its basic elements [62].

The Latin American Psychiatric Association Section on Diagnosis and Classification has prepared and published the Latin American Guide of Psychiatric Diagnosis, Revised Version (GLADP-VR) [63]. It was built starting with the original GLADP [64] and largely incorporating the basic elements of the Person-centered Integrative Diagnosis (PID) model [61]. For coding disorders, it uses the categories and codes of WHO's International Classification of Diseases.

The GLADP-VR is being increasingly used throughout the various Latin American countries. It is the official guide from the Latin American Psychiatric Association.

There are also plans to develop under the auspices of the International College of Person Centered Medicine a PID practical guide intended for use in general medicine.

Person Centered Psychiatry Book

The purpose of this book is to present authoritatively the emerging field of Person-Centered Psychiatry. It is organized under the aegis of the International College of Person Centered Medicine. The World Psychiatric Association (WPA) is officially co-sponsoring it. Eighteen WPA Scientific Sections are engaged in its authorship. It will be published by Springer Verlag, Heidelberg.

Its editors are JE Mezzich, M. Botbol, G. Christodoulou, CR Cloninger, and I. Salloum. It has ninety chapter authors. It includes forty chapters organized into the following five sections: Principles, Diagnosis and Assessment, Person Centered Care Approaches, Person-centered Care for Specific Mental Conditions, and Special Topics.

Introducing this Journal Issue Papers

As expected from this Editorial Introduction, most of the articles in this Journal Issue deal with mental health issues, directly or indirectly.

The first article from a group of researchers from Oxford and other European cities was aimed to assess readiness for mainstream implementation of shared decision making (SDM) in five European countries [65]. It found that all five countries had research groups working on SDM, patient groups calling for its wider use, and ethical and professional standards indicating its desirability, but apart from a small number of demonstration projects, there was no evidence of a systematic approach to implementation in any of the countries as yet. It concluded that greater attention will need to be given to the provision of effective leadership, training and practical support if SDM is to become a regular feature of clinical practice in these countries.

The second article from an eminent pediatrician, educator and person-centered medicine expert in London examined person centered integrated care through the life course. He posited that the health and wellbeing of a person are complex adaptive processes related to the consequences of genetic, biological, social, cultural,

behavioral, and economic determinants at the various stages of the life cycle. He showed that research on health disparities has demonstrated the effect of many determinants interacting in various contexts at developmentally sensitive points. We need an integrated conceptual approach to translate this knowledge into effective health and social care.

The third article from a group of Indian clinical scholars led by the secretary general of the World Psychiatric Association, present international mental health perspectives on person centered integrated care. Modern medicine, with all its scientific and technological advancements overshadowing humanistic components, has time and again found to be falling short of the expectations of clients and service providers alike. They note that person centered integrated care has been rapidly gaining momentum as the reply to the current shortcomings of health care delivery and has consistently been ranked as desirable.

Two experienced clinical scholars from the United Kingdom examined in the fourth article the need for person-centered integrated care for people who experience multimorbidity. The concept of multimorbidity has attracted increasing interest in the past decade with the recognition of multiple burdens of disease and their escalating costs for the individual and the community. It is evident in clinical practice that multimorbidity has become the norm rather than the exception, occurring in an increasingly younger population particularly in areas of socioeconomic deprivation and in low income countries. It is now well established that the mentally ill have a markedly reduced life expectancy due to predominantly cardiovascular and metabolic diseases. The growing evidence and experience for adopting an integrated collaborative person-centered approach demonstrates the need for a more effective model of care which is individualized and focused on patient engagement to prevent disease and manage multiple conditions systematically.

The fifth article from a group of American clinical researchers empirically examine gender comparisons on quality of life on a sample of patients experiencing comorbid alcohol dependence and major depression. Treatment-seeking women with co-morbid major depression and alcoholism report lower quality of life (i.e., happiness and life satisfaction) than their male counterparts. They conclude that quality of life assessments may identify areas of impairment and opportunities for health promotion not assessed through traditional measures used in addiction treatment programs, and these measures may be more sensitive to the specific needs of women. Consideration of all these factors are likely to enhance person-centered care.

The last article in this issue, from the director of an innovative nursing school in Ecuador discusses holistic professional education of the healthcare team. She notes that healthcare services are evolving towards the consideration of comprehensive models of the human being. She also notes the value of the perspectives of Latin American experts in education in order to optimize training plans and making them particularly suitable for the population to be served. Key tenets of their approach are fluid inter-professional communication and collaboration and close interaction with the community. Focusing on the patient it attends to empowerment, and concerning the students it pays particular attention to self-esteem and total personal development.

The Journal issue closes with programmatic information on key international events on person centered medicine.

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References

[1]. Mezzich JE, Snaedal J, van Weel C, Botbol M, Salloum IM (2011): Introduction to Person-centered Medicine: From Concepts to Practice. *Journal of Evaluation in Clinical Practice* 17: 330-332.

[2]. Cassell E (2010): The person in medicine. *International Journal of Integrated Care.* Vol 10. Supplement: 50-51.

[3]. Mezzich JE, Snaedal J, van Weel C, Heath I (2010): Toward Person-centered Medicine: From disease to patient to person. *Mount Sinai Journal of Medicine* 77: 304-306.

[4]. Heath I (2005): Promotion of disease and corrosion of medicine. Canadian Family Physician 51: 1320-22.

[5]. WHO (1946): Constitution of the World Health Organization. Geneva: WHO.

[6]. Christodoulou GN (ed)(1987): Psychosomatic Medicine. New York: Plenum Press.

[7]. Plato: Harmidis Dialogue, 156 E. Papyros, Athens, 1975.

[8]. Brundtland G (2001): Preface to Mental Health: A Call for Action by World Health Ministers. Ministerial Rounds at the 54th World Health Assembly. Geneva: World Health Organization.

[9]. World Health Organization (2012). Global Health Status Report on Non-communicable Diseases. Geneva: World Health Organization.

[10]. Greenhalg T (2009). Patient and public involvement in chronic illness: beyond the expert patient. British Medical Journal 338: 49.

[11]. Cloninger CR (2013). What makes makes people healthy, happy, and fulfilled in the face of current world challenges? Mens Sana Monograph 11:16-24.

[12]. International College of Person-centered Medicine (2012). Geneva Declaration on Person-centered Care for Chronic Diseases. *International Journal of Person Centered Medicine* 2: 153-154.

[13]. Seyer J (2012). Development of the Health Improvement Card developed by the World Health Professions Alliance. Paper presented at the 5th Geneva Conference on Person-centered Medicine. International College of Person Centered Medicine, May 2012.

[14]. Keyes, C.L., Shmotkin, D. & Ryff, C.D. (2002). Optimizing well-being: the empirical encounter of two traditions. Journal of Personality and Social Psychology 82 (6): 1007-1022.

[15]. Herrman, H., Stewart, D.E., Diaz-Granados, N., Berger, E.L., Jackson, B. & Yuen, T. (2011). What is Resilience?. Canadian Journal of Psychiatry 56 (5): 258-265.

[16]. Cloninger, C.R., I.M. Salloum, and J.E. Mezzich (2012): The dynamic origins of positive health and wellbeing. International Journal of Person-centered Medicine 2(2): p. 1-9.

[17]. Cloninger, C.R. (2004). Feeling Good: The Science of Well-Being. p.374. New York: Oxford University Press.
[18]. Botbol M (2012) Du manifeste au subjectif: ce qu'est la médecine de la personne [From objectivity to subjectivity: What is Person Centered Medicine] In SD Kipman (Ed.): Manifeste pour la médecine de la personne [Manifesto for Person Centered Medicine]. Paris, Dion.
[19]. Warne C (2007) Aristotle's Nicomachean Ethics: Reader's Guide. London: Continuum.
[20]. Botbol M and Lecic-Tosevski D (2013) Person-centered medicine and subjectivity. In Jeffrey HD Cornelius-White, Renate Motschnig- Pitrik, Michael Lux (eds): Interdisciplinary Applications of the Person-Centered Approach. New York: Springer, pp 73-82 .
[21]. Lebovici S (1999) L'arbre de vie - éléments de la psychopathologie du bébé [The tree of life - Principles of infant psychopathology]. Toulouse : Eres.
[22]. Hochmann J (2012) Une histoire de l'empathie [A history of empathy]. Paris: Odile Jacob.
[23]. Ricoeur P (1983) Temps et récit [Time and narrative]. Paris: Le Seuil
[24]. Kleinman A (1988): The Illness Narratives. New York: Basic Books.
[25]. Chamberlin J (1979): On Our Own: Patient-controlled Alternatives to the Mental Health System. New York, McGraw-Hill.
[26]. Deegan P (1992): The independent living movement and people with psychiatric disabilities: taking back control over our own lives. *Psychosocial Rehabilitation Journal* 15: 3-19.
[27]. Anthony W (1993): Recovery from mental illness. The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal* 16: 11-23.
[28]. Barber ME (2012): Recovery as the New Medical Model for Psychiatry. *Psychiatric Services* 63, 3: 277-279.
[29]. Davidson L, Chinman M, Sells D et al. (2006): Peer support among adults with serious mental illness: a report from the field. Schizophrenia Bulletin 32, 3: 443-450.
[30]. Deegan PE, Drake RE (2006): Shared Decision Making and Medication Management in the Recovery Process. *Psychiatric Services* 57(11): 1636-9.
[31]. Stevenson FA, Barry CA, Britten N, Barber N, Bradley CP (2000): Doctor–patient communication about drugs: the evidence for shared decision making. *Social Science & Medicine* 50, 6: 829-840.
[32]. Hamann J, et al. (2006): Shared decision making for in-patients with schizophrenia. *Acta Psychiatrica Scandinavica* 114: 265-273.
[33]. Schmolke MM, Mezzich JE 2013): Contrasting the essentials of recovery orientation and person-centered care. *International Journal of Person Centered Medicine* 3: 31-35.
[34]. Garrabe J, Hoff P (2011): Historical views on Psychiatry for the Person. *International Journal of Person Centered Medicine* 1:125-127.
[35]. Mezzich JE (2007): Psychiatry for the person: articulating medicine's science and humanism. *World PsyPsychiatry* 6:1-3.
[36]. 36.Mezzich JE (2007): The dialogal basis of our profession: psychiatry with the person. World Psychiatry 6:129-130.
[37]. 37.Christodoulou G, Fulford B, Mezzich JE (2008): Psychiatry for the person and its conceptual bases. *International Psychiatry* 5:1-3.
[38]. Mezzich JE, Christodoulou G, Fulford KWM (2011): Introduction to the Conceptual Bases of Psychiatry for the Person. *International Journal of Person Centered Medicine* 1: 121-124, 2011.
[39]. Thornton T, Schaffner KF (2011): Philosophy of Science Perspectives on Psychiatry for the Person. *International Journal of Person Centered Medicine* 1: 128-130.
[40]. Fulford KWM, Christodoulou G, Stein DJ (2011): Values and Ethics: Perspectives on Psychiatry for the Person. *International Journal of Person Centered Medicine* 1: 131-133.
[41]. Botbol M, Alanen YO, Schmolke M (2011). Psychological Perspectives on Psychiatry for the Person. International Journal of Person Centered Medicine 1: 134-136.
[42]. Cloninger CR, Abou-Saleh MT, Mrazek DA, Möller H-J (2011). Biological Perspectives on Psychiatry for the Person. *International Journal of Person Centered Medicine* 1: 137-139.
[43]. Rutz W, Fernandez M, Trivedi J (2011). Social Perspectives on Psychiatry for the Person. *International Journal of Person Centered Medicine* 1: 140-142.
[44]. Fabrega Jr H, Wintrob R (2011). Ethnomedical and cultural foundations of psychiatry for the person. *International Journal of Person Centered Medicine* 1: 143-145.
[45]. Cox J, Verhagen PJ (2011). Spirituality, Religion and Psychopathology: Towards an integrative psychiatry. *International Journal of Person Centered Medicine* 1: 146-148.
[46]. Sukhanova E, Thomashoff H-O, THoret Y (2011): Literature and Arts Perspectives on Psychiatry for the Person. *International Journal of Person Centered Medicine* 1: 149-151.
[47]. Wallcraft J, Steffen S, Amering M (2011). Service User and Family Perspectives on Psychiatry for the Person. *International Journal of Person Centered Medicine* 1: 152-154.
[48]. Mezzich JE, Ustun TB, editors (2002). International classification and diagnosis: critical experience and future directions. *Psychopathology* 35(2–3): 59-201.
[49]. Banzato CEM, Mezzich JE, Berganza CE, editors (2005). Philosophical and methodological foundations of psychiatric diagnosis. Psychopathology 38(4):155-230.
[50]. World Psychiatric Association (WPA) (2003). Essentials of the World Psychiatric Association's International Guidelines for Diagnostic Assessment (IGDA). *British Journal of Psychiatry* 2003; 182(Suppl. 45):37-66.
[51]. Salloum IM, Mezzich JE, editors (2009). Psychiatric diagnosis: challenges and prospects. Chichester, UK: Wiley-Blackwell.
[52]. Mezzich JE, Salloum IM (2007). Towards innovative international classification and diagnostic systems: ICD-11 and person-centered integrative diagnosis. *Acta Psychiatrica Scandinavica* 116:1-5.
[53]. Mezzich JE, Salloum IM (2008). Clinical complexity and person-centered integrative diagnosis. World Psychiatry 7:1-2.
[54]. Mezzich JE, Salloum IM (2007). On person-centered integrative diagnosis. *Die Psychiatrie* 4:262-5.
[55]. Beaglehole R, editor (2003). Global Public Health: a new era. Oxford: Oxford University Press.
[56]. Herrman H, Saxena S, Moodie R (2005). Promoting mental health: concepts, emerging evidence, practice. Geneva: WHO.
[57]. Rutz W (2006). Social psychiatry and public mental health: Present situation and future objectives. Time for rethinking and renaissance?. Acta Psychiatrica Scandinavica 429 (Suppl): 95-100.
[58]. Strauss JS (1992). The person – key to understanding mental illness: towards a new dynamic psychiatry, III. *British Journal of Psychiatry* 161(18):19-26.
[59]. WHO (2001). The World Health Report 2001: Mental health: new understanding, new hope. Geneva: World Health Organization.
[60]. Mezzich JE, Snaedal J, van Weel C, Heath I (2009): The International Network for Person-centered Medicine: Background and First Steps. *World Medical Journal* 55: 104-107.
[61]. Mezzich, J. E., Salloum, I. M., Cloninger, C. R., Salvador-Carulla, L., Kirmayer, L., Banzato, C. E., Wall-craft, J., & Botbol, M. (2010). Person-centered Integrative Diagnosis: Conceptual Bases and Structural Model. *Canadian Journal of Psychiatry*, 55, 701-708.

[62]. Salloum IM, Mezzich JE (2011): Conceptual appraisal of the Person-centered Integrative Diagnosis Model. *International Journal of Person Centered Medicine*, 1: 39-42.
[63]. Asociación Psiquiátrica de América Latina, Sección de Diagnóstico y Clasificación. (2012). Guía Latinoa-mericana de Diagnóstico Psiquiátrico, Version revisada (GLADP-VR). Lima: Asociación Psiquiátrica de América Latina.
[64]. Asociación Psiquiátrica de América Latina, Sección de Diagnóstico y Clasificación. (2004). Guía Latinoamericana de Diagnóstico Psiquiátrico. Guadalajara: Asociación Psiquiátrica de América Latina.
[65]. Coulter A, Härter M, Moumjid-Ferdjaoui N, Perestelo-Perez L, , and Van der Weijden T (in press): European experience with shared decision making. *International Journal of Person Centered Medicine.*
[66]. Appleyard J (in press): Person-centered and integrated care across the life cycle. *International Journal of Person Centered Medicine.*
[67]. Kallivayalil RA, Garg K, and Tripathi A (in press): International mental health perspectives on person centered integrated care. *International Journal of Person Centered Medicine.*
[68]. Millar HL, Abou-Saleh MT (in press): Multimorbidity in mentally ill people: The need for a person-centered integrated approach. *International Journal of Person Centered Medicine*.
[69]. Hyman SM, Khazai L, Botros M, Torres YI, Miao F, Cornelius JR, Mezzich JE, and Salloum IM (in press): Gender comparisons on quality-of-life and comorbid alcohol dependence and major depression. *International Journal of Person Centered Medicine.*
[70]. Castillo Costa O (in press): Holistic professional education of the healthcare team: Person-centered approach in a new Ecuadorian nursing school. *International Journal of Person Centered Medicine.*