# The Person as Center of Health

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## 2.1 Introduction

Increasing attention to the sick person and the movement for person-centered medicine require more consideration in medical education and practice. The definition of sickness that underlies this discussion is: "*Persons are sick who cannot pursue their purposes and goals because of impairments of function which they believe are in the domain of medicine. The goal of medicine is the well-being of the patient*" [1]. This definition is heavily dependent on an understanding of persons because only persons can know what purposes and goals are important to them, what functions are impaired and in what manner, and when they have achieved well-being. It does not matter that the sick person may not spontaneously know these things; it may take careful history taking and verbal interaction with the physician before they are clear enough to guide clinical action. Another critical facet to incorporate in clinical judgment thus is based on values, both intrinsic and external in respect to the person [5]. Values-based medical practice moves forward across the limitations of traditional twentieth century bioethics.

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The net effect of the impairments of function can be to make the person unrecognizable in his or her own eye. Each particular aspect—for example, sense of self, notions of future and past, life plans, pursuit of goals and purposes—can be specifically called up by the physician and restored even in the face of the most serious or fatal illness. This is a specific task of medicine.

In advance of the core sections of this chapter we should pose the fundamental question; what should be the relationship between the notions of person and ***personality***? Contemporary psychology has contributed extensively to understanding of personality as a complex multidimensional combination of temperament and character traits [2, 3, 4, 6]. Those traits interact permanently in a nonlinear manner with the dimensions of the context, e.g., psychological climate at workplace [13]. In our chapter, we have adopted the view that the person is a more general superstructure around personality in the meaningful connections of social life. In that sense person is not only a psychological and physical construct per se, but should be seen from ethical, aesthetical, communicative, and other perspectives as well.

## 2.2 The Person and Its Existential Being

**A person is an embodied being, purposeful**, thinking, feeling, emotional, capable of choosing, reflective, relational, responsible, very complex human individual of a certain personality and temperament, existing through time in a narrative sense, whose life in all spheres points, both outward and inward, and who does things. Each of these terms is a dynamic function, constantly changing, and requiring action on the part of the person to be maintained—although generally the maintenance is habitual and unmediated by thought.

**Persons are always in action and never quiescent** in the manner of inanimate objects. Persons are complex and can support contradictory thoughts and actions simultaneously, which, however, produce new thoughts and actions. Although fundamentally stable in personality and overall psychological and social being, persons are always changing perceptions, thoughts, and actions in a continuous manner. They are dynamically and interactively responsive to their inner and outer environment.

**A person is a temporal as well as a spatial object**. A person as a temporal object like a piece of music extends through time. As such **persons have an aesthetic dimension** where one can judge whether seeing or knowing about the person through time presents a harmonious aspect to consideration. This understanding of the esthetics of a life over time fits well with the use of the narrative to describe a person over time. As it has been emphasized by Musalek [9] social-aesthetical factors can influence in various ways the treatment, clinical course, and outcome of disease. One part of the story of a life or a part of a lived life generally fits with the preceding and the following parts of the narrative. Or its parts may be in discord or unbalanced. There can be no objective measurement of this idea of "fit," but it is not usually idiosyncratic; as with other things in the aesthetic domain there will mostly be agreement among observers. The general belief that the

life as lived should be concordant allows us to say that what happened to someone does not seem to fit his or her life as lived.

The process of care can be carried out with active thought given to fitting into the aesthetic balance of the person's story and thereby reducing the ugliness of the illness and its care. This requires that clinicians acquire an aesthetic viewpoint of their patient's life and that requires conscious effort. All persons have an innate aesthetic sense, a sense of order, harmony, and beauty (as they know it). This does not mean, as Benedetto Croce explained almost a hundred years ago, that they can paint or make a poem that will bring tears to your eyes. Those are the artistic expression of an aesthetic impulse, not the aesthetic thought itself, which comes prior to its expression.

**A person is a being** who has a sense of self, a notion of a future and past, can hold values, make choices, and who can adopt life plans. To have these capacities a person must be a being with its own point of view on things. A person is a being who in most states (but not when unconscious, anesthetized, or similarly impaired) can be addressed and who can reply. It is these features of persons that underlie the fact that they have goals and purposes and that the fulfillment of the person's purposes leads to a feeling of well-being [14]. **Persons act on the basis of the meanings** of things, not on things themselves. Meaning as used here is about the implied or explicit significance of the thing, what a thing is considered to represent or to be. There is perhaps no object, event, or relationship which does not have or will not acquire meaning. Meaning as used here is more than the denotative meaning or even connotative meaning. Meaning also has emotional, physical (bodily response), and spiritual dimensions.

**All persons are different in virtually every feature of their existence**. Biological, physical, psychological, and spiritual and this as fundamentally true as the communal nature of human life.

## 2.3 The Person as Psychological Functioning

**All persons have a subjective dimension**. "Relating to the thinking subject, proceeding from or taking place within the individual consciousness or perception." [11]. All the information from the senses is subjective—it happens to the person, the subject. The information from the major senses is in part a result of not only a sensory function but also a cognitive function because it is given meaning as it is sensed. An indistinct speech utterance may take several moments before it is sorted out into words that the listener hears. The remainder of the senses such as interior sensations from the gut, joints, skin, and so on are also supplying information which is given meaning if it reaches consciousness. Further, the meaning applied to one group of sensations influences the meaning assigned to other sensory responses. It appears to be possible to retrieve the original unmediated sensory information under certain circumstances. The assignment of meaning is coherent with general attitudes and understandings of the person's world and these are sometimes referred to as ideologies or general attitudes toward the world, or general understandings so

that information received is seen as a this or a that and confirms the persons previous beliefs. Mostly these subjective dispositions toward the world are uniform in the person, however, a person may have more than one general attitude that shows itself in different circumstances. These attitudes are learned and may be present from early childhood.

**Persons generally have more than one self**. A self is an enduring set of cohesive personality and behavioral characteristics (including, sometimes differences in appearance, stance, gait, and speech) that exist over time and that may be public, private, or even secret. Selves arise as a result of occasional differences or even conflict between the manner of life someone must live in a family, group or community and that person's individual inborn nature and behaviors. There are usually only a few such selves each emerging in situations similar to those that originally evoked them, usually in childhood. This implies, correctly, we believe, that whatever other selves a person has, if any, all persons have an authentic self—an inborn and lifetime enduring constellation of personality and physical characteristics—whether it ever reveals itself fully or not. No one would confuse different selves with being a different person; executive control remains with the dominant self. (This distinguishes the phenomenon of different selves from the pathologic entity multiple personality disorder.) Despite the occurrence of different selves there is good evidence that personality is enduring over a lifetime.

**Emotion is a fundamental aspect of mental activity**. Just as there is a flow of thought where ideas seem to be central, there is a stream of thought where emotion and mood is the content. The list of human emotions is well over a hundred in number. Emotion may be experienced as transitory where one brief experience of emotion may follow another as the emotional reactions to thoughts and experiences. One emotion may last for hours. For example, if someone steps on your foot you might have a flash of anger which in its onset occurred too rapidly for you to identify a thought which preceded it or of which it is a component. The anger is the primary result of the emotive response to being stepped on; no thought beyond that is a necessary response. After being stepped on the anger may lasts all day long and you are still talking about the incident hours later. Then we think that the original flash of anger, a response to being stepped on, has been co-opted by another, more lasting idea, the idea that you are (say) commonly abused by other people. As noted above, emotion can take over the stream of thought, and you might be thinking about abuses and the things that have happened that reinforce that idea for hours to come.

Finally, an emotion such as anger may become the dominant mood. Then we might not say that the person is angry but that the person is an angry person. The dominant mood could as well be joy, despair, sadness, or love. In sick persons' emotiveness is blunted, just as cognition is impaired and executive control diminished. While there is experimental evidence of the impairments of cognition and executive control, the evidence for the impact of sickness on emotiveness is anecdotal. Patients report, for example, that although they know they should feel love for a family member visiting and they say the words, they do not feel the emotion.

**All persons may experience fear**, an emotion as universal in animals as is desire. Generally fear is described as an aversive emotional response to a specific stimulus—persons know what, in the situation, they are afraid of. Sometimes the fear is momentary, perhaps in response to an impending needle-stick. Fear may, however, become a pervasive emotion that invades everything; the fear of the hospital, for example. Sometimes fears seem to be less specific such as about dying, unfamiliar situations, loss of control, or dependency. When that is the case it is often possible to track down what the patient is afraid of about hospitals or surgery; loss of control or dependency. If the exact details of the fear can be elicited it can often be laid to rest.

The most effective antidote to fear is information; however, in order to be useful, the information should be focused around the particular concerns of the patient, at a level the patient can understand. Too much information, or undesired information, can lead to more fear. Information is transmitted in the context of a therapeutic relationship and for the information to be accepted and to do its job the relationship must be trusting. Trust is not blind trust. Herein lies the importance of truthfulness and honesty.

People in strange and threatening settings such as, for some, hospitals or other medical situations, can be expected to be frightened. Sometimes people have fears that seem understandable, but on further questioning the fear is not what it first appeared to be. The fear of death is very common, but often—perhaps most often—the real fears are not death but the fear of separation from others or from the group, or fear about the dying process.

**All persons may experience anxiety**, which like fear, is a normal response to certain kinds of threatening situations. Anxiety is, however, more complex than fear. It is important to distinguish the kind of anxiety that can occur in anybody as distinct from the psychological anxiety disorders such as generalized anxiety disorder, posttraumatic stress disorder, panic disorder, and social anxiety disorder. Whereas, fear has an identifiable object, anxiety is vaguer and it is less easy to identify what is at the root of the anxiety. When anxiety is present it is experienced as variable feelings of dread, tenseness or jumpiness, restlessness and irritability. There may be an anticipation of bad things or general apprehension. Restlessness, trouble concentrating, anticipating the worst, and waiting for the ax to drop are characteristic, as are nightmares and bad dreams. The anxious person's world threatens but what is actually the source of the threat is not obvious. Physical manifestations are almost universal and can be quite extreme; heart palpitations, shortness of breath, and chest pains which may seem like a heart attack. Fatigue, nausea, stomach aches, headaches, diarrhea, or other physical symptoms may make the anxious person sure he or she is physically ill. Physiological manifestations are common such as elevated blood pressure, increased heart rate, sweating, pallor, and dilated pupils. However, anxiety can make itself known by mild feelings of unease, irritability, and apprehension without obvious physical symptoms or go all the way to a full blown panic attack where the person is sure that death is imminent.

The source of the conflict that is always present in anxiety may be simple or more complex. For example, a person may seem to be very anxious in response to the threat of death, but it is really not death itself, but conflict about it that is evocative. A very sick person has come to terms with his impending death, but his wife is extremely upset at the idea of his death and he feels that his acceptance of death is a betrayal of his intense love and loyalty. He is afraid of what will happen to his wife when he dies, but he is tired of fighting an illness when the inevitability of death seems to offer surcease. As a consequence of this conflict of which he is unaware he becomes anxious and his anxiety is wrongly interpreted by observers as evidence of his fear of death. There was a period where great credence was given to something called "death anxiety" which was believed to be nearly universal. More careful recent research has failed to support the concept and its universality [7, 8].

Anxiety is sometimes aroused in situations where different selves in the same person come into conflict. An older woman found herself anxious in situations where she kept asking herself, "which me am I supposed to be, the compliant, hard working, but resentful me, or the hardworking but interested and creative me?" Without being aware of such a conflict, anxiety is evoked which resolves when the conflict is made clear. Anxiety is extremely common, especially in the medical setting. There are effective anti-anxiety drugs, but they do not expose, clarify, or generate understanding of the conflict that always exists. It may not require sophisticated psychotherapy to uncover and resolve the conflict. That is preferable to medication and but anything that works is better than allowing someone to endure chronic anxiety in serious illness, for example, wanting to live but not wanting to suffer, wanting to be cared for but feeling guilty about it; the anxious person is often of two minds, ambivalent and conflicted, and these feelings are commonly sources of anxiety. There may be partial awareness of these feelings of conflict, or even perhaps clarity about them, but the tension that creates the anxiety is not being able to have both desired outcomes even when they are known.

**In all persons emotive thought also operates** on content from perception and memory producing specific instantaneous evaluations which are felt as emotions. Emotions are feelings, affections such as, pleasure, love, amusement, amazement, anger, sadness, dejection, or joy. Pain is spoken of as an emotion by some, but it regularly evokes emotion. Much less is known about emotion and emotiveness than about ideas and reasoning because from antiquity emotions were thought to contaminate thinking and interfere with reasoning. Sometimes, even in contemporary writing about cognition, emotions are dismissed as lesser than or contaminations of thought. They are not; they are a central and essential element of the mental life. The emotions that sick patients have about their sickness are as much a part of the sickness as are the symptoms.

**Persons are thinking all the time**. They are mostly constantly aware of thought while awake, but mental quietude can be trained The mind is always occupied by and aware of a stream of thought—of cognitive activity usually in the form of language—that varies from moment to moment as focus, interests, occupations, and preoccupations shift. Content of the stream of thought also arises from memory as the information from the world evokes ideas and associations that have been stored

in both distant and recent memory. The stream of thought is personal and it provides for further thought. That thought influences the focus of the subsequent mental activity which may change what is of interest and further change the direction of thought, and so on. The train of thought is also a commentary on the person's activities so that it may offer a meaning to explain something that happens, such as some difficulty lifting a weight. The focus of thought can become captured by one subject—for example, a fear or love so that all these aspects of thought are in the service of what can become monomania. This can happen when sickness occupies the person. Then all the facts generated by the various modalities of thought are interpreted in the light of the sickness—e.g., shortness of breath previously interpreted a result of steep stairs now becomes evidence for heart failure. Thought is also occurring below awareness as problems, including technical, mathematical, or others are solved and come to awareness in various forms. The nature of this kind of thought including how, when, and why it takes place is a matter of present speculation and investigations.

**All persons understand their world, it is generally believed, by two kinds of thought; reasoning and emotiveness**. Reasoning is based on what are believed to be facts and is able to follow ideas to their ends, take them apart, combine them to form new ideas, and generally go beyond the information given. Reason is a method of thinking which can be used to understand and follow any set of ideas whatever their subject. If the ideas are faulty—internally incoherent, or such as cannot be logically connected with other ideas, then the reasoning will be faulty, but its subject will not have been irrational. The mind also employs intuition to know things from objects or events apparently without the intermediary of reasoning. Conventional ideas about intelligence are now being challenged. The combination of new technologies in neuroscience and increased attention by psychologists to the operations of thought are leading to a reappraisal of older concepts about thinking. Ideas are probably generally in the form of words, but artistic, sculptural, or musical ideas (which may be called motifs) are in the form of the art in which they occur—sketches or musical notes, for example.

**Persons are adaptive**. Starting in very young childhood, the necessity is that persons must conform to a greater or lesser degree to the demands of their physical, emotional, and social circumstances and to the significant persons who are part of their context. Different selves are a manifestation of that adaptability. Children must accommodate to or attune themselves to the family of their birth (or developing years) even if they are, by nature different. The original inborn self, which may not fit in the family, then fades into the background and may not show up except in congenial environments. Persons are more or less aware, involved in, and largely influenced by the surrounding environment physically as well as cognitively, socially, and morally. An example of this last is that where all around the person others are talking from a specific frame of reference—for example, the oncology care environment where patient survival and response to chemotherapy is the dominant frame of reference—that is the set that will also frame the person's response to the actions and words of others as well as his or her own. Persons in such a context may experience themselves in such terms even though doing so may

be against their interests as they know them They will often be unaware of the presence and impact of the frame of reference.

**Events in childhood back to infancy may form the basis for adult behaviors**. These events, even though they have this impact, may not come to awareness. Events in this sense are not restricted to brute facts but are also the person's emotional response to recall of early relationship with parents, siblings, caretakers or others. These memories may not be actively repressed. Even actively repressed early memories or their emotional content—memories that are not in and cannot be brought to consciousness—may have an impact on behaviors, including speech and bodily responses to stimuli (including sexual stimuli) which seem to come out of the blue or seem completely unexplainable. (This is what is usually meant by reference to the unconscious or "the Freudian Unconscious.") All of this may be particularly important in illness in which things happen which are in themselves reminiscent of childhood. When that happens, the door may be opened for the effect of childhood events and their emotional content, remembered (dissociated, incomprehensible and therefore shoved aside before even being remembered), or repressed (remembered but hidden from consciousness), to have an impact on the course of the illness.

**All persons have the ability to evaluate themselves**. As persons judge others they also judge themselves and their behaviors. This is an aspect of the fact, described above that everything from how and what they do to how brave or cowardly they have been is both shown outwardly and known inwardly. Persons are not always aware of what feelings or behaviors they have displayed to others. They may also evaluate themselves in a manner that does not reflect how they are actually seen by others.

**All persons have a past, a present and a future**. The neurobiology of memory is complex—more than one kind of memory and more than one perspective on past events. Further it depends to a great extent on some phenomenological features of time experience which transcend biological explanations, such as autobiographical memory; the phenomenon of "frozen" time in schizophrenia [10], etc. The past is often in terms of the things that matter personally. Persons are capable of great detail if prompted or otherwise helped to remember. As they go further into the past, unsupported memory becomes less reliable—particularly for unpleasant or unhappy events or circumstances Traumatic events in the past may stand out in memory or may be selectively forgotten. The experiences gathered during living one's life are a part of today as well as yesterday. Events of the present can be checked against the past, and events of the past contribute to the meanings assigned to present happenings. Memory can be evoked by sensory experience.

Life experiences—previous illness, experiences with doctors, hospitals, medications, deformities and disabilities, pleasures and successes, or miseries and failures—form the background for illness. The personal meaning of the disease and its treatment arise from the past as well as the present. The future is always uncertain; it cannot be otherwise. People tend to have enduring ideas about what the future will bring and how they will make it happen. Everybody indulges in hoping—formed by both desire and expectation—and their hopes are part of their ideas of the

future. Hope is of concern in medicine where the dangers of hopelessness and of losing hope are emphasized.

**People generally consider themselves unitary beings**. Despite this belief, below the surface of consciousness there are other entities that in certain circumstances (for example, in hypnotic states) can openly voice opinions that are not necessarily the same as those expressed in ordinary everyday consciousness. This has been known for at least 150 years, demonstrated in the famous French neurology clinics of Jean Martin Charcot and Pierre Janet. These other, inner, voices are not ruled by dailiness. On the other hand, as experienced using hypnosis, or even by persons as inner "voices" they are usually shy and hesitant. They are easily dismissed and they are overridden by doubt and/or anxiety. More than one inner voice, however, is not uncommon. These voices rarely speak in full sentences or paragraphs, instead they are cryptic. (EJC Personal experience.) This inner world and the inner voices come to consciousness and are not what is usually meant by reference to the unconscious, or the Freudian unconscious (see below).

**All persons have an inner negative voice**. It is the voice of caution, of damping down expectations, suggesting that given the positive or negative possibilities, the negative will win out: so the inner voice suggests being prepared. It seems to serve the purpose of keeping the person from taking chances. The inner negative voice is not the same as optimistic versus pessimistic personality profiles. The problem for the person is that the negative voice points out evidence in support of its position. These "voices", selves, inner expressions are directly experienced by everyday persons and not as pathological events. Their presence has been encountered regularly by one of the authors (EJC) using hypnosis for more than 35 years in working with persons with life threatening illness. This experience is thus far unpublished.

**All persons have a secret life**. Sometimes it takes the form of fantasies and dreams of glory, and sometimes it has a real existence known to only a few. Within that secret life are fears and desires, love affairs of the past and present, hopes or fantasies, and ways of solving the problems of everyday life known to only the person. Disease may not only destroy the public person but the secret person as well. A secret beloved friend may be lost to a sick person because he or she has no legitimate place by the sickbed. When that happens, the sick person may have lost that part of life that made tolerable an otherwise embittered existence. The loss may be of only the dream—the wish or fantasy (however improbable) that one day might have come true. Such loss can be a source of great distress and intensely private pain.

**All persons can dissociate themselves** partly or completely from events, experiences, memories, or bodily sensations. Dissociation is defense psychological mechanism described by Freud (*abwehrmechanismen*), which is different from simply not remembering or forgetting, where a memory can be jogged back into existence by a clue or someone actively helping. Dissociation is an active process that selectively bans the dissociated material from consciousness or conscious recall. The memory of traumatic events may be hidden by dissociation, as may dreams, unpleasant conversations, or things people have been told that they did not

want to know. Clinicians learn this when they tell a patient bad news and shortly the person behaves as if, or even says that they have never been told. People are also able to dissociate themselves from the experience of physical pain as though they cannot feel the sensation. One self may dissociate itself from other selves as though they or their behaviors did not exist.

## 2.4 Persons and Their Relationships with Others

**All persons require recognition of their existence from others**. Imagine a person in an environment in which he or she is absolutely and completely unnoticed. No one turns around or turns aside, no one looks up, no one speaks, all acted as if the person is nonexistent. Rage and impotent despair would soon well up. Imagine such person on a gurney in an emergency ward, in the hallway outside an operating room, in a hospital bed. Then when things were done to the person's body even if unexplained, uncomfortable, or painful the person might be grateful for the attention. With these painful scenes in mind you will understand the almost animal gratitude such persons will have for personal voices, little pleasantries, answered questions from even total strangers.

Relationships may be very difficult to understand. Nowhere is that mystery more important than in clinical medicine, where relationships abound, waiting to provide information and aids or barriers to the attentive clinician. How odd is this? A person can go to see a physician who is a stranger and within minutes the physician has a finger in the patient's rectum. And the person (now a patient) says "thank you." What made that otherwise inexplicable event possible? The name, the doctor–patient relationship, labels but does not explain it. What happened was guided by a complex set of rules and entitlements that applied to both patient and physician. We might guess that the doctor learned those rules and entitlements (not called such) during the long years of training. The physician's behavior is expected to be as described. Why did the patient bend over to expose the reluctant anus to the finger's penetration, something almost universally abhorrent? Perhaps the patient contains the same rules and entitlements (or their mirror image). This suggests that role behavior (for they were playing the parts required by their respective roles) resides in both of them. In fact, each of us has a library of roles that we follow throughout the living of daily life and which are quite detailed. They make daily life possible. But they also imply that even when we are complete strangers our behaviors are not strange. The degree to which our daily behaviors are rule guided is startling since we generally believe our behaviors are spontaneous and responsive to our chosen purposes.

**All persons have a capacity to love** to a greater or lesser extent. All seem to be captivated by the idea of love. Except for the most unfortunate, love—flowing in both directions—is a fact of infancy and young childhood. From that young experience we get the basic characteristic of the feeling of love; a merging of two people. Under even the best of circumstances the merging of loving persons (or at least the feeling of merging) is of relatively short duration but their belief in their

love may be enduring. The feeling of merging, attachment, or connection can occur in the absence of recognition of the feeling of love and it is usually pleasant, but sometimes threatening as it may be accompanied by frightening awareness of vulnerability.

**All persons have a capacity for trust**. "Trust is confidence or reliance on some quality or attribute of a person or thing, or the truth of a statement" [11]. Trust in their care or the caregivers is necessary for sick persons because they live in a world of unknowns and uncertainty. The enhancement of trust is a necessary activity of clinicians. Some persons are unable to trust and their world is necessarily experienced as dangerous.

**All persons have a variable capacity to merge with others**. The *capacity* to merge with others seems to be accompanied by a *desire* to merge that is greater in some people than others, occasionally being extreme. When people are sick, especially very sick, their ability to connect to others—particularly caregivers—is greater than at other times. This may be the source of the sometimes very strong attachment of the very sick to their clinicians. This is a situation when the fact and the manner of the attachment of sick persons to their caregivers are reminiscent of the attachment of these persons to their mothers in infancy. Psychoanalysts generally believe that these attachments by the sick are similar to the phenomenon of transference in general where the patients react to the psychiatrists as they reacted to their mother or father. Not surprisingly, persons who care for the sick also seem to have more than the usual ability to form connections. In general the loving attachment seems to be a conduit to the feelings, thoughts, and even the body of the merged persons. Little is known of this because it is so difficult to study and because it shares in the disbelief in the everyday world of such things.

There is little doubt, judging from ordinary experience, that some degree of knowing what others are thinking is a commonplace. It is possible to feel the feelings of another person and that capacity is not uncommon among experienced clinicians, especially psychiatrists and psychotherapists.

**All persons have sexual feelings and desires** to one degree or another. In the past, physicians in general were often not good at taking a sexual history from patients because of embarrassment. With the emergence of the HIV/AIDS epidemic a sexual history became important and clinicians learned that it was not difficult once the questions were learned. Very sick patients usually lose sexual desire and do not have sexual thoughts until they start to recover. On the other hand, patients who are chronically ill, even if dying, may experience sexual thoughts and sexual desire. For that reason, questions about sexuality should be part of taking a history, even in a dying patient. Sexuality is not simply about physical desire and orgasm even in healthy persons; intimacy is an integral part of the human experience and may be vitally important to a patient even in the absence of normal erectile or vaginal function. Clinicians show their recognition of these and other intimate problems by asking simple and unembarrassed questions.

**All Persons want to be accepted, admired, and valued by others** (and themselves) and they want to be like those that they admire.

## 2.5 The Person and Its Context

**All persons behave in a manner that is responsive to context**. Whatever the behavior and whatever the context the self experienced now, that was experienced a few minutes and more time ago, that might emerge in different circumstances and that might be expected (without awareness of the expectation) to be experienced as time unrolls is what the person calls me. The person will not be aware, usually, that he or she is behaving like a different self than (say) in the doctor's office just minutes before. This me has a frame of mind and a bodily state of feelings, both of which the person is more or less aware, and is involved in some purposeful activity with some subsidiary goal in mind. Dailiness, the occurrences and settings of everyday life, is the overriding context in which life is lived and is a major source of the behavioral rules by which people are guided. Further, especially in psychiatry, it is of utmost importance to acknowledge the contextual factors, which impact both person's narrative behavior and professional judgment. This is probably the one essentially context-dependent area of medical expertise. Imagine for instance a person who is walking through the lobby of a luxurious hotel in a bath towel. This outfit can well be understood as normal in the context of a SPA hotel in some health resort and judged as abnormal (psychopathological) if it takes place in a business hotel downtown in New York. Overall the process of inference is governed by the so called logics of practice [12].

## 2.6 Persons Live Continuously in a Context of Relationships with Other Persons

Some relationships are close while others are formal. Close or formal persons are all separate beings. A variable degree of trust in both the self and others is necessary for the initiation and maintenance of relationships. In every thought, feeling, and action and in virtually every idea about oneself and in every dream, fantasy, and fear the presence of others is reflected. In everyday life, physical appearance, dress, walking and other bodily movements and actions, language, speech, and gesture, everything is tuned to others (even facial expression is a social construction). The same is true of ideas and beliefs—even ideas about how the world works. Humanity is divided into cultures, subcultures, and ever smaller groups—but always groups. The same is true about language groups consisting of shared language and meanings from large ones like national groups to small individual groups such as airline pilots, golfers, or doctors. Where there is common language there are common beliefs and prevalent sentiments. Part of the molding of individuals to each other must necessarily be physiological although the extent of such conforming is unknown.

**Persons live in a figurative public space**. The idea of human relationships is not exhausted by speaking of direct relationships of persons to each other or with groups. Persons also live in something that has been called a figurative public

space, not an actual physical public space. An example might be or sitting side by side on a bus and one says to the stranger along side, "really crowded, isn't it." Here the person acknowledges he or she and the respondent (and perhaps others) are in the relationship of *immediate understanding* without further explanation. Similarly a patient might say, "I'm really sick," and we would understand not what sickness the person has or even that he or she is sick in the doctor's sense of the word but in the public social sense.

**All persons have a family**. The intensity of family ties cannot be overemphasized; people frequently behave as though they were physical extensions of their parents. Things that might cause suffering in others may be borne without complaint by someone who believes that the disease is part of the family identity and thus inevitable. Many diseases where no heritable basis is known may be acceptable to an individual because others in the family have been similarly afflicted.

**All persons have a cultural background**. It is well known that socially determined factors, such as diet, environment, and social behaviors, contribute to disease patterns. Because culture also contributes to beliefs and values, cultural factors play a part in the effects of disease on a person. Culture defines what is meant by masculine or feminine, what clothes are worn, attitudes toward the dying and the sick, mating behavior, the height of chairs and steps, attitudes toward odors and excreta, where computers sit and who uses them, bus stops and bedclothes, how the aged and the disabled are treated. These things, mostly invisible to the well, have an impact on the sick and can be a source of untold suffering. They influence the behavior of others toward the sick person and that of the sick toward themselves. Cultural norms and social rules regulate whether someone can be among others or will be isolated, whether the sick will be considered foul or acceptable, and whether they are to be pitied or censured.

**All persons have a spiritual dimension**. Spiritual and spirituality are words most often applied in a religious context. The meaning that has been assigned to spirituality is primarily a result of the history of the idea. Spirit and spirituality refer to matters which transcend the individual. Patriotism and team spirit are topics in the spiritual realm since the feelings transcend the boundaries of individuals.

## 2.7 Persons and Their Social Responsibility

**All persons have a sense of responsibility to and for self and to and for certain others**. Persons seem to accept that they a have responsibility to be who and what they are. Who they are in the sense of their presentation to the world and to some degree for their spoken words, their actions, and their appearance. Most people acknowledge their responsibility for their behaviors, actions, and responses to events, circumstances, and other persons. This fact of responsibilities accepted arise from the same roots as the aspects of persons that make them always in relationship to others. They usually hold themselves responsible also for their expressions of emotion even though they may not know why they responded in a particular way [14].

**All persons have some choice in the kind of person they want to be**. Persons have with limits an ability to choose how others see and behave toward them. Persons can also choose their goals and purposes. They can choose and work to accomplish being other than they are now. Within limits that vary from population to population, and may be at least partially determined by socioeconomic status, education, and other social and personality characteristics, they can choose what future they want to inhabit. The freedom to make such choice is characteristic of the egalitarian societies of Western democracies. To make a choice implies the responsibility to stand and accept the consequences of your actions and not to attribute them to external factors and circumstances. Persons do not always assume or act on the consequences of their choices.

## 2.8 Person and Body

**All persons have a body**. This person's body is different than any other person's body because it is this person's body. The body is an aspect of person. Person and body are integrated and in constant interplay. They can never be separated except in death. The body can do some things and not others. People become habituated to their body's enormous range of abilities and incapacities. They generally know exactly what every part can do (of which they are or can be conscious). These capacities become accepted as a part of their person ("me"). This physical view of persons has been partly hidden by the cultural importance of and attention to individuality developed over the past number of centuries in Western European and American societies. Individuals sometimes presented themselves as though they were not also bodies. It sometimes seems as though the body has its own intentions that are not the known intentions of the person. People also generally know when parts are not working properly and these impairments of function—if they come on quickly enough to be noticed and are lasting and important enough—become symptoms as they are joined to other incapacities. On the other hand, if impairments of function emerge only slowly, are easily accommodated, or are deemed unimportant, even quite impressive impairments will soon be adapted to or dismissed. This is particularly so because of the importance of impairments of social, psychological and spiritual function that is part of the understanding of sickness where the person is the object of concern, not merely the body.

The truth about bodies is that things happen to them—they can be injured or get sick. Bodies sometimes bleed, smell bad, make embarrassing sounds, have embarrassing functions, make inopportune demands, create strong desires, sometimes look bad, and become old and slow, and sometimes ugly. (These facts are frequently denied or hidden in everyday life.) Persons grow up with profound ignorance about how the body works even though most people learn about it in school. Unfortunately, clinicians can have considerable knowledge about diverse diseases but be quite ignorant about the body's everyday functions. This limits their ability to ask questions in the hunt for impairments of patients' functions. It also reduces their ability to make things function better.

**All persons who are experiencing themselves** include an awareness of the body and many of its functions. The function of the special senses and the somatic senses are generally within the awareness of the individual so that if they develop abnormalities, the functional loss reaches awareness. Muscle strength, walking speed, pulmonary capacity, bowel and bladder function, and others are part of what persons know of themselves. This is true of healthy as well as sick persons although persons will adapt to slowly losing function and sometimes be unaware of significant impairment until it is pointed out to them. This same adaptiveness allows persons to change the way they carry out tasks or the manner in which certain actions are performed so that they can do things despite major losses in function in virtually every system from the cognitive to the hand and other extremities. On the other hand, as impairments in function develop, particularly in systems such as bowel and bladder that impact on social function persons may change their habitual behavior to avoid embarrassment.

Psychological conflicts might also be converted into physical symptoms.

**All persons die**. The inevitability of death, mourning, and grief entailed present one significant issue to manage in health care delivery both from ethical and psychological perspectives.

**In Summary** a person is an embodied being, purposeful, thinking, feeling, emotional, capable of choosing, reflective, relational, responsible, very complex human individual of a certain personality and temperament, existing through time in a narrative sense, whose life in all spheres points both outward and inward and who does things. Each of these terms is a dynamic function, constantly changing, and requiring action on the part of the person to be maintained—although generally the maintenance is habitual and unmediated by thought.

## 2.9 Conclusions

This chapter presented a multidimensional perspective on what a person is and how it should be understood in the many different facets of its existence. Virtually nothing about persons that we have discussed in this chapter is unaffected by sickness. What sickness does is impair function but the functions that it limits may be found in every sphere of a person's life as it is lived. The knowledge of this provides an opportunity to understand sickness, but it also creates therapeutic opportunities that are far greater than are usually considered. The fundamental understanding that must not be forgotten diagnostically or therapeutically is that whatever happens to one part of a person happens to the entire person. Also, however, whatever is done for one aspect of a person has an impact on the whole person.

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