Principles of Psychosomatic Assessment

Giovanni A. Fava\textsuperscript{a,c} · Nicoletta Sonino\textsuperscript{b,c} · Thomas N. Wise\textsuperscript{d,e}

\textsuperscript{a}Laboratory of Psychosomatics and Clinimetrics, Department of Psychology, University of Bologna, Bologna, and \textsuperscript{b}Department of Statistical Sciences, University of Padova, and Department of Mental Health, Padova, Italy; \textsuperscript{c}Department of Psychiatry, State University of New York at Buffalo, Buffalo, N.Y., \textsuperscript{d}Department of Psychiatry, Inova Health Systems, Falls Church, Va., and \textsuperscript{e}Department of Psychiatry, Johns Hopkins University School of Medicine, Baltimore, Md., USA

Abstract

There is increasing awareness of the limitations of disease as the primary focus of medical care. It is not that certain disorders lack an organic explanation, but that our assessment is inadequate in most clinical encounters. The primary goal of psychosomatic medicine is to correct this inadequacy by incorporation of its operational strategies into clinical practice. At present, the research evidence which has accumulated in psychosomatic medicine offers unprecedented opportunities for the identification and treatment of medical problems. Taking full advantage of clinimetric methods (such as with the use of Emmelkamp’s two levels of functional analysis and the Diagnostic Criteria for Psychosomatic Research) may greatly improve the clinical process, including shared-decision making and self-management. Endorsement of the psychosomatic perspective may better clarify the pathophysiological links and mechanisms underlying symptom presentation. Pointing to individually targeted methods may improve final outcomes and quality of life.

The concept of ‘psychosomatic disorder’ was strongly criticized by several psychosomatic researchers, notably Engel and Lipowski. Engel wrote that the term ‘psychosomatic disorder’ was misleading, since it implied a special class of disorders of psychogenic etiology and, by inference, the absence of a psychosomatic interface in other diseases [1]. On the other hand, he viewed reductionism, which neglected the impact of nonbiological circumstances upon biological processes, as a major cause of mistreatment [2]. Lipowski [3] criticized the concept of psychosomatic disorder since it tended to perpetuate the obsolete notion of psychogenesis, which is incompatible with multicausality, a core postulate of current psychosomatic medicine. Kissen [4] clarified that the relative weight of psychosocial factors may vary from one individual to another within the same illness and underscored the basic conceptual flaw of considering diseases as homogeneous entities.
Stemming from Lipowski’s original definition [3] and subsequent developments [5–7], psychosomatic medicine may be defined as a comprehensive, interdisciplinary framework for: (a) assessment of psychosocial factors affecting individual vulnerability, course and outcome of any type of disease; (b) holistic consideration of patient care in clinical practice; (c) integration of psychological therapies in the prevention, treatment and rehabilitation of medical disease (psychological medicine).

Psychosomatic medicine has become in the US a subspecialty recognized by the American Board of Medical Specialties [8]. This has led to identifying psychosomatic medicine with consultation-liaison psychiatry [8], a subspecialty of psychiatry concerned with diagnosis, treatment, and prevention of psychiatric morbidity in the medical patient in the form of psychiatric consultations, liaison and teaching for non-psychiatric health workers, especially in the general hospital [9]. Consultation liaison psychiatry is clearly within the field of psychiatry; its setting is the medical or surgical clinic or ward, and its focus is the comorbid state of patients with medical disorders [10]. Psychosomatic medicine is, by definition [1, 5–7], multidisciplinary. It is not confined to psychiatry, but may concern any other field of medicine. Not surprisingly, in countries such as Germany and Japan, psychosomatic activities have achieved an independent status and are often closely related to internal medicine [11]. In the US, family medicine endorses a comprehensive psychosocial approach as integral to their training and practice [12].

Interestingly, the general psychosomatic approach has resulted in a number of sub-disciplines within their own areas of application: psychooncology, psychonephrology, psychoneuroendocrinology, psychoneuroimmunology, psychodermatology and others. Such sub-disciplines have developed clinical services, scientific societies and medical journals [5–7]. The psychosomatic approach has resulted in important developments also in the psychiatric field, subsumed under the rubric of psychological medicine [13, 14].

Assessment of Psychosocial Factors Affecting Individual Vulnerability

It is becoming increasingly clear that we can improve medical care by paying more attention to psychological aspects of medical assessment [13], with particular reference to the role of stress [5–7, 15–17]. A number of factors have been implicated to modulate individual vulnerability to disease, e.g. healthy habits and psychological well-being positively promote health rather than merely reduce disease.

Early Life Events

The role of early developmental factors in susceptibility to disease has been a frequent object of psychosomatic investigation [15–17]. Using animal models, events such as premature separation from the mother have consistently induced pathophysiological
modifications, such as increased hypothalamic-pituitary-adrenal axis activation. They may render the human individual more vulnerable to the effects of stress later in life. There has been also considerable interest in the association of childhood physical and sexual abuse with medical disorders, such as chronic pain and irritable bowel syndrome [18]. A history of childhood maltreatment was significantly associated with several adverse health outcomes, e.g. functional disability and greater number of health risk behaviors, yet the evidence currently available does not allow any firm conclusions [19].

Recent Life Events

The notion that events and situations in a person's life which are meaningful to him/her may be followed by ill health has been a common clinical observation. The introduction of structured methods of data collection and control groups has allowed to substantiate the link between life events and a number of medical disorders, encompassing endocrine, cardiovascular, respiratory, gastrointestinal, autoimmune, skin and neoplastic disease [16, 20–24].

Chronic Stress and Allostatic Load

The role of life change and stress has evolved from a simplistic linear model to a more complex multivariant conception embodied in the 'allostatic' construct. McEwen and Stellar [20] proposed a formulation of the relationship between stress and the processes leading to disease based on the concept of allostasis, the ability of the organism to achieve stability through change. The concept of allostatic load refers to the wear and tear that results from either too much stress or from insufficient coping, such as not turning off the stress response when it is no longer needed. Biological parameters of allostatic load, such as glycosylated proteins, coagulation/fibrinolysis and hormonal markers, have been linked to cognitive and physical functioning and mortality [16]. Recently, clinical criteria for determining the presence of allostatic load have been determined [17]. Thus, life changes are not the only source of psychological stress and subtle and long-standing life situations should not too readily be dismissed as minor and negligible, since chronic, daily life stresses may be experienced by the individual as taxing or exceeding his/her coping skills.

Health Attitudes and Behavior

Unhealthy lifestyle is a major risk factor for many of the most prevalent diseases, such as diabetes, obesity and cardiovascular illness [25]. In 1985, Geoffrey Rose [26]
showed that the risk factors for health are almost always normally distributed and supported a general population approach to prevention, instead of targeting those at the highest risk. Switching the general population to healthy lifestyles would be a major source of prevention. The need to redesign primary care practice to incorporate health behavior changes has been recently underscored [6], e.g. the American Academy of Pediatrics in 2008 emphasized the need to address the current epidemic of childhood obesity through enhanced adherence to dietary guidelines and physical activity [27].

**Social Support**

Prospective population studies have found associations between measures of social support and mortality, psychiatric and physical morbidity, and adjustment to and recovery from chronic disease [5]. An area that is now called ‘social neuroscience’ is beginning to address the effects of the social environment on the brain and the physiology it regulates [16].

**Psychological Well-Being**

Positive health is often regarded as the absence of illness, despite the fact that, half a century ago, the World Health Organization defined health as a ‘state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ [28]. Research on psychological well-being has indicated that it derives from the interaction of several related dimensions [29, 30]. Several studies have suggested that psychological well-being plays a buffering role in coping with stress and has a favorable impact on disease course [31, 32]. Antonovsky’s sense of coherence (a resource that enables people to manage tension, to reflect about their external and internal resources, and to promote effective coping by finding solutions) has been found to be strongly related to perceived health, especially mental health, and to be an important contributor for health maintenance [33].

**Personality Factors**

The notion that personality variables can affect vulnerability to specific diseases was prevalent in the first phase of development of psychosomatic medicine (1930–1960), and was particularly influenced by psychoanalytic investigators, who believed that specific personality profiles underlay specific ‘psychosomatic diseases.’ This hypothesis was not supported by subsequent research [3, 5]. Two personality constructs that can potentially affect general vulnerability to disease, type A behavior and alexithymia
(the inability to express emotion), have attracted considerable attention, but their relationship with health is still controversial [34, 35]. The social-cognitive model of personality assumes that personality variables interact with social and environmental factors and result in differences in the features of the situations that individuals select [36]. In this sense, personality variables (e.g. obsessive-compulsive, paranoid, impulsive) may deeply affect how a patient views illness, what it means to him/her and his/her interactions with others, including medical staff [37].

**Psychiatric Disturbances**

Psychiatric illness, depression and anxiety in particular, is strongly associated with medical diseases. Mental disorders increase the risk for communicable and non-communicable diseases; at the same time, many health conditions increase the risk for mental disturbances, and comorbidity complicates recognition and treatment of medical disorders [38, 39]. The potential relationship between medical disorders and psychiatric symptoms ranges from a purely coincidental occurrence to a direct causal role of organic factors – either medical illness or drug treatment- in the development of psychiatric disturbance. The latter is often subsumed under the rubric of organic mental disorder whose key feature is the resolution of psychiatric disturbances upon specific treatment of the organic condition, such as depression in Cushing’s syndrome [40]. Not surprisingly, a correct diagnosis of depression in primary care is a difficult task. A recent meta-analysis [41, 42] indicated that there are more false positives than either missed or identified cases. Major depression has emerged as an extremely important source of comorbidity in medical disorders [43]. It was found to affect quality of life and social functioning and lead to increased health care utilization, to be associated with higher mortality (particularly in the elderly), to have an impact on compliance, and to increase susceptibility to medical illness [43–49]. The relationship between anxiety disorders and comorbid medical illness has also been found to entail important clinical implications [50–52].

**Psychological Symptoms**

Current emphasis in psychiatry is about assessment of symptoms resulting in syndromes identified by diagnostic criteria (DSM). However, emerging awareness that also psychological symptoms which do not reach the threshold of a psychiatric disorder may affect quality of life and entail pathophysiological and therapeutic implications led to the development of the Diagnostic Criteria for Psychosomatic Research [53] together with a specific interview to assess patients [54]. The DCPR were introduced in 1995 and tested in various clinical settings [53–56]. They also provide a
classification for illness behavior, as the ways in which individuals experience, perceive, evaluate and respond to their own health status. The DCPR allows a far more sophisticated qualitative assessment of patients than the one dimensional DSM checklist of psychological symptoms.

Fava and Wise [57] have suggested to modify the DSM-IV category concerned with Psychological Factors affecting Medical Conditions, that is a poorly defined diagnosis with virtually no impact on clinical practice. They suggested a new section which consists of the six most frequent DCPR syndromes [54]. The clinical specifiers (table 1) include the DSM diagnosis of hypochondriasis and its prevalent variant, disease phobia. Both the DSM somatization disorder and undifferentiated somatoform disorder are replaced by the DCPR persistent somatization, conceptualized as a clustering of functional symptoms involving different organ systems [58]. Conversion may be redefined according to Engel’s stringent criteria [59], involving features such as ambivalence, histrionic personality, and precipitation of symptoms by psychological stress of which the patients is unaware. DCPR illness denial, demoralization, and irritable mood offer further specifiers. Persistent denial of having a medical disorder and needing treatment (e.g. lack of compliance, delay in seeking of medical attention) frequently occurs in the medical setting [60]. Demoralization connotes the patient’s consciousness of having failed to meet his or her own expectations (or those of others) with feelings of helplessness, hopelessness, or giving up [61, 62]. It can be found in almost a third of medical patients and can be differentiated from depressive illness. Irritable mood, that may be experienced as brief episodes or be prolonged and generalized, has also been associated with the course of several medical disorders, carrying important clinical implications [63, 64].

The advantage of this classification is that it departs from the organic/functional dichotomy and from the misleading and dangerous assumption that if organic factors cannot be identified, there should be psychiatric reasons which may be able to fully explain the somatic symptomatology. The presence of a nonfunctional medical disorder does not exclude, but indeed increases the likelihood of psychological distress and abnormal illness behavior [65].
In 2004, Tinetti and Fried [66] suggested that time has come to abandon disease as the primary focus of medical care. When disease became the focus of medicine in the past two centuries, the average life expectation was 47 years and most clinical encounters were for acute illness. Today the life expectancy in Western countries is much higher and most of clinical activities are concentrated on chronic disease or non-disease specific complaints. “The changed spectrum of health conditions, the complex interplay of biological and nonbiological factors, the aging population, and the interindividual variability in health priorities render medical care that is centred primarily on the diagnosis and treatment of individual diseases at best out of date and at worst harmful. A primary focus on disease, given the changed health needs of patients, inadvertently leads to undertreatment, overtreatment, or mistreatment’ [66, p. 179]. Disease-specific guidelines provide very limited indicators for patients with multiple conditions [67]. Tinetti and Fried [66] suggest that the goal of treatment should be the attainment of individual goals, and the identification and treatment of all modifiable biological and non biological factors, according to Engel's biopsychosocial model [2].

But how should we assess these nonbiological variables? In clinical medicine there is the tendency to rely exclusively on ‘hard data', preferably expressed in the dimensional numbers of laboratory measurements, excluding 'soft information' such as impairments and well-being. This soft information can now, however, be reliably assessed by clinical rating scales and indexes which have been validated and used in psychosomatic research and practice [68]. It is not that certain disorders lack an explanation; it is our assessment that is inadequate in most of the clinical encounters, since it does not reflect a global psychosomatic approach [68, 69].

The Clinimetric Approach

In 1967, Alvan Feinstein [70] dedicated a monograph to an analysis of clinical reasoning that underlies medical evaluations, such as the appraisal of symptoms, signs and the timing of individual manifestations. In 1982, he introduced the term ‘clinimetrics’ [71] to indicate a domain concerned with the measurement of clinical issues that do not find room in customary clinical taxonomy. Such issues include type, severity and sequence of symptoms, rate of illness progression (staging), severity of comorbidity, problems of functional capacity, reasons for medical decisions (e.g. treatment choices), and many other aspects of daily life, such as well-being and distress [72]. Feinstein [72], in his book on clinimetrics, quotes Molière's bourgeois gentleman who was astonished to discover that he spoke in prose as an example of clinicians who may discover that they constantly communicate with clinimetric indices.

Feinstein, when he introduced the concept of comorbidity, referred to any ‘additional co-existing ailment’ separated from the primary disease, even in the case this secondary phenomenon does not qualify as a disease per se [73]. Indeed, in clinical
medicine, the many methods that are available for measuring comorbidity are not limited to disease entities [74]. In psychiatry, comorbidity is limited to psychiatric diagnoses. In this regard, the majority of patients with mood and anxiety disorders do not qualify for just one, but for several axis I and axis II disorders [75]. As Cloninger [76] remarks, mental disorders can be characterized as manifestations of complex adaptive systems that are multidimensional in their description, multifactorial in their origins, and involve non-linear interactions in their development. As a result, efforts to describe psychopathology in terms of discrete categorical diagnoses result in extensive comorbidity and do not lend themselves to adequate treatment strategies [76]. Very seldom, comorbid diagnoses undergo hierarchical organization (e.g., generalized anxiety disorder and major depression), or the longitudinal development of mental illnesses is taken into account. There is comorbidity which wanes upon successful treatment of one mental disease, e.g. recovery from panic disorder with agoraphobia may result in remission from cooccurring hypochondriasis, without any specific treatment for the latter [77]. Other times, treatment of a single disorder does not result in the disappearance of comorbidity. For instance, successful treatment of depression may not affect pre-existing anxiety disturbances [77].

A new method has been developed in psychiatry for organizing clinical data as variables in clinical reasoning. Emmelkamp et al. [78, 79] have introduced the concept of macroanalysis (a relationship between cooccurring syndromes and problems is established on the basis of where treatment should commence in the first place). Fava and Sonino [68] have applied macroanalysis to assessing the relationship between medical and psychological variables. Macroanalysis starts from the assumption that in most cases there are functional relationships with different more or less clearly defined problem areas [78] and that the targets of treatment may vary during the course of disturbances [68].

The hierarchical organization that is chosen may depend on a variety of contingent factors (urgency, availability of treatment tools, etc) that include also the patient's preferences and priorities. Indeed, macroanalysis is not only a tool for the therapist, but can also be used to inform the patient about the relationship between different problem areas and motivate the patient to change [78, 79]. The concept of shared decision is getting increasing attention in clinical medicine [80], but it is still seldom practiced in psychiatry [81]. Macroanalysis also requires reference to the staging method, whereby a disorder is characterized according to seriousness, extension and longitudinal development [82].

Macroanalysis should be supplemented by microanalysis, a detailed analysis of specific symptoms (onset and course of the complaints, circumstances that worsen symptoms and consequences) [78, 79]. For instance, when anxiety characterizes the clinical picture, it is necessary to know under which circumstances the anxiety becomes manifest, what the patient does when he/she becomes anxious, whether an avoidant behavior occurs and what the long-term consequences of the avoidance behavior are.
Feinstein [83] remarks that, when making a diagnosis, thoughtful clinicians seldom leap from a clinical manifestation to a diagnostic end point. The clinical reasoning goes through a series of ‘transfer stations’, where potential connections between presenting symptoms and pathophysiological process are drawn. These stations are a pause for verification, or change to another direction. In psychiatric assessment, however, disturbances are generally translated into diagnostic end points, where the clinical process stops. This does not necessarily explain the mechanisms by which the symptom is produced [83]. Not surprisingly, psychological factors are often advocated as an exclusion resource when symptoms cannot be explained by standard medical procedures, a diagnostic oversimplification which both Engel [1] and Lipowski [84] refused. Macroanalysis may allow to identify modifiable factors and their interactions. Two examples show how clinical assessment and management follow similar patterns in case the disorder is either functional or organic.

The case which is illustrated in box 1 and figure 1 exemplifies the use of macroanalysis in the setting of a functional bowel disorder. Recurrent headaches together with additional symptoms of autonomic arousal and exaggerated side effects from medical therapy, signs of low sensation threshold and high suggestibility, indicated a syndrome of persistent somatization [54]. This category identifies patients in whom psychophysiological symptoms tend to cluster [58], as is frequently the case in patients with irritable bowel syndrome [85]. The clinical psychologist approached the psychological problems according to a sequential approach [86], starting from lifestyle modification, proceeding to explanatory therapy [87] and then to exposure, cognitive restructuring and well-being therapy [88]. The treatment team was multidisciplinary and involved the collaboration of a primary care physician who referred the patient to a psychiatrist, a gastroenterologist, a clinical psychologist and a nutritionist.

The example depicted in box 2 and figure 2 is that of an apparently straightforward hypothyroidism on replacement therapy. The endocrinologists the patient had previously consulted only looked at her thyroid hormone levels; they did not understand what was wrong since thyroid function parameters were satisfactory. As the patient was pointing out, however, quality of life may be compromised even when the patient is apparently doing fine by a hormonal viewpoint. In clinical endocrinology, in fact, there is often the tendency to rely exclusively on ‘hard data’, preferably expressed in the dimensional numbers of laboratory measurements, excluding ‘soft information’, such as disability and well-being [68]. Soft information, however, can now be assessed.

The issue is to take full advantage of clinimetric tools within the clinical process. It is not that certain disorders lack an organic explanation; it is that our assessment is inadequate in most clinical encounters, and this particularly strikes when ‘hard data’ are missing. As Feinstein remarks, ‘even when the morphologic evidence shows the actual lesion that produces the symptoms of a functional disorder, a mere citation of the lesion does not explain the functional process by which the symptom is produced (...). Thus, the clinician may make an accurate diagnosis of gallstones, but if the
Box 1. A 24-year-old woman with irritable bowel syndrome.

Ms. X is a 24-year-old woman who was diagnosed with irritable bowel syndrome (abdominal pain, diarrhea) on the basis of her symptomatology, after extensive negative medical workup. She was in a situation of chronic stress and suffered from recurrent headache (muscle-tension type). Symptomatic medications that were prescribed yielded very limited relief. She was then referred for psychiatric consultation. Interviewing did not identify a specific psychiatric disorder, but disclosed the presence of a considerable allostatic load (she felt overwhelmed by her job demands as a journalist), a tendency to perfectionism, and also phobic avoidance (she thought that certain types of food could worsen her symptoms) and lack of assertiveness (both at work and within her family). No psychotropic drugs were prescribed. She was referred to a clinical psychologist who found persistent somatization and first introduced some lifestyle modifications as to her allostatic load. The psychologist then addressed abnormal illness behavior with explanatory therapy for correcting hypochondriacal fears and beliefs, phobic food avoidance with exposure and with the help of a nutritionist, perfectionism with cognitive restructuring, and lack of assertiveness with well-being therapy. After a few months, there was a remarkable general improvement, which was maintained at a 2-year follow-up. The various elements of macroanalysis are highlighted (underlined bold letters) and shown in figure 1.

Fig. 1. Ms. X. a. Assessment by macroanalysis. b Therapeutic approaches according to macroanalysis.

diagnosed gallstones do not account for the abdominal pain, a cholecystectomy will not solve the patient’s problem’ [89, p. 270].

Pathophysiological Implications

Alvan Feinstein was also the one who warned against the destruction of the pathophysiological bridges from bench to bedside [90]. Indeed, the lack of a psychosocial
Box 2. A 54-year-old woman with hypothyroidism.

Mrs. Y is a 54-year-old woman who was diagnosed with hypothyroidism. She was prescribed replacement therapy which restored thyroid hormone levels within the normal range, but kept feeling miserable, with a very bothersome globus in the throat. She consulted several endocrinologists, who all stated that her thyroid replacement was fine and there was nothing wrong with her, which made her angry and dissatisfied. She was then referred by her primary care physician to a Psychoneuroendocrinology Service. Careful interviewing in this setting disclosed the presence of agoraphobia (fear of public spaces and going out alone) with sporadic panic attacks and that she attributed the globus and panic to the thyroid. She was adjusting by herself the thyroid replacement in relation to her current feelings. She also reported marital problems. The psychosomatic assessment and physical examination led to diagnosing persistent somatization. She was explained that agoraphobia is a psychological disorder, her globus was related to it (not to the thyroid) and that changing herself thyroid replacement could only make things worse. A brief course of cognitive treatment by a psychologist did improve her agoraphobia and marital problems greatly, with disappearance of panic attacks and only sporadic symptoms of globus related to anxiety. The various elements of macroanalysis are highlighted (underlined bold letters) and shown in figure 2.

Fig. 2. Mrs. Y. a. Assessment by macroanalysis. b. Therapeutic approaches according to macroanalysis

perspective, as is generally the case in current medicine, deprives the clinical process of a number of important links:
A The biological correlates of allostatic load [16, 17], such as glycosylated proteins, coagulation/fibrinolysis and hormonal markers, carry important clinical implications in terms of vulnerability risk.
B Recent advances in psychoneuroimmunology offer links between endogenous danger signals and the brain cytokine system that organizes the sickness response in its subjective, behavioral and metabolic components [91]. The neurobiology of
illness behavior, including the placebo effect [92], is beginning to unravel a number of clinical phenomena [92, 93].

C The autonomic system has been a traditional target for exploration of psychosomatic research. Autonomic imbalance, such as a state of low heart rate variability, may be associated with a wide range of psychological and medical dysfunctions [94, 95] and may affect response to medical treatments [96].

D Mood and anxiety disorders have been associated with a variety of medical conditions [43, 97]. The neurotransmitter imbalances associated with reinforcement-reward dysregulation, central pain and psychomotor functioning may provide pathophysiologic bridges for a number of clinical phenomena [98]. Similar considerations apply to the neurobiology of anger and irritability [99, 100].

E Research on the neurobiologic correlates of resilience and well-being [101] has disclosed how different circuits may involve the same brain structures, and particularly the amygdala, the nucleus accumbens, and the medial prefrontal cortex.

F The neurobiology of personality features, such as reward dependence and novelty seeking [102], alexithymia [35, 103–105] and type A behavior [54, 106], provides other valuable pathophysiologic insights into the tendency to develop symptoms and abnormal illness behavior in the setting of medical disease.

**Clinical Implications**

A satisfactory psychosomatic assessment may entail a number of implications for management of medical disorders:

A **Subtyping according to psychological variables.** There is now increasing evidence on the fact that the presence of psychological variables such as depressed mood in the medically ill is associated with a worse prognosis and deserves specific consideration [38, 40, 43–49, 107]. Interestingly, the need of subtyping has recently emerged within the psychiatric definition of depression [108–110].

B **Lifestyle modification.** An increasing body of evidence links the progression of severe medical disorders to specific lifestyle behaviors [25, 111–114]. The benefits of modifying lifestyle have been particularly demonstrated in coronary heart disease [21] and type 2 diabetes [111]. Further, a number of psychological treatments have been found to be effective in health-damaging behaviors, such as smoking [115]. A basic psychosomatic assumption is the consideration of patients as partners in managing disease. The partnership paradigm includes collaborative care (a patient-physician relationship in which physicians and patients make health decisions together) [80, 81] and self-management (a plan that provides patients with problem-solving skills to enhance their self-efficacy) [116].

C **Treatment of psychiatric comorbidity.** Psychiatric disorders, and particularly major depression, are frequently unrecognized and untreated in medical settings, with widespread harmful consequences for the individual and the society. Treatment of
psychiatric comorbidity such as depression, with either pharmacological or psychotherapeutic interventions, markedly improves depressive symptoms, health-related functioning and the patient’s quality of life, even though an effect on medical outcome has not been demonstrated [117, 118].

D Psychosocial interventions. Use of psychotherapeutic strategies (cognitive-behavioral therapy, stress management procedures, brief dynamic therapy) in controlled investigations has yielded a substantial improvement in a number of medical disorders [119–121]. Examples are interventions that increase social support, improve mood and enhance health-related behavior in patients with cancer [122–125], foster self-control and self-management in chronic pain [126] and asthma [127] and improve emotional disclosure [128, 129].

E Treatment of abnormal illness behavior. For many years, abnormal illness behavior has been viewed mainly as an expression of personality predisposition and considered to be refractory to treatment by psychotherapeutic methods. There is now evidence to challenge such pessimistic stance [54]. For instance, several controlled studies on psychotherapy indicate that hypochondriasis is a treatable condition by the use of simple cognitive strategies [87]. The correlation between abnormal illness behavior and health habits may have implications in preventive efforts: individuals with excessive health anxiety were found to take worse care of themselves than control subjects in several studies [130]. Indeed, they may be so distressed by their belief of having an undiagnosed or neglected disease that choices which may yield benefits in the distant future appear to be irrelevant to them.

Current Issues

There have been major transformations in health care needs in the past decades. Chronic disease is now the principal cause of disability and use of health services consumes almost 80% of health expenditures [116]. Yet, current health care is still conceptualized in terms of acute care perceived as a product processing, with the patients as a customer, who can, at best, select among the services that are offered. As Hart [131] has observed, in health care the product is clearly health and the patients is one of the producers, not just a customer. As a result ‘optimally efficient health production depends on a general shift of patients from their traditional roles as passive or adversarial consumers to become producers of health jointly with their health professionals’ [131, p. 383].

The exponential spending on preventive medication justified by the potential long-term benefits to a small segment of the population is now being challenged [132], whereas the benefits of modifying lifestyle by population-based measures are increasingly demonstrated [133] and are in keeping with the biopsychosocial model.

Medically unexplained symptoms occur in up to 30–40% of medical patients and increase medical utilization and costs [13]. The traditional medical specialties, based
mostly on organ systems (e.g. cardiology, gastroenterology), appear to be more and more inadequate in dealing with symptoms and problems which cut across organ system subdivisions. The need for a holistic approach is underscored by the implementation of interdisciplinary services [69, 133, 134]. In the UK, the establishment of psychological treatment centers within the National Health System for providing psychotherapy to patients with anxiety and depressive disorders [135, 136] is an unprecedented opportunity of integration of different treatments.

The need to include consideration of functioning in daily life, productivity, performance of social roles, intellectual capacity, emotional stability and well-being, has emerged as a crucial part of clinical investigation and patient care [137, 138]. These aspects have become particularly important in chronic diseases, where cure cannot take place, and also extend over family caregivers of chronically ill patients and health providers. Patients have become increasingly aware of these issues. The commercial success of books on complementary and mind-body medicine exemplifies the receptivity of the general public to messages of well-being pursuit by alternative medical practices. Psychosomatic interventions may respond to these emerging needs within the established medical system and may play an important role in supporting the healing process.

References

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