

REVIEW ARTICLE

The Psychosomatic Practice

Giovanni A. FAVA^{1,2}, Jenny GUIDI¹ and Nicoletta SONINO^{2,3}

¹Department of Psychology, University of Bologna, Bologna, Italy, ²Department of Psychiatry, University at Buffalo, Buffalo, New York, USA and ³Department of Statistical Sciences, University of Padova, Padova, Italy

There is increasing awareness of the limitations of the disease-oriented approach in medical care. The primary goal of psychosomatic medicine is to correct this inadequacy by incorporation of innovative operational strategies into clinical practice. Psychosomatic practice can be recognized by 2 distinctive features: the holistic approach to patient management (encompassing psychosocial factors) and the clinical model of reasoning (which reflects a multifactorial frame of reference). 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) and implementation of self-management (a plan that provides patients with problem-solving skills to enhance their self-efficacy). Pointing to strategies that focus on individual needs may improve patient quality of life and final outcomes. Key words: psychosomatic medicine; stress, psychological; quality of life; psychological well-being; Diagnostic Criteria for Psychosomatic Research.

Accepted Apr 6, 2016; Epub ahead of print Jun 9, 2016

Acta Derm Venereol 2016; Suppl 217: 9–13.

Giovanni A. Fava, MD, Department of Psychology, University of Bologna, Viale Berti Pichat 5, IT-40127 Bologna, Italy. E-mail: giovanniandrea.fava@unibo.it

In 1960, George Engel sharply criticized the concept of disease: “The traditional attitude toward disease tends in practice to restrict what it categorized as disease to what can be understood or recognized by the physician and/or what he notes can be helped by his intervention. This attitude has plagued medicine throughout its history and still stands in the way of physicians’ fully appreciating disease as a natural phenomenon” (1). His unified concept of health and disease was subsequently elaborated within the biopsychosocial model (2). Not surprisingly, Engel was very critical of the disease concept of functional medical disorders or medically unexplained symptoms. As an increasing body of literature documents (3), 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.

Among leading authors in the field, Tinetti & Fried (4) 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 expectancy was 47 years, and most clinical encounters were for acute illness. Today the life expectancy in Western countries is much higher and most clinical activities are concentrated on chronic diseases or non-disease-specific complaints. “The changed spectrum of health conditions, the complex interplay of biological and non-biological factors, the aging population, and the inter-individual 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 under-treatment, overtreatment, or mistreatment” (4). Tinetti & Fried (4) pointed out 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).

The question arises as to how we should assess these non-biological factors. In clinical medicine there is a 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, however, can now be reliably assessed by clinical rating scales and indexes which have been validated and extensively used in psychosomatic research and practice (5, 6).

Psychosomatic medicine may be defined as a comprehensive, interdisciplinary framework for the: (i) assessment of psychosocial factors affecting individual vulnerability, course, and outcome of any type of disease; (ii) holistic consideration of patient care in clinical practice; and (iii) integration of psychological therapies in the prevention, treatment, and rehabilitation of medical disease.

Psychosomatic medicine is, by definition, multidisciplinary. In clinical practice, the traditional boundaries among medical specialties, that are mostly based on organ systems (e.g. dermatology, cardiology), appear to be inadequate in dealing with symptoms and problems which cut across organ system subdivisions (3–6). Interestingly, the general psychosomatic approach has resulted in a number of sub-disciplines within their

own areas of application: psycho-oncology, psychoneurology, psycho-neuroendocrinology, psychoneuroimmunology, and psycho-dermatology, among others. Such sub-disciplines have developed clinical services, scientific societies, and medical journals; they stem from the awareness of the considerable limitations that the artificial boundaries of medicine (traditional specialties) entail for clinical practice. The history of psychosomatic medicine is often a two way street. On one end, there are psychiatrists who progressively extend their approach to consideration of the role of psychosocial factors in medical disease; on the other end there are non-psychiatric physicians who recognize the importance of the psychosomatic approach in medical practice. Emiliano Panconesi was an eminent example of the clinical broadening of dermatology into psychodermatology (7, 8). Regardless of their initial point of origin, psychosomatic clinicians can be recognized by two common features: the holistic approach to their practice (encompassing psychosocial factors) and their model of clinical reasoning.

ASSESSMENT OF PSYCHOSOCIAL FACTORS AFFECTING INDIVIDUAL VULNERABILITY TO MEDICAL DISEASE

Psychosocial factors may operate to facilitate, sustain, or modify the course of disease, even though their relative weight may vary from illness to illness, from one individual to another, and even between 2 different episodes of the same illness in the same individual (9). Whitlock was a dermatologist who pursued his psychosomatic interest to become a psychiatrist and who wrote a milestone book on psycho-dermatology (10). He emphasized how, in patients with skin disorders, the potential success of proposing a psychological treatment to a very large extent depends on the quality of the recognition by the dermatologist of the psychosocial component of illness (10). It is becoming increasingly clear that medical care can be improved by paying more attention to psychological aspects in the setting of medical assessments, with particular reference to the role of stress (5). A number of factors have been implicated to modulate individual vulnerability to disease.

Illness behavior

Lipowski (9) remarked that once the symptoms of a somatic disease are perceived by a person, or "he has been told by a doctor that he is ill even if symptoms are absent, then this disease-related information gives rise to psychological responses which influence the patient's experience and behavior as well as the course, therapeutic response, and outcome of a given illness episode". The study of illness behavior, defined as the ways in which individuals experience, perceive, evaluate,

and respond to their own health status has yielded important information in medical patients (11). In the past decades research has focused on illness perception, frequency of attendance at medical facilities, health care seeking behavior, delay in seeking treatment, and treatment adherence. In dermatology, factitious dermatitis is an extreme form of abnormal illness behavior in which patients intentionally produce skin lesions in order to assume the sick role (12). Abram et al. (13) underscored the importance of subjective disease perception in rosacea and their findings may apply also to other skin disorders. Assessing illness behavior and devising appropriate responses by health care providers may contribute to improvement of final outcomes in dermatology (12).

Recent life events and allostatic load

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 (5). The role of life changes and chronic stress has evolved from a simplistic linear model to a more complex multivariate conception embodied in the "allostatic" construct. McEwen (14) 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. Clinical criteria for determining the presence of allostatic load are also available (15). Thus, life changes are not the only source of psychological stress, and subtle and long-standing life situations should not be too readily dismissed as minor or negligible, since chronic, daily life stresses may be experienced by the individual as taxing or exceeding his/her coping skills. The concept of cumulative life course impairment refers to the burden of dermatologic disease over time (stigma, medical and psychological comorbidities, social and economic correlates) that may hinder full life potential (16). Such impairments have been illustrated in a number of disorders, such as psoriasis, vitiligo, and chronic wounds (16).

Health attitudes, social support and well-being

Unhealthy lifestyle is a major risk factor for many of the most prevalent diseases and disorders, such as diabetes, obesity, and cardiovascular illness (17). Helping

the patient to modify his/her own behavior and switch to healthier lifestyles may be a major source of clinical benefit (6). For instance, weight loss is associated with reduction in the severity of psoriasis (18).

Prospective population studies have found associations between measures of social support and mortality, psychiatric and physical morbidity, as well as adjustment to and recovery from chronic disease (5), and this applies also to skin disorders (16).

An impressive amount of studies have suggested that psychological well-being plays a buffering role in coping with stress and has a favorable impact on disease course (19). Its assessment is thus of considerable importance in the setting of a medical disease.

Psychiatric disturbances

Psychiatric illness, depression and anxiety in particular, is strongly associated with medical conditions. 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 the presence of comorbidity complicates both recognition and management of medical disorders (5). Major depression has emerged as an extremely important source of comorbidity in medical disorders. It has been found to affect quality of life and social functioning, lead to increased health care utilization, be associated with higher mortality (particularly in the elderly), have an impact on compliance, and increase susceptibility to medical illness (5). Depression and anxiety are associated with various manifestations of somatization and abnormal illness behavior (20). In dermatology, as in other medical specialties, a substantial proportion of patients meet the psychiatric criteria for mood and anxiety disorders (12, 21). Trichotillomania (12) and body dysmorphic disorder (22) are two other disturbances that may be encountered in clinical practice.

Psychological symptoms

Current emphasis in psychiatry concerns the assessment of symptoms used for the diagnosis of syndromes identified by set diagnostic criteria (e.g., Diagnostic and Statistical Manual of Mental Disorders (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 (DCPR) (23, 24). The DCPR were introduced in 1995 and tested in various clinical settings (23, 24). Of the subclinical syndromes assessed by the DCPR, demoralization and irritable mood were the most common. Demoralization connotes the patient's consciousness of having failed to meet his/

her own expectations (or those of others) with feelings of helplessness, hopelessness, or giving up. 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. Both syndromes were the most frequent also in patients with dermatological disorders (21). The DCPR also provide a classification for illness behavior encompassing persistent somatization (conceptualized as a clustering of functional symptoms involving different organ systems), conversion (involving features such as ambivalence, histrionic personality, and precipitation of symptoms by psychological stress of which the patients is unaware), illness denial (persistent denial of having a medical disorder and needing treatment, lack of compliance, delay in seeking medical attention).

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 that may be able to fully explain the somatic symptomatology. The presence of a non-functional medical disorder does not exclude, but indeed increases the likelihood of psychological distress and abnormal illness behavior (9).

THE PSYCHOSOMATIC CONCEPTUAL FRAMEWORK VERSUS EVIDENCE-BASED MEDICINE

Engel (25) identified the key characteristic of clinical science in its explicit attention to humanness, where observation (outer-viewing), introspection (inner-viewing), and dialogue (inter-viewing) are the basic methodological triad for clinical assessment and for making patient data scientific. The exclusion of this interaction by medical science continuing to adhere to a 17th century scientific view makes this approach unscientific. Accordingly, "the human realm either has been excluded from accessibility to scientific inquiry or the scientific approach to human phenomena has been required to conform to the reductionistic, mechanistic, dualistic predicates of the biomedical paradigm" (25). This restrictive ideology characterizes evidence-based medicine (EBM) (26). The gap between clinical guidelines developed by EBM and the real world of clinicians and patients has been widely recognized and it does not seem that EBM has actually improved patient care (27). Each therapeutic act may be seen as a result of multiple ingredients, which may be specific or non-specific. Expectations, preferences, motivation, and patient–doctor interactions are examples of non-specific variables that may affect the outcome of any specific treatment, such as pharmacotherapy or psychotherapy (26). While there is growing awareness that the aim of treatment should refer to personal goals (4), EBM does not do justice to the relevance of

psychosocial variables and provides an oversimplified and reductionistic view of treatment. Even though personalized medicine, described as genomics-based knowledge, has promised to approach each patient as the biological individual he/she is, the practical applications still have a long way to go, and neglect of social and behavioral features may actually lead to “depersonalized” medicine (28). 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) and implementation of self-management (a plan that provides patients with problem-solving skills to enhance their self-efficacy) (5). Endorsement of a psychosomatic conceptual framework, including the consideration of psychosocial variables, comorbidity, and multimorbidity, may lead to more effective and shared decision making. This alternative conceptual model is centered primarily on clinical judgment.

CLINICAL REASONING

Feinstein (29) remarks that, when making a diagnosis, thoughtful clinicians seldom leap from a clinical manifestation to a diagnostic endpoint. Clinical reasoning goes through a series of “transfer stations”, where potential connections between presenting symptoms and the pathophysiological process are drawn. These stations are a pause for verification, or change to another direction. 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 (29). 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 (9) refused. 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, a clinician may make an accurate diagnosis of gallstones, but if the diagnosed gallstones do not account for the abdominal pain, a cholecystectomy will not solve the patient’s problem” (29).

In psychodermatology clinical judgment is required for evaluating the primary or secondary nature of psychiatric disorder (12), the impact of psychosocial factors on disease course (16), and the potential indications for psychotropic drug therapy (12, 30) and/or psychotherapeutic strategies, such as cognitive behavior approach to body dysmorphic disorder (31) or internet-based self-help for trichotillomania (32).

CONCLUSION

Whether in psychiatry, in general medicine, or in specialties such as dermatology, clinicians endorsing the psychosomatic approach share features that are uniquely geared to addressing current challenges.

Chronic disease is now the principal cause of disability and consumes almost 80% of health expenditures (4). Yet, current health care is still conceptualized in terms of acute care perceived as processing of a product, with the patient as a customer, who can, at best, select among the services that are offered. As Hart has observed, in health care the product is clearly health and the patient is one of the producers, not just a customer (33). 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” (33). In this view, the exponential spending on preventive medication, justified by potential long-term benefits to a small segment of the population, is now being challenged. Instead, the benefits of modifying lifestyles by population-based measures are increasingly demonstrated and are in keeping with the biopsychosocial model (2, 4).

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 (5). Psychosomatic medicine is timelier than ever.

REFERENCES

1. Engel GL. A unified concept of health and disease. *Perspect Biol Med* 1960; 3: 459–485.
2. Engel GL. The need for a new medical model: a challenge for biomedicine. *Science* 1977; 196: 129–136.
3. Fava GA, Sonino N. Psychosomatic assessment. *Psychother Psychosom* 2009; 78: 333–341.
4. Tinetti ME, Fried T. The end of the disease era. *Am J Med* 2004; 116: 179–185.
5. Fava GA, Sonino N. Psychosomatic medicine. *Int J Clin Pract* 2010; 64: 1155–1161.
6. Fava GA, Sonino N, Wise TN, editors. *The Psychosomatic Assessment*. Basel: Karger, 2012.
7. Panconesi E. Psychosomatic dermatology: past and future. *Int J Dermatol* 2000; 39: 732–734.
8. Panconesi E. Psychosomatic factors in dermatology: special perspectives for application in clinical practice. *Dermatol Clin* 2005; 23: 629–633.
9. Lipowski ZJ. Physical illness and psychopathology. *Int J Psychiat Med* 1974; 5: 483–497.
10. Whitlock FA. *Psychophysiological aspects of skin disease*. London: Saunders, 1976.
11. Sirri L, Fava GA, Sonino N. The unifying concept of illness behavior. *Psychother Psychosom* 2013; 82: 74–81.
12. Brown GE, Malakouti M, Sorenson E, Gupta R, Koo JYM. Psychodermatology. *Adv Psychosom Med* 2015; 34: 123–134.
13. Abram K, Silm H, Maaros HI, Oona M. Subjective di-

- sease perception and symptoms of depression in relation to healthcare-seeking behaviour in patients with rosacea. *Acta Derm Venereol* 2009; 89: 488–491.
14. McEwen BS. Physiology and neurobiology of stress and adaptation: central role of the brain. *Physiol Rev* 2007; 87: 873–904.
 15. Fava GA, Guidi J, Semprini F, Tomba E, Sonino N. Clinical assessment of allostatic load and clinimetric criteria. *Psychother Psychosom* 2010; 79: 280–284.
 16. Linder MD, Kimball AB, editors. *Dermatologic diseases and cumulative life course impairment*. Basel: Karger, 2013.
 17. Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. *JAMA* 2004; 291: 1238–1245.
 18. Upala S, Sanguankeo A. Effect of lifestyle weight loss intervention on disease severity in patients with psoriasis. *Int J Obes* 2015; 39: 1197–1202.
 19. Ryff CD. Psychological well-being revisited. *Psychother Psychosom* 2014; 83: 10–28
 20. Fava GA, Guidi J, Porcelli P, Rafanelli C, Bellomo A, Grandi S, Grassi L, et al. A cluster analysis-derived classification of psychological distress and illness behavior in the medically ill. *Psychol Med* 2012; 42: 401–407.
 21. Picardi A, Pasquini P, Abeni D, Fassone G, Mazzotti E, Fava GA. Psychosomatic assessment of skin diseases in clinical practice. *Psychother Psychosom* 2005; 74: 315–322.
 22. Phillips KA. Body dysmorphic disorder. *Psychother Psychosom* 2014; 83: 325–329.
 23. Porcelli P, Sonino N, editors. *Psychological factors affecting medical conditions. A new classification for DSM-V*. Basel: Karger, 2007.
 24. Porcelli P, Guidi J. The clinical utility of the Diagnostic Criteria for Psychosomatic Research. *Psychother Psychosom* 2015; 84: 265–272.
 25. Engel GL. How much longer must medicine's science be bound by a seventeenth century world view? *Psychother Psychosom* 1992; 57: 3–16.
 26. Fava GA, Guidi J, Rafanelli C, Sonino N. The clinical inadequacy of evidence based medicine and the need for a conceptual framework based on clinical judgment. *Psychother Psychosom* 2015; 84: 1–3.
 27. Every-Palmer S, Howick J. How evidence-based medicine is failing due to biased trials and selective publication. *J Eval Clin Practice* 2014; 20: 908–914.
 28. Horwitz RI, Cullen MR, Abell J, Christian JB. (De)personalized medicine. *Science* 2013; 339: 1155–1156.
 29. Feinstein AR. An analysis of diagnostic reasoning. II. The strategy of intermediate decisions. *Yale J Biol Med* 1973; 46: 264–283.
 30. Fava GA. Rational use of antidepressant drugs. *Psychother Psychosom* 2014; 83: 197–204.
 31. Veale D, Anson M, Miles S, Pieta M, Costa A, Ellison N. Efficacy of cognitive behaviour therapy versus anxiety management for body dysmorphic disorder. A randomised controlled trial. *Psychother Psychosom* 2014; 83: 341–353.
 32. Weidt S, Klaghofer R, Kuenburg A, Bruehl AB, Delsignore A, Moritz S, Rufer M. Internet-based self-help for trichotillomania. *Psychother Psychosom* 2015; 84: 368–376.
 33. Hart JT. Clinical and economic consequences of patients as producers. *J Pub Health Med* 1995; 17: 383–386.