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.

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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, psychonephrology, psycho-neuroendocrinology, psych-immunology, 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 psycho-dermatology (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 allostatics: 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, psy-
chiatric 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 im-
portance in the setting of a medical disease.

Psychiatric disturbances

Psychiatric illness, depression and anxiety in particular,
is strongly associated with medical conditions. Men-
tal disorders increase the risk for communicable and
non-communicable diseases. At the same time, many
health conditions increase the risk for mental distur-
bances, 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 sub-
stantial proportion of patients meet the psychiatric
criteria for mood and anxiety disorders (12, 21). Tri-
chotillomania (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 assess-
ment 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 psychologi-
cal symptoms which do not reach the threshold of
a psychiatric disorder may affect quality of life and
taill 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 asses-
sed 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 encom-
passing persistent somatization (conceptualized as a
clustering of functional symptoms involving different
organ systems), conversion (involving features such
as ambivalence, histrionic personality, and precipita-
tion 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 FRAME-
WORK 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, mechanis-
tic, 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, motiva-
tion, 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 aware-
ness that the aim of treatment should refer to personal
goals (4), EBM does not do justice to the relevance of

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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 intermed-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.

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