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The Psychosomatic Perspective

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In 2010, Drs. Lianov and Johnson wrote a commentary which laid the foundation of Lifestyle Medicine Competencies in primary care [1]. The competencies were developed by a group of representatives from primary care medical specialties and other interested medical professional societies to address the identified gap in physicians' armamentaria: leadership in promoting healthy behaviors as foundational to medical care, disease prevention, and health promotion; knowledge of the evidence that specific lifestyle changes can have a positive effect on patients' health outcomes; assessment of social, psychological, and biological predispositions of patients' behaviors and the resulting health outcomes; management skills to assist patients in self-managing health behaviors and lifestyles; use of office and community support to work in interdisciplinary team of healthcare professionals and support lifestyle medical care. Such competencies were aimed at guiding continuing medical education activities for primary care and preventive care physicians, and many of the individual competencies proposed were suggested as relevant for all clinical disciplines [1]. The authors encouraged physician educators at both the undergraduate and graduate medical education levels to incorporate the Lifestyle Medicine Competencies into education and training programs. Each medical specialty was encouraged to review the competencies and adopt them. Lifestyle Medicine Core Competencies were updated in 2022, maintaining the modality format of the original 2010 version [2].

This journal has recently highlighted the psychosomatic foundations of Lifestyle Medicine in an editorial by Fava [3], starting from the concept of patients as health producers, originally suggested by Hart [4] in 1994 and derived from the sociology literature [5]. In his editorial [3], Fava outlined that: (1) patients are health producers when they embrace healthy lifestyles which may entail health promotion and when they participate in their own management via collaborative care and shared decision making or self-management [3]; (2) physicians are health producers when they apply shared decision making, provide medical information and adequate explanation, and refrain from prescribing pharmacological treatments if an adequate indication is lacking [3]. Fava also described the psychosomatic framework, which is the basis of Lifestyle Medicine. Psychosomatics expanded the concept of lifestyle, initially restricted to nutrition, fitness, sleep, and refraining from smoking and substance abuse, to psychological (including euthymia), social, and economic factors that shape lifestyle in the life course trajectories of human health, always considering the interacting mechanisms at individual, interpersonal, and environmental levels [3].

Starting from the Psychosomatic Foundation of Lifestyle Medicine outlined by Fava [3], it is worth expanding the psychosomatic contribution to Lifestyle Medicine to make it really applied in practice and in a fruitful way. Effectively motivating patients to change lifestyle and behavior has been widely recognized as a challenging activity, and merely encouraging patients at the end of an office visit to attempt changes has been shown to present very limited effects [1]. Nevertheless,

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Lianov and Johnson [1] suggested solutions which seem to be of limited utility: developing curricula, training materials, evaluation, system-based practice tools, and performance measures.

An action can be successful if it is sustained by a strong perspective. In other words, if the mentioned strategies are proposed to clinicians who adhere to the reductionistic, pragmatic biological model of medicine, they will follow the curricula and training to have the education in medicine credits and will not use what they have learned in their clinical practice, probably due to the lack of time to devote to medical consultations or because they prescribe drugs for any health issue.

This reminds me of the history of a patient who was diagnosed with hypercholesterolemia by the general practitioner (GP). When I asked the patient to tell me which lifestyle changes he implemented due to the diagnosis, he replied, "none, the GP gave me a list of food containing high levels of cholesterol which I should not eat, but fortunately, I do not like that food." Going into details, I discovered that the list given by the GP contained basic food, such as, for instance, butter, that the patient was not used to consume plain. When I asked the patient whether he was used to eat, for instance, biscuits or cakes, which contain butter, he candidly replied to be gluttonous and to have about 3–4 portions of them per day. It was evident that the GP's action was too weak to modify the patient's lifestyle and might legitimate the patient to believe that the only solution for his hypercholesterolemia was taking statins.

If Lifestyle Medicine keeps on having roots in the pragmatic and reductionistic biomedical model, any strategy will fail. The psychosomatic perspective might, instead, make Lifestyle Medicine of clinical impact when implemented. The roots are in the biopsychosocial model outlined by George Engel [6], one of the fathers of psychosomatics together with John Romano. Advantages of using psychosomatics as a perspective to let patients become health producers are here illustrated with specific reference to two domains, one pertaining to patient's assessment and the other one pertaining to patients' involvement.

Patients' Assessment under the Psychosomatic Perspective

Patients are producers of clinical data. However, in the reality of clinical disciplines, they are often left passive. This, among others, means a mismatch between patients' status and expectations, the latter becoming at risk to be violated, with possible negative consequences on health [6].

Engel [7], already in 1992, described the power of collecting the clinical history from the patient. Engel considered the clinical interview the most powerful, encompassing, sensitive, and versatile instrument available to clinicians [7]. Later on, the psychosomatic armamentarium has been enriched by clinimetric indexes. Clinimetrics is an innovative discipline developed by Feinstein [8, 9] and further refined by Bech [10], Fava [11, 12], and their collaborators, concerned with the measurement of clinical parameters which do not find room in customary clinical taxonomy. The Diagnostic Criteria for Psychosomatic Research [13] are a clinimetric tool assessing psychosomatic syndromes, worthy of clinical attention being potential drivers of unhealthy behaviors. The spectrum of such syndromes ranges from hypochondriasis to illness denial, passing through disease phobia and health anxiety on one hand, delaying in seeking treatment and lack of adherence to medical advice on the other hand [14]. For instance, health anxiety, which is characterized by worries and fears that readily respond to medical reassurance, can be an obstacle in adhering to screening campaigns but, at times of pandemic, it served as the function of enhancing safety practices (e.g., use of protections, social distancing) [15]. Of course, these two different connotations of health anxiety characterize individuals with different attitudes and behaviors related to health and disease. These factors shape the recognition of illness, the access of patients into care, the patterns of health practice and adherence to medical advice, the course of illness, and the treatment process [14].

Clinimetric Patient-Reported Outcome Measures (PROMs), that are self-rated scales and indices detecting patients' subjective experiences, have also been developed under the psychosomatic perspective (e.g. [16–18]), together with specific criteria to create new PROMs or adapting existing ones according to clinimetric principles [19].

Of course, clinical data need to be organized. Following the psychosomatic perspective, macroanalysis and microanalysis can be used [20–22]. Macroanalysis is the analysis of the relationship among co-occurring problematic areas. It allows to group symptoms, problems, diseases in macro-areas. In each macro-area, a hierarchical configuration is established, that is which ailments [23] are the most important. The final use is to make a

proper decision on what and how to treat first. Microanalysis is a complementary clinimetric tool of macroanalysis which brings the detailed dimensional analysis of symptoms for functional assessment [20–22].

A comprehensive evaluation of a disorder also needs to assess the extent of its progression [24–26]. The staging model allows assessing longitudinally the stages of illness. Once an index identifies the existence of a particular disease, its seriousness, extent, and longitudinal characteristics are evaluated [24, 25].

Finally, "any distinctive additional clinical entity that has existed or that may occur during the clinical course of a disease" having the potential to impact a person's prognosis, alter therapeutic plans and outcomes [23] should be properly examined. The Charlson Comorbidity Index represents a useful clinimetric tool to assess comorbidity and its prognostic impact on health, including mortality [27, 28].

Patients' Involvement under the Psychosomatic Perspective

It can be claimed that patients commonly prefer asking for a visit, and thereafter, swallowing a pill rather than actively change something (e.g., renegotiating their marriage, eating 30% less fat, giving up cigarettes). However, such passivity is not innate in patients but it is usually learned from practitioners. Physicians embracing the reductionistic biological model have a strong preference in prescribing drugs, even when they are not needed, while they do not devote time to patients, transfer information, and educate them. The issue of overtreatment is largely considered a problem in medical disciplines (e.g., geriatrics, psychiatry, oncology, palliative care). It has been suggested that the hippocratic oath "to treat the ill to the best of one's ability" is now more actual than ever and requires improving entire healthcare systems, whose efficiency in care delivery and providing best outcomes is compromised by overtreatment, overdiagnosis, inattention to warmth and sympathy, medicalization of normal, failure to attend to prevention [29].

Therefore, the only limits to what patients can learn, or the responsibilities they can take, are the initial education clinicians provide, and the encouragement clinicians give them to discard passive consumerism and find out for themselves [4]. Patients with chronic diseases, for instance, become expert managers of their problems if they receive reasonable education and support from professionals. The psychosomatic perspective encourages reappraisal of the relationship between the clinician and the patient, of careful listening and observation, of spending time with patients. Upon leaving a patient's room, Engel was used to ask students and residents what they had noticed. If they noted patient's pallor, jaundice, cyanosis, Engel commended them but also pressed them to observe more than physical indicators of disease: "Did you notice that the patient has got no get-well cards up on the wall and no flowers from well-wishers?" [30]. He urged students and residents to explore and be interested in the personal and social circumstances of patients, recognizing that the patient is both an initiator and a collaborator in the clinical process, not merely an object of study [31].

Unhurried shared decisions are necessary for providing strength and credibility to suggestions for lifestyle modifications [4]. Not surprisingly, when patients with prediabetes were engaged in shared decision making for diabetes prevention using a decision aid with information about two evidence-based options, 55% chose intensive lifestyle change, 8.5% chose metformin, and 15% chose both [32]. Imaginative approaches to participation of patients in their own management and shared decisions are needed also for or against inception of medication [4]. This is a rather hot issue when referring to antidepressant prescription. Practitioners tend to suggest patients to start with a selective serotonin reuptake inhibitor without sharing the information of the risk of withdrawal at its decrease, switch, or discontinuation [33]. Patients may discover this problematic implication of selective serotonin reuptake inhibitor use when they reduce or discontinue the drug that is too late, being already in the track of iatrogenesis [34].

If patients are actively involved in their care path according to the psychosomatic perspective, they become interested in the information collected on their health status. From their own experience, they learn that clinical manifestations fluctuate, so that it cannot be right to take big decisions on a single assessment, and that symptoms can be related to several individual variables, including psychosocial factors (e.g., social relations, worry). Engel proposed a multifactorial model of illness [6, 7] which allowed a comprehensive view of patients as the result of interacting systems at the cellular, tissue, organismic, interpersonal, and environmental levels in need of being assessed and eventually addressed for changes. Biology is not destiny [35]; biography, represented by life experiences, should be integrated in the conceptual paradigm for understanding the origin and development of both illness and disease [36].

Clinicians who devote quality time to patients, encourage the narration, listen with attention, carefully assess problematic areas are already putting patients in context, creating the conditions to explain behaviors that

would not otherwise be understandable, shaping their lifestyle. In parallel, they are avoiding unnecessary diagnostic procedures or pharmacological treatments, with a benefit in terms of final outcomes [37].

Conclusions

Motivating people to make beneficial changes in their lifestyle is currently still regarded as a major healthcare challenge [3]. There is, however, very little recognition that health production requires major individual, clinical, financial, and organizational changes. There must be collaboration between patients, health economists, and clinicians, not only about choices within real constraints but also about how we break those constraints by developing resources we already have, but which are now largely unused or badly used; that is, the brains, imagination, and readiness to accept long-term continuing responsibility of patients [4] and invest on self-efficacy, self-management, self-therapy.

Patients cannot be seen as mere objects, useful as disposable parts of the production machine, or as consumers. Patients are people worthy of being seen in their potential dignity of producers for human needs rather than profit; this has to do with the psychosomatic perspective that is a participative clinical practice and research, rather than corporate management.

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Author Contributions

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