

Hoyle Leigh *Editor*

Global Psychosomatic Medicine and Consultation- Liaison Psychiatry

Theory, Research, Education, and
Practice

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For Vinnie

Preface: Origins and Cross-Currents

My career choice was a compromise between my attraction to Freudian psychodynamics and my love of physiology – the mechanisms of how the mind and body work. The natural venue in which both could be practiced was in the consultation-liaison setting of the general hospital.

I had the good fortune of being trained at Montefiore/Einstein Medical Center in New York by such luminaries as Morton F. Reiser, Herbert Weiner, Edward Sachar, Myron Hofer, and James Strain. Later, as a faculty member at Yale, Morton Reiser became my mentor, with whom I wrote *The Patient: Biological, Psychological, and Social Dimensions of Medical Practice*, a textbook for medical students, which was an attempt to operationalize a comprehensive biopsychosocial model that can be practiced by all physicians. (Leigh and Reiser 1980, 1985, 1992) At Yale, I also absorbed wisdom from Theodore Lidz, Stephen Fleck, and Sally Provence. Mort Reiser, a founding member and President of the *International College of Psychosomatic Medicine*, invited me to join the organization where I met many international colleagues such as Wolfram Schuffel and George Christodoulou. At Yale, and later at University of California, San Francisco (UCSF), I collaborated with one of my Yale friends, Jon Streltzer, in publishing the *Handbook of Consultation-Liaison Psychiatry*, now in 2nd Edition (Leigh and Streltzer 2014). I was stimulated by the wisdom of my *Massachusetts General Hospital* colleagues Tom Hackett, Ned Cassem, and Ted Stern during my career, especially during my sabbatical there. I chaired a number of symposia at the *American Psychiatric Association Annual Meetings*, where Don Lipsitt of Harvard, Seth Powsner of Yale, and Beena Nair of UCSF, were regular panelists and at the *World Congress of Psychosomatic Medicine* of the *International College of Psychosomatic Medicine*, where Craig Van Dyke, a colleague from Yale and UCSF, and William B. Choi, an internist and friend from my medical school days and Yale, were regular participants.

In the course of my half century career in consultation-liaison psychiatry and related research, it became increasingly clear that the mechanisms of the mind were better explored by tools of physiology (including endocrinology, pharmacology,

etc.) and neuroscience than abstract psychodynamics. On the other hand, I became increasingly aware of the role of information and memory in the very expression of genes and thus behavior (Leigh 2010).

It is generally believed that ancient concepts of healing, and indigenous beliefs in different regions of the world concerning illness and healing were holistic and thus “psychosomatic.” The scientific information systems (memes) concerning “body” and “mind” that developed separately along Cartesian lines spread throughout the modern world as Western Medicine. How did the new “scientific” biological and psychodynamic memes interact (or not) with indigenous memes about mind and body? Does the interaction depend on the region and the power of indigenous memes and their readiness to adapt and evolve (e.g., acupuncture, yoga, Mindfulness)? This volume may provide some clues in this regard.

Within Western medicine, I noted there is a point of departure between the approaches of consultation-liaison psychiatrists mostly in the United States and the United Kingdom Commonwealth countries and psychosomaticists mostly in Continental Europe. Is there a conceptual divergence in our field?

The term, *Psychosomatic Medicine*, seems largely embraced wholeheartedly in Europe but only ambivalently in the United States, where the subspecialty of *Psychosomatic Medicine* changed its name to *Consultation-Liaison Psychiatry* in 2018, and the *Academy of Psychosomatic Medicine* to *Academy of Consultation-Liaison Psychiatry*. Does this name change symbolize the ambivalence I experienced in choosing the field? Between physiology-neuroscience on one hand, and psychodynamics on the other?

This volume is a global survey of this somewhat confusing field that might potentially find a pathway to the future. This volume is organized into an Introduction and seven parts. The Introduction by Don Lipsitt, my friend and colleague of many symposia together, sets the stage for this volume with an illuminating, sweeping flow of the origins and development of PSM and C-L psychiatry. Part I provides an overview of the development and major trends of the field on a macro-regional basis. Parts II–VI provide an overview of the current status of the field in some representative countries in each continent. I apologize that not all the countries, some with vibrant PSM or C-L activity, are represented. For example, I am aware that the field is thriving in countries like the Netherlands, Italy, Portugal, and Brazil, but I simply could not find someone to write the chapter for various reasons. Italy and Sweden are at least represented by responding to the survey questionnaires. Part VII concludes the volume with ideas about the future of psychosomatic medicine and consultation-liaison psychiatry. Wolfram Schüffel, an old friend and colleague and a truly humanistic physician explains in his three chapters the German humanistic philosophical approaches to PSM and proposes a humanistic perspective of the future of psychosomatic medicine. My concluding chapter is a brief commentary on the state of the field in each region of the world and my ideas about the concept of memes or information supplanting both the psyche and the soma.

I thank Janice Stern, Senior Editor Emeritus of Springer, with whom I collaborated fruitfully for decades, and Katherine Chabalko, Springer’s new Senior Editor, for their enthusiasm and help in bringing this volume to print. My personal thanks to my wife, Vinnie, whose encouragement and support were indispensable.

I am grateful to the stellar contributors who spent countless hours of thought and energy in writing their chapters. I am grateful to all my mentors, teachers, colleagues, and especially my students who never stop stimulating me and enliven me, and my patients who are a continuing source of intellectual challenge, human connection, and understanding.

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Hoyle Leigh is a Professor Emeritus of Psychiatry at University of California, San Francisco (UCSF), and Director Emeritus of the Psychosomatic Medicine Program and Psychiatric Consultation-Liaison Service at UCSF Fresno. He is well-known as the author of the textbooks, *Handbook of Consultation-Liaison Psychiatry* (with Jon Streltzer, M.D. of University of Hawaii), now in the 2nd Edition, and *The Patient: Biological, Psychological, and Social Dimensions of Medical Practice* (with Morton F. Reiser of Yale), now in its 3rd edition, and of the pioneering book, *Genes, Memes, Culture, and Mental Illness: Toward an Integrative Model*. In addition, he is the author of more than one hundred publications. Before coming to UCSF, Dr. Leigh was Professor of Psychiatry and Assistant Chief of Psychiatry at Yale University School of Medicine and the Yale New Haven Hospital, in New Haven, Connecticut. He received his MD, summa cum laude, from Yonsei University, and MA at Yale. He trained at Long Island College Hospital, University of Kansas, Albert Einstein College of Medicine in New York, and at Yale. Dr. Leigh is a Distinguished Life Fellow of the American Psychiatric Association, a Fellow of American College of Physicians, American College of Psychiatrists, Academy of Psychosomatic Medicine, and International College of Psychosomatic Medicine. He is a diplomate of the American Board of Psychiatry and Neurology both in General Psychiatry and Consultation-Liaison Psychiatry. Dr. Leigh has developed a computerized database for consultation-liaison psychiatry which is in use at the Fresno Community Regional Medical Center, which also serves as a fertile database for research by residents and faculty. His research interests include global psychosomatic medicine, psychiatry training for medical students and primary care physicians, the nature of psychiatric diagnosis, and the gene x meme x environment interaction in mental health and illness.

Chapter 1

Introduction



Don R. Lipsitt

“The person is more than just the mere body, but also more than just the mere soul: it is the whole man”

–Heinroth, 1818

Exactly 200 years ago, in his book on “disorders of the soul,” the German physician Johann Christian Heinroth, was the first to use the term “psychosomatic” in its application to medicine; some dubbed him the father of psychosomatic medicine (Steinberg et al. 2013). Heinroth always embraced a holistic approach to disease, but, in time, with advances in medicine, specialization, and the advent of dualism, at least two enclaves of professionals evolved, one we might call “separatists,” the other “integrationists.”

1.1 An Age of Dualism

This dualism of medicine has endured for decades, making holistic medicine once again a remote goal. The history of psychosomatic medicine and consultation-liaison psychiatry is, in essence, the history of psychiatry itself, with its many efforts to reunite with its medical progenitor (Lipsitt 1981). Both psychosomatic medicine (PM) and consultation-liaison (C-L) psychiatry have at times been described as disciplines that evolved to restore humanism to a biological medicine, endeavoring to bridge the so-called “mind-body problem,” through an integration of *psyche* with *soma* (Leigh 1990; Lipsitt 2000, 2001, 2002).

Psychiatry’s distance from medicine was partly self-imposed through the asylum (alienist) system. Then psychoanalysis, while enriching our understanding of mental

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illness, abandoned its relationship to medicine. Psychiatrists themselves have often chosen to remain in their own separatist silos. Some trainees “resented” their assignment to C-L service; some chairs of departments had “other fish to fry.”

Many of these obstacles have begun to “fade into the woodwork” and the utility of psychiatry rejoining medicine has begun to reap tangible benefits in the important care of the chronically ill, elderly, complex medically ill and others. The integrationist movement attracted those in pursuit of a resolution to the “mind-body problem,” namely psychosomatists and consultation-liaison practitioners. Gradually, evolution of the concept and clinical application of psychosomatic medicine has surmounted many challenges and hurdles, some more successfully than others.

1.2 Psychosomatic Medicine on the March

Almost 150 years after Heinroth, in 1967, Eric Wittkower, a Canadian psychiatrist/psychosomatist and the first president of the International College of Psychosomatic Medicine, delivered a plenary speech at an international congress in Kyoto, Japan (Wittkower et al. 1969). He reported on a limited “global” survey of psychosomatic medicine’s progress, opening with “Psychosomatic medicine has indeed come a long way since the early thirties [his reference point was not Heinroth, but rather Dunbar and her pioneer associates] [when] a small group of research workers, internists, and psychiatrists in various parts of the world laid the foundation stones of what afterwards became the practice and science of psychosomatic medicine” (p. 499).

Wittkower believed that a measure of success for the discipline’s absorption into medicine would be its own demise. He expressed the characteristic excitement and devotion at the time for the discipline’s future; his “optimism” did not anticipate the complaints of a number of his psychosomatic successors who registered frustration at the slowness with which the movement was taking hold.

While the more optimistic psychosomatic enthusiasts shared Wittkower’s perverse optimism, other more pessimistic advocates brayed at the sluggishness with which the field showed any noticeable impact on its associated disciplines and practitioners. The impatience of George Engel, for example, is reflected in the title of one of his late papers, entitled “How much longer must medicine’s science be bound by a 17th century world view? (Engel 1997)”. Even earlier, David Graham, an internist and president of the American Psychosomatic Society in his 1979 presidential speech asked aloud what place the tenets of psychosomatic medicine would become part of all medicine (Graham 1979). Were Wittkower alive today, his prognostication might be tempered with a glance at the cluster of countries where psychosomatic medicine and C-L psychiatry are in full bloom. In the 50 years since Wittkower’s “global” survey of four countries (Germany, Japan, Russia, United States), a global survey has burgeoned to include at least 18 countries where PM and C-L now flourish.

1.3 Measurement of Progress

How do we assess changes in acceptance of psychosomatics and consultation-liaison psychiatry? While change is often difficult to measure, the present contributions to this volume serve as one measure of how PM and C-L have thrived. The last such review appeared in the 1983 volume of *Advances in Psychosomatic Medicine: Consultation-Liaison Throughout the World* (Wise and Freyberger 1983). That issue contains 16 chapters, representing activity in C-L practice in Panama, Israel, Poland, Japan, United Kingdom, Italy, Norway, Belgium, and West Germany. Almost one-quarter of the chapters reflect American programs. The current volume expands the vista to 25 chapters, with additions of China, India, North Africa, France, Middle East, Korea, Egypt, Canada, South America, and Australia, a few authors of 1983 providing updates for their countries. That purview itself is testimony to the avidity with which the value of C-L service and psychosomatic research has been recognized around the world. Strangely omitted from both volumes are countries like Portugal, and the Netherlands (more about the latter below), where interest in these topics has been evident. Proceedings of the first international congress of the Academy of Psychosomatic Medicine reported on 47 presentations, with only one referring to liaison psychiatry (Dunlop 1967).

1.4 Multiple International Determinants

To what can we attribute this palpable growth? How have other countries dealt with the obstacles that have faced development in the United States? What contributions worldwide have enriched the soil in which psychosomatic research and clinical activity have matured? (Lipsitt 2006). While American practitioners of PM and C-L plowed their own fields, a litany of European contributions provided underpinnings for developments in other countries.

Indeed, many predated influences from other countries, without fanfare, have furnished the scaffolding upon which today's successes have built. Johannes Reil named psychiatry in 1808 (Reil and Hoffbauer 1808) and Heinroth first posited a theory of psychosomatics in 1818, while Felix Deutsch in Vienna is reputed to have first supplied the term "psychosomatic medicine" in 1922.

Reaching far back historically, Greece can claim Hippocrates and Galen for early engagement with mind-body mysteries. Important psychiatric discoveries emerged from famous institutions like Leipzig University in Germany and Salpetriere and Bicetre Hospitals in France. Freud, although never using the word "psychosomatic" in his writings, began his psychoanalytic odyssey with Charcot at the Salpetriere and gave the world a new way to ponder mind-body connections. More recently, Leiden University in the Netherlands has been an important center of psychosomatic research (Hentschel and Eurelings-Bontekoe 1993). In 1845, von Feuchtersleben published a *Principles of Medical Psychology*, reprinted in 1995 in English.

Other countries addressed the “mind-body problem” with their own customs and cultures; Asia has zen Buddhism, China has chi, Germany had psychosomatic hospitals and so on. Netherlands is noted for the early work of social psychiatrist Arie Querido, who proposed a form of “integrative medicine” beginning in the 1930s through the 1960s, strongly coloring future developments in that country (Weijel 1958).

The psychosomatic research endeavors of Thure von Uexkull (1997) endeavored to make clearer the concept of psychosomatic medicine through his research in Germany. Hungarian psychoanalyst Michael Balint (1951) showed groups of general practitioners in England and around the world how they could incorporate psychological awareness in their everyday practices. Karl Friedrich von Weizsacker, a physicist and philosopher rather than psychiatrist, claimed in 1951 that “something really revolutionary has taken place with the introduction of psychology into internal medicine.” He also attempted to eliminate the idea of dualism through quantum mechanics in 1971 with a holistic theory of medicine (von Weizsacker 1971).

More contemporaneously, the formation of European groups to collaborate on promoting C-L psychiatry has unquestionably influenced the propagation of programs in ways which may not be entirely measureable. There was a biannual conference of the European Conference on Psychosomatic Research (ECPR) beginning in the 1950s. A later organization, the European Association of Consultation Liaison Psychiatry and Psychosomatics (EACLPP), founded in 1998, fostered greater interest, communication and collaboration in the field, and gave rise to the European Consultation Liaison Workgroup (ECLW), supported by the European Union, to more actively undertake projects of common international interest (Huyse et al. 2000).

There has always been a trend toward internationalism in psychosomatic medicine and C-L psychiatry. The previously referenced 1983 world survey described how in Belgium, Pierloot, with training in both internal medicine and psychiatry was appointed “consultant on psychosomatics” at his hospital (St. Rafael of University of Leuven) in 1953, although organized liaison activities did not begin until 1968 (Pierloot and Nijs 1983). As the founding editor of two international journals on *Psychiatry in Medicine* and *General Hospital Psychiatry*, I have had the good fortune of receiving and reviewing an extensive worldwide output of publishable work in the specialty of C-L psychiatry, with the opportunity to interact with a host of like-minded individuals around the world.

In 1970, a group of interested psychiatrists (“psychosomatists”) gathered informally in Guadalajara, Mexico to deliberate the founding of an international group of interested clinicians: Wittkower from Canada, Ikemi from Japan, Reiser and Krakowski from the US, Kertesz from Argentina, Mauricio Knobel from Brazil, Musaph, Bastians and Groen from the Netherlands, von Uexkull from Germany, and Collomb from Africa. The group drew up a constitution and began meeting every 2 years in different countries, with the usual funding problems. It did not limit itself to psychiatrists since it held that psychosomatic medicine and C-L psychiatry were “team” enterprises and wished to promote the objective of “spreading the word” to all who showed interest. Sequential presidents have represented Canada, Germany, Israel, Japan, United States, Spain, Australia, United Kingdom, Scotland, Sweden, and Portugal.

An interesting example of how at least one C-L program, somewhat serendipitously, began from international connections is that of Santo Tomas Hospital of the University of Panama (Sabonge et al. 1983). The chairman of the Department of Medicine, a gastroenterology specialist, developed a strong interest in the psychosocial aspects of his patients' complaints and illnesses. In 1976, he elected to spend a sabbatical year with Dr. Z.J. Lipowski at Dartmouth Medical School. On his return, he arranged the administrative structure and advocacy for a liaison program. Dr. Jaime Arroya, with an interest in preventive psychiatry and psychoanalysis, had completed a master's degree in public health at Johns Hopkins University. Dr. Rafael Sabonge trained in Peru with the famed psychosomatic specialist Dr. Carlos Seguin, and also completed residency training at University of Maryland where he participated in an active liaison program. With their various intellectual skills and international training, they organized an integrated psychiatric liaison service and general hospital department in Panama by 1975. Such random beginnings were not uncommon in some countries.

Like a bee cross-pollinating flowers, these early developments may have sown seeds in each other's countries through traveling scholars and exchange fellowships. Researchers like Alan Gregg, Rockefeller Foundation associates like Abraham Flexner, Theodore Lidz, John Romano and others benefitted greatly by their surveys of other countries to bring back ideas to incorporate in applicable models in the United States. James Strain has been a veritable ambassador of American C-L psychiatry around the world and, with Stanley Grossman, published one of the early volumes on the benefits of psychological care of the medically ill (Strain and Grossman 1975). Organizational, theoretical and clinical aspects were subsequently prodigiously written about by Lipowski throughout his lifetime (Lipowski 1986, 1988, 2002). The U.K. has been well-represented for decades (Tuke 1873; Mayou 1987).

Unquestionably, many others contributed to the corpus of knowledge that became psychosomatic medicine and consultation-liaison psychiatry; unfortunately, many reports not written in English had limited circulation. A number of journals in English with international readership and authors helped to overcome this handicap: *Psychosomatics*, *International Journal of Psychosomatic Research*, *Psychotherapy and Psychosomatics*, *International Journal of Psychiatry in Medicine*, *General Hospital Medicine*, *Journal of Psychosomatic Ob-Gyn* and *Journal of Psychooncology*. Other journals dealing with topics in health psychology and behavioral medicine added to the pool of resources.

1.5 American Psychosomatic “Diaspora”

Many hurdles have had to be surmounted to arrive at their current level of achievement. History of these special fields of endeavor is not monolithic. Such accomplishments must be accredited not only to social changes in institutional and clinical medicine, but also to the efforts of specific individuals whose interests and motivations have kept the “fires burning” even when they would seem on the verge of extinction. If not for early funding by the Rockefeller Foundation at the behest of

Dr. Alan Gregg, an internist who wished to see a more prosperous application of psychiatry to health care, as well as the Macy Foundation through its benefactress Katy Macy Ladd, C-L psychiatry might have been long delayed or perhaps completely non-existent. Fortunately, addressing many challenges, the integrationists have made much progress against heavy odds, persistently plodding the bumpy road to specialization (Lipsitt 2017).

Other unpredictable forces besides politics could determine the life or death of C-L programs: the chairperson of one's department, who might wish to husband scarce resources for other preferred programs; the receptivity of the hospital administrator and the chief of medicine (Lipsitt 2013); attitudes of one's colleagues toward psychiatry; external funding sources; decisions of insurance companies to reimburse or not services designated as "psycho" or "social"; changes in entire networks of providers of service through alphabetized programs like HMOs (health maintenance organizations), PPOs (preferred provider organizations), "managed care," "carve outs" and a medley of other vectors; endless controversy over what the clinical activity should be named; reversal of specialization designation by accrediting boards; debates over whether "liaison" should or should not be part of C-L, and so on.

Listing major contributors runs the risk of omitting some, but early contributors that come to mind include Maurice Levine, whose program at Cincinnati spawned a veritable diaspora of psychiatrists interested in facing the challenge of bringing medicine and psychiatry together, from which the latter had strayed in its fostering of asylums and alienists far removed from their communities and general medical institutions (Levine 1943). Progeny of Levine's program included a roster of leaders like Milton Rosenbaum, Morton Reiser, Herbert Weiner, John Romano and other pioneers in psychosomatic medicine. John Romano became chair at Rochester, Milton Rosenbaum became chair at Einstein, Morton Reiser became chair at Montefiore and then Yale. In earlier years, those who trained with Adolf Meyer at Johns Hopkins also became chairs of departments around the country. All of these individuals had a strong predilection to see psychiatry and psychoanalysis as heavily contributing to an integrated form of medicine. Franz Alexander, an émigré psychoanalyst from Europe, (with early Rockefeller funding) in his Chicago Institute, trained an impressive group of researchers in psychoanalytic psychosomatic medicine, which initially had a major impact on trends throughout the profession, but gradually diminished as its findings were questioned.

The salient impact of Adolph Meyer's commonsense psychiatry, with its focus on the whole person, for too long remained in the shadow of psychoanalysis. But many who trained under his tutelage, became prominent purveyors of a holistic approach that nourished consultation-liaison psychiatry. Dr. Eugene Meyer (no relation) became a forceful leader in Johns Hopkins' liaison program, (Meyer and Mendelson 1961) which in turn trained others to pursue professional interests in the integration of psychiatry and medicine.

Others can be assigned credit for resilience and persistence, much of which is quite serendipitous. As suggested, where one is trained and with whom has much to do with attitudes, practices and perspective on how psychiatry and medicine are married in health care. In the United States, one can observe an educational panorama wherein many trainees have adopted their teachers' orientation to medicine and psychiatry. Examples abound: coincidentally, several of the institutions

to which funds were funneled by Gregg in the 1930s to develop psychosomatic medicine are the very ones that contributed to a dispersion of psychosomatic and C-L psychiatrists.

Yale is especially of interest since its chairman before Reiser, Theodore Lidz, a student of Adolf Meyer, published an influential weighty tome in 1968 on *The Person: His (later, and Her) Development Throughout the Life Cycle* added importantly to a focus on the whole person as the rightful pursuit of medical students, trainees and practicing physicians. Wrote Lidz, "The good physician has always known that the majority of his patients come to him because of emotional difficulties...the physician is in a particularly difficult position. Patients come to him with physical complaints derived from emotional difficulties and problems in living of which the patient is unaware, which he seeks to banish from consciousness in order to retain his equanimity, but for which substitute physical symptoms appear."(p. xvi).

The Yale legacy persisted in 1980, following Engel's call for a more biopsychosocial model of practice (Engel 1977) in the properly entitled book "*The Patient: Biological, Psychological, and Social Dimensions of Medical Practice*," by Hoyle Leigh and Morton Reiser. In the interim, a book on "The Role of Psychiatry in Medical Education" by Sidney L. Werkman (1966) was graced with a foreword by Lidz beginning "The Conference on Psychiatry in Medical Education in 1951 marked the formal recognition by medical educators that psychiatry is not only a specialty but also a discipline with knowledge and skills basic to all branches of medicine" (p. xiii). Werkman's book, the result of surveys of European and domestic schools, with Lidz's encouragement, marked the beginning of psychiatry's enhanced place in the curricula of many medical schools and in general hospitals.

Another example of how the orientation of a department affects a whole legacy of trainees is the case at Colorado University, another institution that had its beginnings with an infusion of Rockefeller money. Franklin Ebaugh (1932) was the chair at a time when psychiatry's impact on medicine was a major endeavor. Ebaugh appointed Edward Billings in 1934 to direct a liaison service, the first in the country (Billings 1936, 1939). Other examples include the program of Grete Bibring at Boston's Beth Israel Hospital (Bibring 1956) and Stanley Cobb's innovative program at Massachusetts General Hospital (Cobb 1952).

Other changes that influenced psychosomatic medicine and C-L in the United States included the deinstitutionalization process in 1955, previously called for in Europe by Pinel and others; S. Weir Mitchell (1894) famously berated psychiatrists (alienists) for keeping patients in asylums and themselves isolated from the communities they should serve. Along with the explosive development of psychopharmacology and community mental health centers, general hospitals became more needy of psychiatric collaboration to care for patients released into their communities.

C-L and PM have always attracted those physicians and others with a professional objective of seeing psychologic and social disciplines more allied with medicine than has been the custom throughout history. In the United States, the field was fortunate to have Dr. James Eaton as Chief of the Psychiatric Education Branch of the National Institute of Mental Health, where, before

political pressure curtailed his work, he was able to pick up where Rockefeller and Macy money left off by funding and “Johnny-appleseeding:” many accredited C-L programs throughout the United States (including Puerto Rico).

Out of a *mélange* of interests and investigations has grown the corpus of knowledge referred to as “psychosomatic medicine.” Some observers aver that prior to medicine’s modern organizational structure, the care and treatment of patients by doctors (earlier by priests, barbers, and witch doctors) has always been “psychosomatic,” that is, treatment of the “whole person.” Credit advances in biological medicine, technology and establishment of specialization with, in the perception largely of psychiatrists and psychoanalysts, with sullyng of that holistic approach in ministering to the sick and suffering.

Why do I ponder these historical features of American psychiatry, psychoanalysis, and psychosomatics? Not to be provincial, as we are sometimes rightly accused, but to suggest that the beginning of psychosomatic medicine in 1939 with Flanders Dunbar (1935) and the definition of C-L psychiatry by Henry (1929) and Billings (1936) did not emerge full-blown but represented the accretion of concepts, knowledge and skills to create a model of medical care that had not existed previously. Principles of consultation and liaison laid down by those pioneers have not changed appreciably since their time. Henry wrote: “The staff of every general hospital should have a psychiatrist who would continue the instruction and organize the psychiatric work of interns and who would attend staff conferences so that there might be a mutual exchange of medical experience and a frank discussion of the most complicated cases” (p. 494). Less than a decade later, Billings described a liaison service as fulfilling several functions: (1) “to sensitize physicians and students to the opportunities offered to them by every patient, no matter what complaint or ailment was present, for the utilization of a common sense approach for the betterment of the patient’s condition, and for making that patient better fitted to handle the problems---somatic or personality---determined by both; (2) to establish psychobiology as an integral working part of the professional thinking of physicians and students of all branches of medicine; and (3) to instill in the minds of physicians and students the need the patient-public has for tangible and practical conceptions of personality and sociological functioning.”

The array of countries represented here very likely would subscribe to these tenets. They would also contradict the sometimes alleged insularity of PM and C-L psychiatry. It will, of course, be of interest to learn how some countries have dealt with their own obstacles: the politics, governmental support or the opposite, funding, institutional endorsement and receptivity, educational challenges, and so on.

1.6 Conclusion

As mentioned above, Wittkower was one of those who believed that, in time, psychosomatic medicine would extinguish itself by total acceptance into the broad stream of general medicine. A review of today’s successes would probably temper that prediction. In my presidential address at the 16th World Congress of the

International College of Psychosomatic Medicine in Sweden in 2001, the first such meeting of the twenty-first century, I said “I do not think, as Wittkower had worried, that we will ultimately be the cause of our own dissolution. Each new discovery brings with it more opportunities for further exploration into the complex interrelatedness of mind and body. But I do believe that we have to spend more time and creativity on how to encourage the application of biopsychosocial knowledge to the larger community of medical practice, the place where all science must be brought to bear on the health and well-being of the patient. Failure at this important link will leave our task incomplete.”(p. 15). The imagination, dedication, and creativity manifest in the reports in this volume attest to a vigorous and encouraging prospect for the new century.

My comment echoes Lipowski’s, who, in 1988, editorialized that “the task of linking closely mental and medical health care remains unfinished.” He does, however, acknowledge “how far we have overcome psychiatry’s isolation of the 19th century asylum era.” (p. 249, v. 29(3):249–253). Linking mental and medical health care: an unfinished task. It is certainly doubtful that he (or I) could have fantasied any “endpoint” to the process, but impressive progress clearly whets the appetite for even greater accomplishments.

Now, with this volume, there is reason for resurrected optimism. Each of the countries’ programs will reflect its own successes and failures, its unique cultural characteristics, and its ways of addressing funding problems and the like. But there is no question today that, as Wittkower stated in 1967, “psychosomatic medicine (and we would now add C-L psychiatry) has indeed gone a long way since the early thirties.”

As long as the world turns, the task will **always** remain unfinished. Progress around the world reacts to governments, politics, institutions, monetary systems, individuals and so many social factors that the future is always uncertain. Nevertheless, we can rejoice in the progress we have at hand and be hopeful that it will continue in the “right” direction. This compendium of international achievements portends bright prospects for the unending objective of integration of mental and medical health care in all its holistic richness.

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Part I
Major Trends in Psychosomatic Medicine
and Consultation-Liaison Psychiatry
in the World

Chapter 2

Psychosomatic Medicine in Ancient Greece: An Overview



Nikos Christodoulou

2.1 Introduction

“ἀπορίαν δ’ ἔχει καὶ τὰ πάθη τῆς ψυχῆς, πότερόν ἐστι πάντα κοινὰ καὶ τοῦ ἔχοντος ἢ ἔστι τι καὶ τῆς ψυχῆς ἴδιον αὐτῆς· τοῦτο γὰρ λαβεῖν μὲν ἀναγκαῖον, οὐ ῥάδιον δέ”. (Aristotle)

(A further question arises as to whether the passions of the psyche are always shared by the body that contains it, or if some are specific to the psyche itself. Understanding this is necessary, but not easy.)

As Aristotle humbly tells us, understanding the psyche-soma interaction is “... necessary, but not easy” (Gratsiatos 1911; Ierodiakonou 2011). Summarising comprehensively the contribution of Ancient Greece to psychosomatic medicine in a few pages is an equally challenging task. One of the reasons is that the ancient Greeks developed psychosomatic medicine in the same way as they developed most of their great achievements: They emerged not as a planned development but as part of a multi-disciplinary flurry of advancements of civilisation as a whole. Retrospectively that period seems to have yielded specific advances, however prospectively this journey must have seemed neither targeted nor structured, but rather germinal and nebulous.

A good example is that of Democritus: In his attempt to formulate a philosophical theory on the nature of the psyche, inadvertently he discovered the most pivotal idea for modern physics and chemistry – the atom, and at the same time set a paradigm for holistic psychosomatic medicine. This serendipitous pattern of multidisciplinary discovery is evident in many other ancient Greek achievements, in the fact that their inventors were not unidimensional scholars, but excelled and

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explored multiple areas of life. Just to name a few examples: Pythagoras, a mathematician, astronomer, physician, psychiatrist, musician, philosopher, and poet, among others, used harmonic music based on mathematics in group psychotherapy... Aristotle, a philosopher, teacher, biologist, logician... Thales a mathematician, astronomer, physicist, psychologist... Solon a politician, an expert in commerce, military, poetry, medicine... Aristophanes was a dramatist, a philosopher, a sociologist, who publicly tackled psychiatry, the relationship between psyche and soma and psychosomatic medicine in his plays. For example, in "Wasps" he describes treatment options for mental illness (Meineck 1998) and in "Clouds" he ridicules the notion of "pneuma", the mixture of blood and air thought to affect mental processes and cause mental illness if disproportionately composed (Roccatagliata 1986).

Another difficulty is the natural evolution of Greek language. The ancient Greeks not only introduced complex terms such as "psyche" and "soma", but meant them very differently at different times in the course of history. For instance, the "self" denoted by "psyche" was almost always meant as the emotional self rather than the rational self before the fifth century BC. This transition is evident in Sophocles' Oedipus Rex (first performed in 429 BC) where "psyche" and "soma" are used interchangeably to define the protagonist (Dodds 2004). The word "psyche" acquired very different meanings for Homer, Plato and Aristotle as it travelled through time. Homer differentiated between the "psyche" (a life-soul that animates the body), which had no specific seat in the body and had no psychological attributes, and other kinds of souls: "Thymos" was the emotive soul, residing in the chest and in particular the diaphragm (the "phrenes"). To complicate things, "phrenes" also meant "thought", while "nous" was the rational soul, apparent through thoughts, residing in the chest (Gundert 2002). 'Menos' was the impulsive soul, capable of rage (Tzeferakos and Douzenis 2014). For Plato, the psyche broadly preserved these three functions, but in the context of a tripartite soul, composed of the "logistikon", the "thymoeides", and the "epithymetikon" (Plato 381_BC). For Aristotle the actuality of the soma is linked to the potentiality of the psyche, and the soul is not an exclusive characteristic of humans. The natural evolution of abstract notions such as "psyche" has been enhanced even further by use of the term in varied situations, ranging from direct communication in daily life to use in Tragedy (Webster 1957).

Last but certainly not least, a major difficulty in summing up Psychosomatic Medicine in Ancient Greece is that it coincides with one of the most important philosophical questions: *Soma and Psyche*. As Democritus and Epicurus put it, what Medicine does for the body, Philosophy does for the soul (Yapijakis 2009; Dimou 1987; Rigatos and Scarlos 1987). Therefore, a decent summary of that era can only compose of a salient amalgam of both Medicine and Philosophy (Pigeaud 1981; Christodoulou et al. 2011).

2.2 Mythical and Divine Psychosomatic Medicine

Ancient Greek myths are more than stories; they are a sophisticated narrative record of the history of civilisation. A myth of importance for psychosomatic medicine is that of Melampus, the legendary healer who is a pivotal character for Psychiatry. In one of his adventures, Melampus was called to help Iphiclus, son of King Phylacus of Thessaly, who was suffering with a kind of impotence. Melampus accepted and began his treatment by offering two sacrificial bulls to the Gods. Using his ability to understand the language of animals, Melampus heard the summoned vultures recount a story whereby as a youngster, Iphiclus watched his father sacrifice an ox to the Gods, and was traumatised by the sight of the bloody knife in his father's hand. King Phylacus subsequently stuck the knife, still bloody, on the bark of a pear tree, which eventually with time encompassed the knife. The vultures went on to suggest that, if a potion was made using the blade's rust, and was given to Iphiclus, his impotence would be cured. Iphiclus took the medicine for 10 days and eventually had a son, called Podacres. Beyond the obvious psychodynamic allegory and the evident psychosomatic thinking that come across so naturally as if taken as granted by ancient Greeks, this beautiful myth serves as an allegory for the passage of Medicine from an age of magic to an age of reason.

Yet, the magical coexisted with the rational in Ancient Greece, as they catered for different and complementary needs. Temples to gods with healing powers, notably Asklepios, offered psychiatric services throughout antiquity. An indication for the extent of sacred Psychiatry comes from the story of Aelius Aristides, an orator and hypochondriac who visited numerous temples across the Mediterranean, while seeking treatment for his various ailments through incubation (the practice of sleeping in the temple, in the hope of receiving divine treatment or a divine dream, which was then interpreted), and other methods (Israelowich 2012; Wallace and Gach 2010).

2.3 The Philosophers of Nature (Physikoi)

In the sixth century BC the Philosophers of Nature moved away from a theocentric perspective and theorised a largely biological model of mental illness, employing materialistic approaches to negotiate the physical and mental worlds. By examining the basic science, they attempted to explain mental phenomena by identifying elementary components of the soul. Their reductionism later attracted criticism for being too simplistic, but the fact remains that for Psychosomatic Medicine this was the pivotal point where mental phenomena were linked to physical phenomena. A basic approach suggested that an imbalance in the various elements of the body (water, air, earth and fire), and their state (hot-cold, dry-humid) results in various symptoms. The latter depended on the various combinations of elements and their states, resulting in a diagnostic schema akin to today's dimensional diagnosis. Those

elements, their combinations and their qualities extended to define mental disorders, personalities and their manifestations.

Thales of Miletus (c.624–c.546 BC) was instrumental in suggesting that psychic phenomena were physical in nature, and not mystical. According to Thales, water was the primordial substance of life, the various states of which caused epiphenomena, including psychological ones. He thought that matter was everything, and that it changes in mental illness. Beyond this very basic of psychosomatic principles, he has left the famous inscription “Know Thyself” in Delphi, a precious outcome of any psychotherapy. He was also the first to give us an advanced and sophisticated roadmap for mental health promotion and resilience, in the context of a simple but meaningful definition of happiness:

Τις ευδαίμων; Ο το μὲν σώμα υγιής, τὴν δὲ ψυχὴν εὐπόρος, τὴν δὲ φύσιν εὐπαιδευτός.
(Thales)

(Who is happy? He who has a healthy body, a resourceful soul, and a well-trained nature)

Anaximander (610–550 BC) suggested that there is a dynamic homeostasis between opposites (unification-separation, hot-cold, love-hate). Biological function stemmed from a single, indestructible base (soul), and the onward implications of his thoughts would be that an imbalance of the soul’s homeostasis would result in symptoms. A similar view was held later by Heraclitus of Ephesus (535–470 BC), who implied that psychological balance is not only biological in nature, but also based on harmony between opposite elements in the soul. Zeno of Elea (490–420 BC) thought that the soul is balanced when its physical qualities are balanced. Anaximenes (600–530 BC) considered the nature of the soul to be air, and that the soul has the ability to hold the body together, which implies that a disruption of the soul could have effects on the body. The idea of various iterations of air being involved in mental life later gave rise to the notion of “pneuma” – the substance of mental life.

Pythagoras of Samos (570–500 BC) was a unique, plethoric scholar who – among an array of achievements – employed a rich mix of mathematics, music, philosophy and medicine, to explore and treat psychopathology. He believed that the mental state was governed by the degree of harmony between opposites (e.g. actions, energies, properties). Pathology emerged from disequilibrium between those opposites (e.g. sleep/wakefulness, euphoria/depression, good/bad). He believed in a tripartite soul, of which the first two parts (reason and intelligence) resided in the brain and the third part (impulses) was somatic in origin. He expressed an encephalocentric theory suggesting that rational mind sat in the brain, irrational/impulsive sat in the heart. He considered feelings to be able to disturb the normal functions of the organism. He employed group psychotherapy, music therapy, physical exercise and certain medicines, attempting to control bodily functions with reason.

Alcmaeon (550–485 BC) used scientific methods to posit that the central nervous system was the site of mental activity. Anaxagoras (500–428 BC) emphasised a psychosomatic approach through a biological paradigm. The psyche and the soma were distinct, but affected each other. He suggested that organic tissue was built of

small blocks of matter, called homeomerics or homoiomerics (in fact, the term is likely Aristotelian, and came to be applied retrospectively to Anaxagoras' concept). The mind (*nous*) was constructing reason by organising sensory data. The nerves consisted of homeomerics and ethereal substance. Therefore disorganisation of homeomerics could result in biological nervous anomalies, which in turn could cause mental illness. Diogenes of Apollonia (490–420 BC) formulated the notion of “*pneuma*”, a mixture of air and blood which affected vital functions, including mental ones, resulting in mental illness. This biological, psychosomatic formulation affected subsequent thought, including that of Praxagoras and Hippocrates (Roccatagliata 1986; Rigatos and Scarlos 1987; Mitropoulos 1963; Desclos and Fortenbaugh 2011).

2.4 Atomism

Atomism was a revolutionary theory initially implied by Anaxagoras' homeomerics, later developed by Leucippus in the fifth BC, and was brought further together by his pupil, Democritus (c460–c370 BC). It was elaborated even further and more directly involving psychiatry by Epicurus in the fourth-third century BC and Asclepiades of Prusa in the second-first century BC. Atomism advocated that the body and the soul are made of atoms – i.e. infinitely small particles. There is no structural difference between body, mind and soul. They are all made of atoms but different densities, speed and other characteristics identify them further. The body was driven by the soul. Mental functions resulted from the motion of atoms in the canalicular structure of the brain, and disordered motion resulted in psychiatric phenomenology. For example, delirium was the result of disorder of the motion of atoms. Although Democritus and the other atomists proposed a deeply biological psychosomatic model, he did accept that this model could not “attain profound truth” and that “gradual training produces a second nature” (Roccatagliata 1986; Rigatos and Scarlos 1987).

2.5 Plato

Plato (427–348 BC) offers few, but decisive references for Psychosomatic Medicine, especially in “*Charmides*”, but also in “*Phaedros*”. In “*Charmides*”, Plato recounts Socrates' dialogue with Charmides, a young man who is afflicted by a persistent headache. Socrates has a leaf which can cure the headache, but informs Charmides that the leaf will work only if accompanied by a “spell”. He then goes on to quote the Thracian King Zalmoxis, who believed that the body cannot be cured without curing the soul in the same way that the eyes may not be cured without curing the head, and the head may not be cured without curing the whole body. Plato's *Charmides* raises two points: Firstly, physical treatment for an illness may only be

effective if accompanied by the right words. Secondly, curing the part depends on curing the whole, and curing the whole includes curing the soul (Plato 380_BC).

“... ἄνευ δὲ τῆς ἐπωδῆς οὐδὲν ὄφελος εἴη τοῦ φύλλου.” (Plato)

(... without the spell, the leaf will offer no benefit.)

A pivotal point from Charmides is the synopsis of the two basic concepts of psychosomatic medicine: psychogenesis and holism (Christodoulou 1987). In “Timaeus”, Plato explores conditions of the soul, including those that arise from the body (Plato 360_BC). In “Phaedros”, Plato suggests that Medicine should not just be a mechanical and empiric exercise of offering medicines against diseases, but rather an Art. He suggests that the Art of healing requires the examination of both the body and the soul and goes on to suggest that, in the same way as medicines treat the body, the soul is cured through words (Plato 370_BC).

Prior to Plato, Solon (640–558 BC) in one of his poems suggested that different patients react differently to therapies and implies that any therapy’s effectiveness depends on the healer. Rigatos and Scarlos (Rigatos and Scarlos 1987) observed parallels of Solon’s with Balint’s views.

2.6 Hippocrates

Hippocrates (460–370 BC), one of the greatest physicians of all time, introduced a biological paradigm, which involved neurocentrism and humorism. This paradigm was inspired by both scientific and philosophical advances - Pythagoras’ and Embedocles’ work, among others (Davison 2006). It considered the brain as the centre of mental life and an imbalance of the humors as the medium leading to mental illness. Two prime examples of this approach were epilepsy and melancholy. Epilepsy (the “sacred disease”) was caused by a complex alteration of humoral metabolism in the brain, and not a divine cause, as was thought previously. Melancholy was brought about by excess black bile, which was produced in the gall bladder (in Greek, melancholy is a composite word: μέλαινα (melaena) = black + χολή (chole) = bile). Similarly though, he explored the idea of epilepsy being a brain disease as opposed to melancholy being a disease of the mind, and observed that in many patients the presence of one coincided with the absence of the other. Further, he postulated that soma and psyche are integrated and held together by a balanced metabolism of humors. This meant that imbalances in the body’s humors could result in mental disorder. He was also holistic in this approach; traumatic events, toxic states and hereditary factors could also disrupt the humoral equilibrium.

Hippocrates, in his “ΚΩΑΚΑΙ ΠΡΟΓΝΩΣΙΕΣ” (Coacae Praenotiones), describes lethargy, delirium, headaches, paralysis, hypochondria and hysteria (Jonstonus 1660). In several scattered points throughout his extensive work he

makes reference to anxiety, sadness and fear directly causing or exacerbating pains in various areas (e.g. the abdomen and the praecordium) or even diffuse pains.

“How the body behaves; when a mill grinds the teeth are set on edge; the legs shake when one walks beside a precipice; the hands shake when one lifts a load that one should not lift; the sudden sight of a snake causes pallor. Fears, shame, pain, pleasure, passion and so forth: to each of these the appropriate member of the body responds by its action. Instances are sweats, palpitation of the heart and so forth.” (Hippocrates) (trans. Jones 1923)

According to Hippocrates, the brain secreted substances that were delivered to the rest of the body by the blood. He also noted that emotions can have a noticeable effect on the body. He placed the site of mental life and disorder at the brain and supported that the humors (which are produced in various parts of the body) can affect the metabolic balance of the brain, thus generating mental symptoms. He described several clinical phenomena conforming to this schema, including what today we would call delirium, organic hallucinations, anxiety, seizures, delirium tremens... (Roccatagliata 1986; Yapijakis 2009; Wright and Potter 2002; Kleisiaris et al. 2014).

2.7 The Dogmatic School

The Dogmatic School followed Hippocrates' death, and was run by his sons (Thessalus and Dracon) and son-in-law (Polybus). The Dogmatic School was called so because it subscribed to the traditional Hippocratic principles. It supported the scientific exploration of mechanisms of disease and attempted to link scientific theories with clinical observation. Among others, it supported the use of physiotherapy (exercise, baths, diets, rubs etc) as psychological therapies. It suggested that the humors are not pathogenic, but their stagnation was. So when humoral metabolism slowed down, humors accumulated, forming toxic substances which caused mental symptoms. Also, observing that fever can affect the mental state, they suggested that excess heat may cause the soul's humors to heat up and cause mental symptoms.

Among the dogmatics, Diocles of Carystus (375–295 BC) made a notable contribution to psychosomatic medicine. He separately described hypochondriacal (or *flatuous*) melancholy, as an autonomous “psychosis” within depression: Toxic substances form due to stasis of black bile during gastric digestion, which through the blood stream alter the soul, bringing about mental symptoms. He also described the effect of hyperventilation on epileptic seizures, described catatonia in relation to muscular contractions and studied delirium.

Philotimus was another dogmatic who studied neurastheny and laxitudo, which he associated with fear and sadness. He described the frequency of what we would call somatoform symptoms in depressed patients and linked depression with “insomnia, diminution of mental activity, palpitations, vertigo”. He described cenesthopathy as “light head, arid, as though nothing exists” in depression. He

thought that presentations like catatonia, melancholy, delirium, and hysterical suffocation (probably the equivalent of panic attacks) are due to the effect of gastric toxic aerial substances on the heart, and the disruption of pneuma. Other dogmatic physicians of the time included Praxagoras of Kos, who studied the pulse in mental illness, believing it was an index of pneuma. He categorised the kinds of acute organic febrile psychoses and seizures. Philagrius and Aspasia (a midwife) studied hysterical disturbances. Aspasia categorised hysteria into three groups: attacks of suffocation, attacks of stupor, and convulsive manifestations (Roccatagliata 1986; Rufus 2008).

2.8 Aristotle

Aristotle's (384–322 BC) views on the mind-body question are impressively relevant to psychiatry today, and in particular for the psychosomatic perspective. Ierodiakonou (Ierodiakonou 2011) points out the humility with which Aristotle accepts the necessity to understand the relationship of soma and psyche, but also his acceptance of the challenge involved, and eventually his adoption of uncertainty. He expressed the view that the soul manifests through certain vital properties of the body, therefore plants and animals have souls as long as their bodies demonstrate these properties. For instance, the ability of some plants and animals to regrow stems or limbs after they are severed was such a property (Gratsiatos 1911). Aristotle uses an empiric and scientific demonstration of a psychosomatic paradigm, in which the soul encompasses, and may actualise the potential form/function of the body. The soul has the capacity to animate matter and is the reason for animate behaviour, but is neither autonomous nor deterministic (as it needs the specific body in order to exist and to actualise its potential). This idea resonates with Aristotelian Entelechy.

Aristotle believed that the soul is capable of affecting the body. He also suggested that the reverse is much more complicated. At one point he refers to the soul as something that can cause motion, but can not be moved (... *ὥστε οὐ τὸ κινεῖν καὶ κινούμενον ἢ ψυχὴ, ἀλλὰ τὸ κινεῖν μόνου*) (Gratsiatos 1911). A necessary note here, is that for Aristotle the term *kinesis* (*κίνησις*), meant more broadly “capacitate” rather than simply “move”, therefore it is likely that the soul has a commanding effect on the body (just like with entelechy) while the body's role is confined to sending stimuli which may trigger thoughts and feelings. The soul can also initiate the latter, through stimulating itself by recollecting memories. Aristotle explored this paradigm extensively, taking examples of human experiences (like anger, love, fear etc) to manifest the psyche-soma interaction.

Practically, Aristotle was an advocate of a person-centred, holistic Medicine. He emphasises that Medicine is not just the Art of knowing what medication to prescribe, but of how to strike the right balance and how to choose the right moment. Aristotle's approach describes an ethos of great importance for psychosomatic theory and practice (Novak 1987).

2.9 The Hellenistic Era: Sceptics, Stoics, and More Atomists

The rise and fall of Alexander the Great and the break-up of the Macedonian Empire into its Hellenistic Kingdoms marked the beginning of a turbulent era for Greece, which saw much scientific activity move to Alexandria, Rome and the Greek colonies. The prevalent philosophical direction at that time was that all psyche was soma, but not all soma was psyche.

Aristotle was succeeded as Head of the Peripatetic School by his friend Theophrastus of Eresus (370–286 BC). Theophrastus expanded Aristotle's system and contributed with many original works relevant to Psychosomatic Medicine, like "On Asthenia", "On Paralyzes", "On Alcoholism", "On Vertigos". Theophrastus considered neurasthenia to compose of "unpleasant sensations in the body, tiredness and depression with a chronic course" (Millon 2004).

Stoicism (founded by Zeno of Citium in 300 BC in Athens) had a psychodynamic vista on mental illness, for which interpersonal relationships and emotions were instrumental. The Stoics had a cardiocentric theory on the psyche, which they thought was affected by emotions, and in turn it affected the soma. The psyche formed a link with the various organs of the body, as was evident from disorders of the psyche which manifested themselves in the soma. These diseases were called affections and were distinguished from physical illnesses (Roccatagliata 1986).

Epicurus (c.341–270 BC) was an atomist who theorised that psyche is soma, and exists dispersed in soma, but constituted of a more intricate (*leptomeres*) atomic matter to the rest of the body. Therefore the psyche can act and be acted upon, but in a different way to the rest of the body. The psyche is most responsible for sentience (*aisthesis*), but only because it is part of the body, with which it has a vital interaction. Therefore there is an integral structural and functional connection between the psyche and the soma, which means that disturbance in the soma can affect the psyche and vice versa (Wright and Potter 2002).

Another atomist, Asclepiades of Prusa (c124–40 BC), applied atomism to psychiatry and tried to explain with it a range of psychiatric presentations, including delirium, hallucinations, phrenitis and catatonia. He thought that mental illnesses were essentially but superficial manifestations of a single underlying pathology (*stasis*), which is ultimately organic. He tried combinations of psychotherapy, music therapy and physical treatments to treat mental illnesses, and was a great advocate for the importance of the therapeutic relationship, which is so central in clinical practice particularly in Psychosomatic Medicine (Roccatagliata 1986; Yapijakis 2009; Gumpert 1794).

The Alexandrine School of Herophilus of Calcedonia (c.330–250 BC) and Erasistratus of Ioulis (c.304–250 BC) combined dogmatism and previous thoughts with empiricism. These two physicians are credited for being the first neuroanatomists and were first to describe the nervous system, directly bringing into question prevalent theories at the time. Herophilus first set the foundations of neuroanatomy and physiology and Erasistratus proceeded to compose a psychosomatic theory whereby the psyche resides everywhere in the body by means of distribution through

the nerves, arteries and veins (the *triplokia*). The nerves have the ability to both receive messages from the periphery and transfer to the brain (to the ruling part of the psyche), and to transmit executive messages from the brain to the periphery. Erasistratus also formulated a biological model whereby excessive blood in the brain irritated the meninges, leading to mental symptoms (Roccatagliata 1986; Wright and Potter 2002).

The empiric approach to psychiatry proposed phenomenology as paramount, and therapy was aimed at symptoms. This conceptually presented a polemic against the quest for a psychosomatic aetiological theory, but in practice physicians of the time used empiricism to describe organic mental illnesses and find treatments (pharmacological and otherwise) for them. For instance, Nicias Milesius and Andreas of Carystos investigated encephalitis and sought treatments for acute organic psychoses, Eudemus described delirium tremens and differentiated it from melancholy, Apolonius described psychic disturbances related to cephalaea and trigeminal neuralgia, Demetrius of Apamea researched organic mania and various spasms (Roccatagliata 1986).

2.10 Early Roman Era

Among the many physicians following the end of the Hellenistic period, a notable one is another physician from Apamea, Archigenes (54–117 AD). He was a versatile clinician and scholar, whose contribution ranges from toothpastes and deodorants to psychiatry. In terms of Psychosomatic Medicine, he described the management for delirium (which he considered a secondary effect of the action of toxic metabolites on the body, like a “shadow of the primary disease”). He commented on the management of resistant (psychogenic) headache, and implied the “unknown effect” therapists have when placebo amulets are prescribed: “...*those who have experience with them, who say that they are efficacious because of some unknown effect on diseases...*”. He had a cardiocentric theory and studied the pulse in many psychiatric illnesses including hypochondria and asthenia. He also observed an association between mental syndromes and gastrointestinal dysfunction.

Soranus of Ephesus (98–138 AD) was an influential Greek physician who contributed vastly to Psychiatry, particularly by advocating for the humane and respectful treatment of the mentally ill. He had a psychosomatic theory which employed atomism and supported that psychic functioning depended on the harmonic equilibrium of leptomeres. If leptomeres accumulated due to slow clearance or due to narrowing of the canaliculi, then hysteria or delirium could occur. Mania was also ultimately an organic disturbance. The leptomeres was disturbed in response to fear, anxiety or anger, thus leading to mania. Themison of Laodicea (31 BC–14 AD) was a pupil of Asclepiades and a controversial figure whose practices attracted Soranus’ criticism. However, he is of interest for Psychosomatic Medicine because he described a case series of patients who developed hysterical reactions following dog bites. Apparently, Themison himself must have suffered a panic attack in response to writing on the same subject (Roccatagliata 1986; Pioreschi 2003).

Galen (130–210 AD) was a great Greek physician from Pergamon, who mostly lived and practiced in Rome. For Galen there is essentially no distinction between the mental and the physical. Galen's approach to the nature of the psyche and the psyche-soma interaction is strongly Platonic: He adopts the tripartite soul – the rational (logistikon), the spirited (thumoeides) and the desiderative (epithumētikon). He combined his Platonic influence of the tripartite soul with influences from Herophilus and Erasistratus, and in particular the description of the nervous system and the function of the brain, to arrive at the conclusion of his three respective “archai” and their respective connections, i.e. the nerves, arteries and veins. At the same time he maintained humorism. (Hankinson 1991).

Clinically, Galen observed various instances where physical states and emotional states correlated. Specifically, he described various physical health issues presenting with mental symptoms and explored the mental effects of alcohol. He concluded based on these observations that, since the mortal soul is affected by physical states, it must be an integral part of the body as a whole, as opposed to a separate entity. He went even further to suggest that body and soul may share the same composition. He was not however certain as to whether the logistikon was also mortal and therefore of bodily composition (Singer 2016).

2.11 Conclusion

The birth and early development of Psychosomatic Medicine in Ancient Greece was an integral part of the development of Medicine as a whole, and formative towards major theories of Medicine such as humorism, which influenced medical thinking for 2500 years. Its greatest legacy, however, is educational. Fundamental concepts like the therapeutic relationship, the scientific method, holism and the psyche-soma cross-talk, if taught skilfully through the paradigm of Ancient Greek Psychosomatic Medicine, may benefit many more generations of physicians.

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Chapter 3

History of Psychosomatic Medicine As Scientifically-Based Medicine in Europe: Approaching the Experience



Wolfram Dieter Schüffel

Not only some but all of what is essential from childhood has been retained in these memories (of the adults)”; Freud, XII:148

3.1 Introduction: A New Phenomenological Approach

The four key concepts in the title are *psychosomatic medicine*, *scientific*, *Europe*, *new approach*. To these, three more can be added: the author’s identity, his place of residence, the name of the editor. My reason for this is that each of these key concepts illustrates my intention to stress particular perspectives:

The work of psychosomatic medicine is concerned with the *relationship* of two people. The relationship as an integral part of psychosomatic medicine therefore becomes *the subject of scientific research*. The term Europe is geopolitical and cultural and the use of it here indicates the author’s intention to consider Germany as a power within Central Europe in relation to other European countries and vice versa. In this context, “new phenomenological” is a reference to the last “*one hundred years*”. As the author and as a man, a specialist in internal medicine and a psychotherapist, and also as a German, I must consider my *own* perspectives. Marburg, my place of residence in Germany is regarded as a place of historical importance, and the discussion of its particular geopolitical circumstances can therefore serve as an example for the whole. The editor is a US American physician and academic whose main focus is the USA, but who also promotes a global intercultural perspective. That sums up the network that underpins this article.

My approach focuses on the symptom and I follow its thread throughout the text. The symptom becomes clear by means of a *group work* (explained below).

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This illustrates how the history of psychosomatics is embedded in the history of European identity.

This group work was developed in various parts of the world by students, citizens, medical experts. Over a period of ten years, it was thoroughly checked and revised at least once a year in co-operation with Theo Leydenbach/Paris and Makoto Hashizume/Osaka (Schüffel, Leydenbach, and Hashizume 2015). The result is a reliable working model for group work that facilitates transcultural practice. The following approaches are based on this empirical method for the observation of clinical phenomena.

The group work described here begins with the peer groups on history taking (known as *peegrohits* for short), continues with basic psychosomatic care, is included in the Wartburg Dialogues and finally appears in the Moving Seminar (MOSE) (Schüffel, Leydenbach, and Hashizume 2019).

Each of these groups has its own main focus, but, at the same time, is a part of the whole main group. In the peer groups on history taking, the focus is on a primordial experience of sensations and feelings. In the basic psychosomatic care groups, doctors of all ages discuss “at any time” in their professional life both their sensations and their feelings. The Wartburg Dialogues, that take place once a year, focus on the meeting of the “*Utopians*” of two bourgeois camps. The utopians are a group composed of lay citizens, physicians and medical staff. Finally, in the health group, the focus is on the exchange between generations, that is the twenty-year-olds and those over seventy.

The *aim* of every exchange in each of the four groups is to take the next step towards health on the basis of the primary symptom. Thus the symptom becomes the *leitmotiv*. Typically, this means “how do I stay healthy in this week, in this month, in this semester and in this year, from Wartburg Dialogue to Wartburg Dialogue?”

My interview on the subject of these four groups can be accessed on my home page in both English and German (www.schueffel.eu).

As a doctor, my perceptions start in the NOW (here). This is not identical with the present. I experience the immediate and react affectively, always seeing it as a whole, in relation to the past, present and future. From this standpoint I see seven horizons, that I will term perspectives or horizons as follows:

1. the emerging reality
2. the stage
3. the context
4. the background
5. the rhythm
6. democracy
7. culture

This is a phenomenological approach for which I am indebted to the American phenomenologist Donn Welton (2003, 2012). I should like to emphasize my gratitude to Donn Welton for his invaluable support over the years. However, he is in no way responsible for the above list of perspectives, or “*horizons*”, to use his terminology. The first four horizons are his, and the three I have added are horizons I have come to value in the course of my work. I am writing here on the basis of my own

experience of the development of psychosomatics in Europe. I am well aware that there can be no ONE single history of psychosomatics in Europe but rather a history of one author and his life experiences. It is clear to me that I see the central focus of each of the seven perspectives as the relationship of two people in a medical situation determined by reality and fantasy. It has a voice and is thus verbalized. I make use of these perspectives when I want to examine them in time, so looking back at the past, looking at the present and looking into the future.

I try to look at them in terms of the NOW (here): the past as an apparently completed time in terms of the NOW (here), the ongoing present, acting and perceiving in terms of the NOW (here), and the apparent future in terms of the NOW (here). Psychosomatic Medicine is a product resulting from generational interchange (see sequence of generations).

Psychosomatic medicine originated in the German-speaking regions. In this European version, it then spread from Europe to other parts of the world. As a result, the focus here is mainly on the German-speaking regions, but always in relation to their neighbors. Rivers are seen as real and metaphorical bridges to these neighbors as well as the facilitators of invasions. Rivers are also representations, as for instance, we say “the river of life”, a formulation used by Antonovsky (1987). Our vision of the Mississippi is very different from our vision of the Hudson.

3.2 The Emerging Reality: The Proscenium

Seen from above, Europe could be described as a land of three rivers with Germany at the centre. The three rivers that flow through this central country are the Elbe, that flows north, the Rhine, that flows west, and the Danube that flows east. This is how I perceive the geography of the area, something I have in common with many Germans, even though it does not correspond to geographical fact. On the Elbe are the cities of Dresden, Magdeburg and Hamburg at the mouth of the Elbe that I perceive as “opposite” London. The Rhine flows through the French town of Strasbourg, with its French and German-speaking population, Speyer, Worms (ref. Luther), Mannheim, Ludwigshafen, Cologne and then it flows through the Netherlands and the Rhine-Meuse-Scheldte Delta to the North Sea. The Danube flows through the German towns of Ulm, Regensburg, Passau and beyond the German border through Vienna, Budapest, Belgrade until it reaches the delta town of Odessa, on the Black Sea.

Over millennia, myths and legends arose in these regions and were passed on from generation to generation. In the Elbe region, it is the giant Rübzahl in the Riesengebirge (Sudeten Mountains) where the Elbe rises. In the Rhine region it is the Loreley and the treasure of the Nibelungs together with its guardians. In the Danube regions, it is its source in the mysterious Blautopf (the Blue Pot, a subsurface font), and the Schneider von Ulm (the tailor of Ulm) who was the first German to show that humans can fly. There are many more stories from around the rivers, for instance those collected from regions east of the Rhine by the brothers Grimm in Grimm’s Fairy Tales. What is interesting to note is that not one of their fairy tales refers in any way to these mythical figures. The people who lived in these river

regions developed connections through shared customs on the one hand, and on the other hand through the language of these myths and legends. In addition, there were the important elements of painting and music: the painters Caspar David Friedrich (1774–1840) and Gerhard Richter from the eastern regions of Germany, and the composer Richard Wagner (1813–1883) from both eastern and western Germany, to name just a few. I will make various references to painting later. As a psychosomatic physician, I listen to patients' stories about how they experience their daily life at work and in their free time. I hear how they maintain health on the one hand or develop illnesses on the other. They tell me in whose presence they have these experiences. Thus, I regularly encounter people from various river regions, metaphorically speaking. My preference is to hear these stories from patients within the groups whose members come from various different regions of Germany. This process is particularly fruitful when the region I am working in has a special historical significance. Great rivers do not only support communities, they also offer enemies a means for invasion. Germany has experienced the latter over the centuries and this will form one of the focal points of this paper.

I myself live and work in Marburg, in a tributary valley of the Rhine. The River Lahn flows through this valley, and primarily through the Federal State of Hesse. "Marburg an der Lahn" is historically significant, because its eastern borders are with the Federal state of Thüringen, where the Wartburg, the residence of Elisabeth (1207–1231), is situated. She was the daughter of a Hungarian king who married the Thüringian territorial lord, and, after his death in the crusades, moved from the Wartburg to Marburg. Here she performed many miracles healing the sick. She was beatified when she was in Marburg, the town that in the Middle Ages became one of the principal places of pilgrimage in Europe, comparable to Santiago de Compostela today. In St Elisabeth's honor, the cathedral, the Elisabethkirche, was built in Marburg. It is one of the most beautiful early gothic buildings east of the Rhine (Fig. 3.1).

Drawn by Peter Hahn of Heidelberg in 1951 Peter Hahn of Heidelberg is Professor em. of Psychosomatic Medicine and Psychotherapy, eminent researcher, educationalist and most of all a dedicated physician (Hahn 1976, 1988; Hahn et al.

Fig. 3.1 Elisabeth Church, Marburg, drawn by Peter Hahn of Heidelberg, 1951



1988). He drew the picture when he was a first year student of medicine. This was six years after a devastating war. The church is one of two masterpieces of early Gothic architecture in Germany and it was one of the very few churches in Germany to overcome the war undamaged.

On the hill opposite this cathedral and level with the top of its towers is the Marburg castle, or rather fortress. In 1529 it was the scene of the famous Religious Colloquy (Carrasco and Neebe 2015) in which the most important continental European reformers took part, amongst them Luther, Zwingli and Melancthon.

I will discuss the Colloquy briefly here, and in more detail in the next section because what happened in this town and in this region was a culmination of events that had a lasting influence on German-speaking central Europe and subsequently on wider parts of Europe over centuries:

- Luther (1483–1546) published in 1517 his theses that were ultimately to lead to separation from Rome and reformation of the church
- Luther in the following years (up to 1535) was *responsible* both for unifying the German language and thus beginning its standardization.

Luther's most important political support came from Philipp the Magnanimous in Hesse and from the Elector Friedrich III, the Wise (1463–1525), in Saxony. Both were representatives of a broad and influential Protestant, geopolitical belt that even today stretches from Dresden to Strasbourg, where there is a street named after Martin Luther. To this day, people in Balint groups, medical discussion groups and the Moving Seminar, talk about how Luther came back from the Reichstag (Diet) in Worms in 1521, was arrested near Kassel, not far from the present Autobahn A3, lived in the Wartburg as Junker Jörg, and translated the New Testament into German. Even today, I hear this from participants in the Balint groups and in stories told in the region where this tradition lives on.

The history of this region is reflected in a remarkable way in the history of a 57-year-old general practitioner (Dr. E.) who was an active participant in the Wartburg Dialogues (see Schüffel, www.schueffel.eu) that we founded in 1992 in the Wartburg itself, hence the name (Schüffel 2012). Originally they were founded under the aegis of the former German Foreign Minister, Hans Dietrich Genscher, who himself came from Halle, which is near the Wartburg. When this colleague was on his way to the 22nd Wartburg Dialogue in 2014, he was held up in a traffic jam on the A3 autobahn between Marburg and Frankfurt. He suffered sciatic pain in his right leg that made both braking and accelerating equally painful and the pain went down into his right foot. He decided to discuss this with me and a plenary of 50 participants. While I palpated his leg and within the framework of salutogenesis, so in terms of using personal resources and experiences, we discussed what meaning the symptoms had and how the sufferer could deal with them effectively,

In the supportive and empathetic atmosphere of the fifty participants, he was able to talk about how the symptoms had been with him for 52 years of his life. He associated them with the pitying look on his mother's face when she took him to kindergarten and he came back home in tears for a whole week, because he did not want to be separated from her. This small boy's tears were a *sign* to the mother that she

should give up her secretarial post and stay at home. Seven years later, when the boy was eleven and *had to* attend high school, there was a further dramatic development in the close relationship between mother and son when the boy developed physical symptoms, but this time without tears. He came home one day with his body twisted to one side, something that only his grandmother noticed. He had not shed tears or complained of any pain. With the help of a plaster cast, he was “made” straight and he remained so for the next two decades. When he was 32 there was a decompensation because of an unresolvable conflict (www.schueffel.eu) and he had to undergo an operation. Subsequently, Dr. E. became increasingly aware of his own resources and performed, amongst other things, Thai Chi and meditation and also took up running. At the same time, he attended our sessions “basic psychosomatic care” in Bad Nauheim (Hessen). This program had been introduced in West Germany in 1988 and there after, the fall of Berlin Wall in the whole of Germany. This program is compulsory for all general practitioners and gynecological specialists in Germany. Dr. E also introduced a quality circle of “basic psychosomatic care” at his place of work. He has been attending the Wartburg Dialogues for about 15 years in order to boost his skills as a psychosomatic general practitioner and family doctor. I will refer to this in more detail in the sections “Democracy” and “Culture”.

This “psychosomatic” approach helped Dr. E., during the 40-minute health discussion in Nauheim in 2014, to call to mind his own varied resources. His pain improved very suddenly while I was palpating his leg and we were talking about the places he grew up in – Mannheim and Ludwigshafen am Rhein – and about how he imagined his grandfather who died early and whom he had never seen. When he realized that his pain had vanished, he turned a joyful somersault. About 15 of the 50 participants in this 22nd Wartburg Dialogue did the same (Petzold 2015).

This is a description of a spontaneous experience in the NOW (here). It comes out of a situation at the center of “Germany, in what I have termed the land of three rivers,” It is based, as in the Wartburg Dialogue, on the personal, private situation of the patient or of those present during the health discussion. His willingness to participate and his attitude towards psychosomatic connections are considered in relation to the NOW (here) and addressed. The meaning of that remarkable experience, or symptom, is considered within a physical, bio-psycho-social model – yesterday, today, tomorrow. The next step is specifically *anticipated*, in the imagination as well as in a concrete plan. Imagination enables me (certainly influenced by Luther) to visualise a strong, autonomous man taking a deep breath. ...In the NOW (here) I think about the autonomy that Luther attained when he had to defend his beliefs in Worms. In Britain people are used to looking in the direction of London. Britain (like France) is a highly centralized country. Thus a British citizen, looking towards London, may hear Big Ben ...

Within context of the phenomenological approach, I may turn now to two central questions the editor of this volume has asked. He wonders,

- how the center of Germany the land of three streams, leads to the spontaneous experience? Could it not happen in France, England, or USA?, and
- if there is a particular significance of the three rivers to Dr. E’s case or to the Wartburg Dialogues?

Before I answer these two questions, I must first go into the connections between power and religion.

3.3 The Stage: Power, Religion; the Analogon

In a kind of theatrical performance, alternating between 1529 and 2016, I demonstrate the disastrous permeation of power and religion. Yet positive aspects can be seen, even in the face of terrible warfare: the religious issues shed light upon the issues of 2016 in the sense of an analogon.

3.3.1 *Power: Politics and Humanism*

Marburg was the scene of the above-mentioned Colloquy in 1529. That was two years after the Philipps-Universität in Marburg was founded. The university takes its name from Philipp der Großmütige (Philipp the Magnanimous, 1504–1567). Philipp was 24 at the time, and this was a ground-breaking action by a fatherless man who had been declared of age when he was 13 ^{1/2} by Maximilian (1459–1519), Emperor of the Holy Roman Empire of the German Nation. As an eighteen-year-old, he had taken part in the Diet of Worms in 1521, at the head of a 400-strong army. When Luther was outlawed in 1521 in Worms, everyone in the Holy Roman Empire of the German Nation was given the right to kill him without suffering punishment. Philipp, who was just 26 years old, was the one who, eight years later, defended Luther against the Emperor and the church (see below). Philipp had founded the first university on German soil to be founded without the agreement of the Pope. The university trained and educated administrators, lawyers, teachers and physicians for the Hesse region, whose population already supported the Reformation. This was a time when the Renaissance and Humanism had demonstrated the uniqueness of the individual and when, at the same time, religious reforms and preparliamentary debates were being conducted.

Leading personalities on the side of Humanism were: Erasmus of Rotterdam (1465–1536) and Thomas More (1498–1535) (2003) of London. On the side of religious reforms were principally Martin Luther (1483–1546) and Melanchthon (1497–1560), recorded in history as “Praeceptor Germaniae”, Calvin (1509–1564), Zwingli (1484–1531) and finally Luther’s predecessor Jan Hus (1369–1415) from Prague; at the time Prague was one of the most important universities in Europe. It was the first German speaking university, the oldest in the Holy Roman Empire of the German Nation. Leading proponents of the Reformation in France were the Huguenots. In England, Henry VIII (1421–1547) followed by his daughter Elizabeth I (1533–1603) firmly established the Church of England independent from the Pope, and in the German-speaking regions, the above-mentioned Philipp of Hesse (1504–1567), his ally the influential Friedrich III, known as the Wise, Elector of Saxony (1463–1525), were the opponents of both the Pope and the Emperor.

On the other side, the most crucial political preparliamentary opponents at the time were the Papacy (Leo X) and the Emperor Charles V (1500–1558), Emperor of the Holy Roman Empire of the German Nation, King of Spain and therefore also King of both the Americas, i.e. both present South and North America. He died in a Spanish monastery after voluntarily abdicating. There was a fluid coalition between the Emperor and the Pope on the one hand, and France under Henri IV (1554–1610) and his predecessors on the other. This period of the Reformation and Humanism is characterized by cultural achievements in medicine and philosophy, particularly at the University of Padua (cf. Pomponazzi) in Italy. At the same time, these achievements were, however, endangered by the continuing absolute power of the Church and the Inquisition. As late as 1600, the Church was responsible for the death of Giordano Bruno (astronomer, poet, philosopher and priest, 1548–1600) who was burnt at the stake. His contemporary, Galileo Galilei (1564–1641), only managed to avoid a similar fate by revoking his findings, against his better judgment. This was almost 200 years after the death of Jan Hus, Luther's role model, who had been burnt at the stake in 1415 at the behest of the Church Council of Constance.

3.3.2 *Religion: Communion and the Marburg Colloquy*

Within the framework of the reformation there were disputes of the utmost importance. They found their clearest expression in the above-mentioned Marburg Colloquy of 1529 convoked by Philipp I, Landgrave of Hesse, who invited the leading proponents of the Reformation to his Marburg residence. They met (not unlike the present European Commission) to establish doctrinal unity in the new Protestant faith (Carrasco and Neebe 2015). Agreement was achieved on 14 points out of 15, the exception being the 15th point that dealt with the nature of Communion. Luther's interpretation of Jesus's words: "This is my body which is for you" and "This cup is the new covenant in my blood" was that in the consecrated bread and wine was a real transformation of the body and blood of Christ (EST = he/she/it IS in Latin), while his opponents believed that they were a symbolical representation of God (SIGNIFICAT).

The delegation left without reaching agreement on this issue. Luther was emphatically in favor of "EST" and with him his adherents to the north and in Scandinavia. The Swiss around Zwingli and Calvin were in favor of "SIGNIFICAT". In England, Henry VIII determined the acceptance of "SIGNIFICAT" by royal decree. At this time, he and Philipp of Hesse were in close contact. The discussion in the castle that still stands above Marburg, lasted three days and must have been extremely acrimonious. The ripples travelled as far as the north-west of Europe, to Scotland where, initially, the adherents of the new Lutheran confession had been persecuted. The first martyr in the north-west of Europe was a former Marburg student, Patrick Hamilton of St. Andrews (Carrasco and Neebe 2015:101).

3.3.3 *The Analogon: Feelings and Relations in Psychosomatics*

In the case of Dr. E. and his sciatic pain, I developed the proposition that there was a close connection between the tears shed by the four-year-old boy and the shooting leg pains felt by the 57-year-old man. The tears expressed emotional pain that was communicated to his mother, who soothed it. However, she could not entirely dispel it. Every separation from the home environment caused pain, even though it was increasingly suppressed so that, finally, the process of separation became unconscious (cf. Carus, background). The 11-year-old boy did not want to worry his mother, so he did not mention pain. “Only” his twisted posture, as his grandmother called it, indicated his suppressed pain. The doctor straightened him by means of the cold plaster cast. This helped recovery for the following two decades, but *only in a temporary sense*. At this point, the patient developed degenerative symptoms that required an operation, i.e. an external and manipulative (in the sense of the Latin manus = hand) procedure. The patient was once again able to cope with the demands of daily life, underwent physical training, strengthened his immune system. However, in the years that followed he continued to suffer bouts of back pain that he increasingly experienced as having biographical triggers. At the time, he was working as a psychosomatic physician (see above) and recognized the psychosomatic nature of his symptoms during the health discussion and the palpation and, in the group, he was able to adapt to the new situation. I view this as a transformation of the remembered experience in the body as an analogon of “*becoming flesh*”. The process of “becoming flesh” was accomplished and completed. Over a period of 53 years, a *transformation* of his experience had taken place and could be demonstrated biographically.

I will refer to these two statements later in the sections Background and Rhythm. But here I want to state:

The processes of communion and its different interpretations can help us to understand the psychosomatics of 2017 in its processes as a scientifically practiced branch of medicine. The psychosomatic perspective allows an analogy with the religious process of transformation in the communion. – Later this will facilitate the formulation of concepts for the taking of a next step. This will be a subject of future research in human medicine

Also, I simply wish to comment, with reference to the case of Dr. E., that he had not experienced an inner change, analogous, but not identical, to Lutheran belief, so not a transformation in the sense of Luther’s “EST”. (Luther was a true Catholic in this respect). The “healing” of the young Dr. E. was achieved by a surgeon, and before that by a general practitioner. The former with an operation, the latter with a plaster cast. Both physicians were guided by “sign” not by an “EST”. Thus the period of the Reformation with its various interpretations of holy communion shows us the way towards an understanding of the development of psychosomatic medicine in Europe.

At this point, i.e., speaking about the sixteenth century, there was certainly no scientifically based medicine. This was to develop over the following three centuries (see “rhythm”). It is of paramount importance to recognize here how it is possible,

on the basis of this kind of transformation, to recognize the connection between the symbol and the actual bodily-physical processes: that is, to see “the truth” in the real sense of the word. Hence the problems of the management of a sign (symbol) versus the management of the “EST”, of a “being” of the person. Here it is useful to remember the Bible quotation: “The word became flesh and dwelled among us”. (John I:14). The sign/symbol is valid universally; the “EST” only for the individual case. It is a gap that has to be overcome. How?

In my opinion, this is beautifully illustrated in the letter Philipp von Hesse wrote to his sister in 1530 (Philipp of Hesse 1530). She was now the Duchess of Saxony, inclined towards the Lutheran faith, and asked her brother if the rumors were correct that he was leaning towards Calvinism. Philipp undertook the task of explaining his standpoint to his sister, in a very well-informed way, using around fifty quotations. He implored her as her brother to accept his standpoint and left it completely up to her to reveal her own Lutheranism. He described how the signs left him more room for manoeuvre. In this respect, he was closer to the Swiss, Zwingli and Calvin, than to the Lutherans. Later on, for political reasons he had to indicate his leaning towards Lutheranism more than he wished. The Elector of Saxony, his powerful ally, was himself a Lutheran, and used the kind of pressure to achieve political unity in the north of central Europe that had been impossible in the Marburg Colloquy. Philipp’s letter is a moving indication of the way in which the adherents of one theological direction could have lived with the adherents of the other. The brother told his sister that he had sent her a goblet as a new-year gift and assured her that he would continue to search for the “palfrey” that his sister wanted him to find for her to ride.

We are fortunate that this correspondence has survived. It reminds us that tolerance was possible at a time when Luther called his Swiss fellow reformer Zwingli a heretic and Henry VIII had Thomas More, author and creator of the term “utopia”, beheaded in 1535. About 450 years later, in modern times, in the year 2000, when there was serious social questioning of the Catholic church, Pope John Paul I designated Thomas More the Patron of Rulers and Politicians (Kathpedia, 21.12.15). Marburg in 1529 is the living present, is with us, represents the unity of the NOW (here) with the present. The founding of the Wartburg Dialogues goes back in part to Thomas More, the creator of the term “Utopia” (More 2003) – their ongoing topic of discussion is “Health as a basic right for all: a Utopia?” (www.schueffel.eu).

I shall now return to the editor’s two central questions. To the first it can be said that a German’s spontaneous experience is significantly influenced by the region he/she lives in. The regions in Germany are not only geographically different from one another (that is, Elbe, Rhine, or Danube region), they have been culturally molded over centuries and therefore have also differed geopolitically for ages. By the thirteenth century there were seven by and large politically independent German territories. These were the so-called electorates, the Electorates of Bohemia, Brandenburg, Palatinate, Saxony, Cologne, Mainz, and Trier. The latter three were also bishoprics, regions under ecclesiastical administration.

Today in the twenty-first Century, Germany is made up of 16 territories referred to as *Länder* (states). They are governed independently by regional administrations – governments, parliaments and courts of justice, and oversee public radio and television stations. Each of these states in its own way originates from and developed in an ongoing, 900-year contention with the seven Electorates.

Five hundred years ago the Reformation took place. Saxony became Protestant and also the Reformation's spearhead. It led the movement together with Hesse under Philipp the Magnanimous (see above), and thus stood in opposition to the Pope and the Catholic Church. The Saxon Elector Friedrich III (*der Weise*, the Wise), in a kind of public statement, accepted the Eucharist in the Protestant faith on his deathbed. The bordering Bishopric of Mainz demonstratively maintained the Catholic position and became the opponent to the Reformation. An ecumenical Eucharist between Catholics and Protestants is unthinkable even today. – Nevertheless, the two parties live side-by-side in a common nation. Up to today members of both confessions meet regularly, for example, in continued education courses for medical doctors. In this setting they deal with the human relationships and their underlying emotions.

In France, the preconditions for this kind of process within continued education are of a different nature. The close coexistence between the two confessions did not develop here. It was brought to a violent end in the St. Bartholomew's Day Massacre of 1572, when thousands of Protestants (Huguenots) were slaughtered in the streets of Paris. The survivors fled from France to Central and East European countries. Consequentially, the unifying French culture developed in allegiance to the Catholic Church and exists as such today, and it hasn't developed such a connection to Protestantism. The "spontaneous experience" the editor asks about therefore does not occur in France in connection to the Protestant Church. In the following the situation in England will be presented.

3.4 The Context: William Harvey, Herman Boerhaave, Georg Büchner

As a physician, I contrast the process and the outcome of the Religious Colloquy with what happens in a physiological laboratory. This can give a deeper insight into my perspective. I refer to the laboratory of William Harvey (1578–1657), founder of modern medicine. Harvey began his study of medicine in England and continued it in Padua in Italy. His ground-breaking work is the discovery of the macro-circulatory system of the blood. Until then, the medical world believed that liquid blood lay in the body and remained there, like the other organs. There was no concept of circular movement not to mention a *closed* circular movement (Eckart 2013). Harvey had grown up in the self-confident spirit of the Renaissance that encouraged autonomy, allowed the performance of experiments including on living things. The most important representative of this school of thought was Francis Bacon (1561–1626).

The prevailing attitudes of the time enabled Harvey to experiment (something Bacon continuously supported) with the result that he was able to become a researcher in physiology and anatomy. He describes volume and flow velocity in minute detail, comparable to today's research in wind tunnels to find the best aerodynamic form for a jet plane. Harvey was well aware of the importance of his research. His results did not agree with the prevailing understanding of medicine that had scarcely changed for fifteen hundred (!) years.

European medicine practiced at the time of Harvey had been founded by the doctor Galenus (Galen) of Pergamon (ca. AD 130–200) who was resident in Rome. In Galen's time there was already an enormous body of medical knowledge that was based on the work of the most famous doctor in European antiquity – Hippocrates (460–375 BC) His work had been passed down unchanged over about four hundred years up to the time of Galenus, physician to the Roman Emperor Marcus Aurelius and probably also to the Emperor Severus. Not even the Arabs, who were very familiar with Hippocratic medicine, managed to make changes, although they had made significant advances in medicine. At its center was a view of medicine that saw man as a whole being between soul and spirit on the one hand and the subjective world on the other. This view was similar to that of Empedocles (495–435 BCE), who was pre-Socrates (cf. the section on culture). In all probability, the reason why the medical findings of the Arabs were not well-received in Europe was that they came from a geo-politically dangerous zone. Not dissimilar to today, European countries felt threatened by Turkey and the north-African regions (e.g. Palmiras, Damascus, Aleppo, Cairo). In fact, this threat was not removed until 1683 with the victory of the imperial troops in Vienna over the besieging Turkish army.

Exterritorial Publication

In 1616, Harvey was already able to present his research results to the inner circle of his students and colleagues in Oxford and in St Bartholomew's Hospital in London. He was court physician at the time and generously funded by royalty (Charles I). He was also the son-in-law of the physician to Henry VIII. All this meant he had considerable support in influential society circles in England, but in spite of this, his findings were not published in England; his book was published in Frankfurt in 1628 (William Harvey, *On the Motion of the Heart and Blood in Animals*, Frankfurt 1628). On the one hand, the reason for this was that Harvey's new medicine required the departure from medieval thinking and way of life. The most striking symbol for this is the sentencing to death by the people, and subsequent beheading in 1649, of King Charles I (whom Harvey regarded as "his" king, cf. Swift 2014, see below). It is worth remembering here that the French Revolution and the beheading of the French King Louis XVI and Marie Antoinette did not take place for another 150 years.

On the other hand, it was necessary to embed the new medical ideas in the medical institutions and above all in medical teaching. The clearest expression of this was the fact that Harvey's work was not published in England but in the Holy Roman Empire of the German Nation, in Frankfurt am Main where its Emperor had been crowned. The publication was 12 years after he had already obtained his most important research results, and it was outside the territory of his own ruler.

In addition, Frankfurt was a free imperial city, surrounded, as mentioned previously, by the Protestant belt of Hesse and Saxony. In turn, they were backed by the Protestant Netherlands and the Protestant areas around Basle, Zürich and Geneva, in what is now Switzerland.

In England, one “spontaneous experience” must deal with the experience just described here in connection to Harvey and his discovery of the circulatory system. One would have to research what led to his book being published extratorrionally. Why did such a highly unconventional view within medicine have to be published outside the country? – The question of USA and whether a “spontaneous experience” is not just as possible there I would like to go into later, under the heading “Extraterritorial publication today?” below.

3.4.1 Hermann Boerhaave von Leiden: The New Medical Doctrine

The intellectual freedom prevalent in central Europe culminated around 1650 in the Protestant Netherlands and its universities. The University of Leiden, founded in 1575, had taken the lead in Europe. This was about 50 years after the Philipps-Universität in Marburg was founded in 1527, and a generation after the death of Luther in 1542. Bacon, Descartes (1596–1655), William Harvey (1578–1657) and Thomas Sydenham (1624–1689) had become recognized authorities in medical academic teaching in Leiden. Thomas Sydenham was regarded in England as the creator of a new kind of medical nosology, i.e. an organ-based medical pathology.

The physician Herman Boerhaave (1668–1758) had a leading position in the Medical School in Leiden in the Netherlands. The fact that he was the son of a Calvinist village clergyman was decisive for his stance (he was closer to the sign, further away from EST). He was very well-educated and was called “a physician, chemist and botanist” (Wikipedia). He was regarded as a reformer of the teaching of medicine in Europe and introduced small-group clinical instruction with patients. It would be said today that he raised awareness among his colleagues in the medical faculty that this type of instruction represented the alpha and omega for future doctors. He effectively systematized and processed the knowledge of the time and presented it in the form of a unified and clear medical instruction plan, cf. the above-mentioned nosology of Sydenham within an understanding atmosphere of a Calvinist accepting the Catholic (with his belief in special transformation during communion). This was Holland’s “Golden Age”.

Being a physician means representing a science of negotiation. Boerhaave’s pupils spread his medical approach across almost the whole of Europe. Among these pupils was Gerard von Swieten (1700–1772), physician to Maria Theresia, ruler of Austria. He was an advocate of the spread of information and an enemy of superstition (e.g. that vampires were responsible for epidemics in Transylvania). In Edinburgh (Scotland), there were the leading doctors Munroe, his son and his nephew, and further, there was Albrecht von Haller (1708–1777) who worked

mainly in the German-speaking areas in Switzerland. He worked with Boerhaave to continue Harvey's modern physiology. A network of doctors, who knew one another, was formed all over the continent, including the British Isles.

3.4.2 *Georg Büchner: Two National Medicines*

In spite of this, the German doctor and playwright Georg Büchner (1813–1837), who was also a gifted anatomical researcher, commented on the medical system in Europe as follows

In the physiological and anatomical sciences, there are two opposing basic, even national, viewpoints, the one more prevalent in England and France, the other in Germany. On Cranial Nerves, Inaugural Lecture in Zürich, 1836 (Büchner 1993)

(Es treten uns auf dem Gebiete der physiologischen und anatomischen Wissenschaften zwei sich gegenüberstehende Grundansichten entgegen, die sogar ein nationales (d. h. nationales) Gepräge tragen, indem die eine in England und Frankreich, die andere in Deutschland überwiegt. (Über Schädelnerven, Probevorlesung gehalten in Zürich 1836). (Oper Frankfurt, 1993; 2016)

How did the young, sensitive Büchner come to make this differentiation? He was a gifted dramatist, who wrote the story of “Woyzeck”, the story about everyday life in the Leipzig of 1820. A century later, the play was set to music by Alban Berg in his famous opera “Wozzeck”. Although he was so young, Büchner developed an incredibly clear cultural view in his short life of 24 years which, to me, a 78-year-old German, was quite remarkable. How can this development be understood as an historical process?.

Until early to mid-twentieth century, two opposing concepts of medicine had developed. One followed the line of Bacon/Harvey/Descartes and the other incorporated situation-dependent activities vis-a-vis the patient and emphasized their relationship to the environment. Wittkower (1899–1983), the world renowned pioneer of PM, remarks (1977):

In the second and third decades of this century the psychosomatic movement started in Germany and Austria as a reaction to what Weiss and English called the “machine age in medicine.” Speculations, case histories and hypnosis research were presented by F. Deutsch in 1922 (11), Groddeck in 1923 (12), Heyer in 1925 (13), Mohr in 1925 (14), Schwarz in 1925 (15), Fahrenkamp in 1926 (16), Alkan in 1930 (17), and von Weizsäcker in 1933 (18). In 1931, based on many years of experimental and clinical research, I submitted my Privatdozent thesis (19) on “The Influence of Emotions on Bodily Functions” to the University of Berlin. Dressed in tails (much too wide because on loan) and holding a top hat in my hands, as was customary in those days, I had to face the assembled Faculty of Medicine, and as the subject of my thesis was rather controversial it drew a good deal of fire. Outside the raucous voices of the Nazis, arousing racial hatred, echoed in the streets of Berlin

My arrival in England in 1933 stimulated psychosomatic interest in academic circles. Until then, little research had been carried out in this area in this country. We also held group meetings (similar to those initiated later on by Balint) in which leading physicians of most teaching hospitals in London participated.) (Wittkower 1977:5)

3.5 The Background: Creation, Trauma and a New Beginning

Returning again to the time of Luther (1483–1546), I see this period as a time of great creativity as well as great destructivity. The creativity was the fostering of the standardization of the German language at the center of Europe. The destructivity can be seen in the military disputes in what was known as the German Peasants' War, followed by the struggles (Schmalkaldic War 1546) between the Lutheran territorial powers (Schmalkaldic League) and the Catholic Holy Roman Empire of the Habsburgs. These disputes were the precursors of the Thirty Years' War (1618–1648).

Creation

The prerequisites for the European exchanges in medicine and among its doctors came about because Luther had brought about the unification and standardization of the German language in Central Europe. He wanted the language to represent both the word of God and the word of the common people (MacGregor 2014), because of his unwavering belief in a God who inspires the world. By 1535 he had translated the whole Bible, using the official language of Saxony and the language spoken by the common people. This Bible was so successful that in his lifetime 500,000 copies were sold. One copy cost the equivalent of a teacher's salary for 2 months. According to Neil MacGregor (former director of the British Museum and now chair of the Advisory board to the Berlin Palace-Humboldtforum Foundation):

this man, Martin Luther, in the years after 1517, had turned not just Germany but the whole of Europe upside-down. And in his translation of the Bible into German, he, more than any other single person, created the modern German language. This chapter is about that book – Luther's bible

By long tradition, saints and holy men have been shown as thin, ascetic, other-wordly. Luther is different. He is clearly a man in the world and of the people. It was at least partly in defence of the people that, from his position as a theologian at the University of Wittenberg, he wrote his famous Ninety-Five Theses in 1517. The Theses were a protest against corrupt practices in the Church, above all against the sale of Indulgences by the Pope in order to raise money to rebuild St Peter's in Rome

Luther knew how to speak to both the educated and the common people. He did not include the usual Latin phrases; he used uncomplicated, descriptive, vividly expressive language that had its own rhythm.

This language has a new purpose: to speak to everybody. The Gospel will be translated not as theology, but as conversations you might overhear in the streets or on the quaysides – Jesus speaking as a German carpenter to German fishermen

What has this language to do with psychosomatics in Europe? There are two far-reaching answers to this question: the first is that it helped people in the late sixteenth century to make up their own minds about the Bible and God. And: They had an opportunity for self-realization that had not been given to their forebears.

Trauma

The second answer is that the maturing readers, above all the Protestant ones, had to agree on how to form a new community, because they had different interpretations of the Bible, now they could read and understand it. However, after the Marburg Colloquy, it was impossible to reach an agreement because of ideological power issues. In the following century, these power issues resulted in the “religious war” of 1618–1648, known as the Thirty Years’ War, in which Catholics and Protestants, mainly Lutherans and Calvinists, fought for dominance in Europe. War broke out in all the regions in the three-river areas: on the Elbe, the Rhine, the Danube and into the side valleys. When the war ended with the Treaty of Westphalia (1648), what remained in Germany was a decimated population, a ravaged countryside, and, worst of all deeply traumatized people. The trauma of the Thirty Years War is still remembered in present-day Germany. Any searches for ancestors will end in 1650, the year when all the church records had been burned and houses and monuments had been destroyed. This war has become a kind of matrix in Germany for dealing with subsequent traumas, for creating new forms of continuity and coherence. In particular, the four traumas described by Neil MacGregor (op. cit.), are as follows:

However diverse the experiences of the different regions and states of Germany, all have been marked by four great traumas that live in the national memory

The first, the Thirty Years’ War (1618–1648), saw every German state, and troops from all the major European powers, fighting in Germany. It was devastating for the civilian population and for the economy. horrors were experienced across all Germany, and were never forgotten

The outbreak of European war in 1792 saw French Revolutionary armies invade the Rhineland and occupy large parts of western Germany. Many historic cities, including Mainz, Aachen and Cologne, were incorporated into France and were to remain French cities for nearly twenty years. In 1806, after routing the Prussian army at the battles of Jena and Auerstädt, Napoleon entered Berlin in triumph. By 1812 the French had effectively occupied all Germany from the Rhineland to Russia. ... The memory of the great humiliation of 1806 was burnt into the consciousness of all Germans, enduring to the end of the 19th Century and beyond

The most devastating and intractable of the four traumas was the Third Reich. The crimes committed by the Third Reich, both in Germany and across Europe, and the part played in those crimes by members of almost every German family, are a widely shared memory – in many cases a shared silence – still highly charged today and still far from being exorcised

The ultimate consequence of Nazi aggression was the invasion and occupation of all Germany by the four Allied powers, and its long division between the Federal Republic in the west and the German Democratic Republic in the east. It condemned East Germany to a further forty years of dictatorship and oppression. The human cost of that division, epitomized by those who lost their lives desperately trying to cross the Berlin Wall, is still being assessed. (pp. XXXIV-XXXV; my bold italics)

New beginning

In the section on context, I described how further development towards a modern medicine moved in the direction of central north-west Europe, towards the Netherlands and from there towards the British Isles, including Ireland. This also included Switzerland, and the Austria of the Hapsburgs. Germany, that bordered on these countries, seemed to be the exception. It needed to recover and to take stock of the trauma of the century, first in literature and then in music: Gryphius the poet (1685–1664), Grimmelshausen (1622–1676), the best-known German writing author of the century (2005) and finally Johann Sebastian Bach (1685–1750). At about the same time, Händel (1685–1759) was born in the Protestant town of Halle. With reference to this period and the cultural events in Europa the British author Peter Watson (2010) describes a threefold appearance of the Renaissance: classical antiquity, the “high renaissance” in Italy including the above-mentioned Pope Leo X, Luther’s opponent and finally a third renaissance in the middle of Europe. He writes

Just as, in the Italian Renaissance, Pope Leo X reorganized La Sapienza in Rome, so in Germany a completely new idea of learning, which fundamentally shaped the modern world, was evolved. There were new forms of literature and new forms of inquiry, in which philology once again formed the core. Archaeology – the modern equivalent of antiquarianism – underwent its heroic age. This third renaissance was without question primarily German. (Watson 2010:94)

3.5.1 He Continues

....there was a third classical revival in Europe, that resulted in a flourishing – a renaissance – of the arts and sciences, that saw great reflection and innovation in military affairs, and that stimulated an unparalleled philosophical revival. This promoted a surge in new aesthetic theory, including advances by poets such as Goethe and Schiller – who were also scholars and many-sided men

MacGregor also makes the connection to cultural institutions, among them the university in Berlin, the present Humboldt Universität, now situated in the street Unter den Linden.

The links between Wissenschaft (science), Bildung (education/learning) and Innerlichkeit (Inwardness), formulated most forcefully in the brand-new University of Berlin (founded in 1810), were to be the clearest embodiment of the German idea of humanism. (MacGregor 2014)

In the true sense of the word, that was the background against which a new kind of medicine, an independent medicine, could develop. The third Renaissance received further impetus from the almost complete victory over Napoleon in the Battle of Leipzig (otherwise known as the Battle of the Nations) in 1813. It was the worst and bloodiest battle in the history of the European continent and is still seared on the memory of the local population. This victory over an apparently invincible enemy set free powerful feelings of autonomy and national self-determination.

This was also felt in the medical field where a new and independent medicine was to develop. This happened for the first time in Leipzig that had been a flourishing city for centuries, the hub of east-west trade. Here the chair of “Psychotherapy in Medicine” was established. The physician Johann Christian August Heinroth (1773–1843) (1818, 1825a, 1825b) was given the appointment. He not only published pioneering books (*Lehrbuch der Störungen des Seelenlebens oder die Störungen und ihre Behandlung* (Textbook on the Disturbances of the Soul and their Treatment) Leipzig 1818; *Anweisungen für angehende Irrenärzte zur richtigen Behandlung ihrer Kranken* 1825 (Instructions for Beginners in Psychiatry) (1825a), but he was also involved in the education and care of psychiatric patients when he set up the “Heil- und Verpflegungsanstalt für Irre beiderlei Geschlechtes (Psychiatric Hospital for Members of both Sexes)” (1825b) in Pirna near Dresden on the Elbe.

Christoph Wilhelm Hufeland (1762–1836) and Carl Gustav Carus (1789–1836) are two further doctors who, along with Heinroth, were groundbreaking precursors in the field of scientific medicine in the psychosomatic sense. They both came from the present-day federal state of Thüringen, between Hesse and Saxony. Hufeland became founding Dean of the above-mentioned Medical School of the University of Berlin. He initiated “macrobiotics”, that places the patient’s own powers at the center of the medical approach, which he describes systematically. He might be called a forerunner of Aaron Antonovsky (1987) and his sense of coherence (SOC). At the same time he was not only personal physician to the Prussian Royal Family, but also a socially committed doctor and promoter of the smallpox vaccination that had been developed by Jenner in England in 1798.

Carl Gustav Carus, physiologist and comparative anatomist, was the strongest supporter of the idea of integrated psychosomatics and forerunner of Freud. It was Carus who introduced the concept of the unconscious to medicine. He was a friend of the romantic painter Caspar David Friedrich and of Wolfgang von Goethe and, like Hufeland, he was also a personal physician to “his” king, King Friedrich August II of Saxony. He is not well known outside Germany and Europe, but he is the most original and outstanding psychosomatic physician, as he represents a triad: the evolution scholar, the artist painter and the wholistic physician.

The fourth outstanding medical personality of the first half of the nineteenth century is Johannes Peter Müller (1801–1858). His *Handbook of Physiology* (1833–1840) was a global success. He was a member of the American Academy of Arts and Sciences, the Royal Society of England and the Académie des Sciences (Scientific Academy) in Paris. It was his research in marine biology and above all of the sensory organs that led him to the conclusion that all perceptions are subjective. He anticipated the philosopher Edmund Husserl’s (1859–1938) epistemology. These four physicians would probably have been able to make a similar interpretation to mine of Dr. E.’s symptoms on the motorway (as described above). Johann Peter Müller would have used the “Law of specific sensory energy” to interpret the pain. Hufeland would have based his interpretation on the relationship of man to his environment (cf. microbiotics), Carus would have used his concept of the unconscious and Heinroth would have examined the concept of the “person”, the focus of his “*Störungen des Seelenlebens*” (*Disturbances of the Spirit*). All four

doctors had experienced the Napoleonic Wars, Müller while still a boy. These were traumatic times. They were all Germans, and besides the memory of the Napoleonic Wars they carried the collective trauma of the Thirty Years' War. This is exemplified by the fate of the psychosomatically weakened Georg Büchner. He died of typhus in Switzerland at the age of 27. Prior to this, he had lived through years of rebellion in Hesse and suffered the traumas of continual persecution by an authoritarian ducal police system.

However, the time was not yet ripe for viewing him as traumatized. Trauma, as an integral part of psychosomatic work was only identified around 1889 by Oppenheim (1889a, b, 1916) in Berlin. He used the term "traumatic neurosis", which is identical in meaning to the modern term *post traumatic stress disorder* (PTSD). – The severe trauma remained "under cover" for centuries. It is worthy of note that Georg Büchner was born during the actual days of the Völkerschlacht, the "Battle of the Nations" which took place in Leipzig in 1813. Georg Büchner was born in the small Hesse town of Geroldsheim. His father was to become the medical hospital director of Darmstadt, being well respected by the autocratic Duke of Hesse who, on the other hand, persecuted the rebellious son.

In the second half of the nineteenth century, there was a revolutionary development in scientific medicine that pushed into the background the wholistic and humanistic medicine of the third renaissance that might have mitigated the terrible consequences of trauma. Decisive influences here were, surprisingly, pupils of Johannes Müller. Frequently cited (Th. von Uexküll and Wesiack 1988; Eckart 2013). In this connection is a letter from the then world-famous physiologist Dubois-Raymonds (1818–1896):

"Brücke and I have sworn to assert the truth that in the organism there are no other forces than the general physical and chemical". Emil Dubois-Raymonds and Brücke, along with other famous physiologists (Jakob Hehne, Theodor Schwann, Rudolf Virchow, Françoise Magendie) represented an exclusively scientifically-orientated medicine, or what they understood as "science" in medicine. Magendie declared that the hospital is "simply the vestibule of scientific medicine, the first area of clinical observation" and that the laboratory is the temple of medical science (all quotations from Eckart 2013). It is surprising that most of the scientists and physicians mentioned here were associated with Johannes Müller, who remained true to the "law of specific sensory energy" until the end of his life. Unlike the Brücke-Helmholz Circle, he was unable to accept the concept of "objective truth".

The representatives of the wholistic-romantic school were dismissed as vitalists, mesmerists, physiological idealists and so on. By contrast, the representatives of scientific medicine received considerable support, as they were also active in social medicine, Virchow for instance, and, indirectly, Koch. When Japan had to open its ports and implement reforms, German medical representatives were asked to introduce cutting-edge medicine there. Until the Second World War, the language of medical training was largely German. The US government had sent an official delegation to Europe to obtain ideas for American medical training. The delegation, the Flexner Committee, named after its chairman, went to Paris, Vienna, Berlin and London. In the Flexner Report of the year 1910 the committee opted for the German

system to provide ideas for the further development of the American system (Flexner 2015). Although English is the standard language in America; a considerable amount of German influence entered the field of medical education in the United States.

German medicine had, at the time, gone through a rushed process toward science and assumed dominance world wide,. The whole world, as well as Germany, was taken by surprise by the possibilities offered by technical progress. Science-based medicine became dominant in 1890 (the year the Meiji Constitution was enacted) in Japan and in 1910 in the USA four years after.

At this point, I can return to the concept of change, also in the context of Transformation – within the holy communion but also in an existential relationship.

The reason for going back to the concept of change at this point are the events between 1890 in Japan and 1910 in the USA. Shortly after the publication of the Flexner Report, Freud (1914) published his “Erinnern, Wiederholen, Durcharbeiten” (Remembering, Repeating and Working Through) in Vienna. In this work, the NOW (here) is set against the apparently immovable laws of science. It confirms Büchner’s dictum of national medicines, with Freud here as an example representing German-language medicine. At the time, Vienna (along with Berlin) was considered the focal point of advanced medicine in the German-language countries. Up until a short time before (until the Napoleonic Period 1806), the royal seat of the Holy Roman Empire of the German Nation had been in Vienna. Freud’s ancestors had been raised in this Empire, Freud himself born into this environment. This means that a new form of diagnosis, treatment, treatment plan, treatment and epicrisis was born in the here and now, developed out of the approaches of both partners in the therapy. Apparently fixed natural laws were being upset without those concerned noticing. *This was, in my view, the true beginning of psychosomatic medicine in Europe.*

3.6 The Rhythm: The Power of the Symptom, Transference and Countertransference, Generation-Dependent View of the Symptom, Anamnesis Groups as Primordial Experience; the Commencement of Scientific Psychosomatics

In this part, I deal with my own experiences as a physician in Marburg in 1976, i.e. just 50 years later. Not forgetting Erich Wittkower’s second remark, however:

But looking back at my lifetime, it appears regrettable that psychosomatic medicine, which started off as a reaction to prevailing laboratory orientation, at least in some aspects has gone full circle. Regarding psychosomatic theory, the evolution of a multitude of conceptual models indicates uncertainty of acceptance. At the 25th anniversary of the American Psychosomatic Society in 1964 many of its previous presidents attended its Annual Convention. There was a division between the older generation which adhered to the time-honored conceptual models and the younger generation which discarded them. (Wittkower 1977)

The concept of transformation will play a major role. It will lead back to the *roots* of psychosomatic medicine. That is three quarters of a century after the transformation at the end of the 19th “long century” (Hobsbawm 1987, 1994), when scientific medicine enjoyed a success that owed much to German influence.

Since then, two world wars had taken place and my academic teachers had all had the formative experience of WW II and of the Nazi terror regime. For my part, I had the good fortune to study in Hamburg, Berlin and Heidelberg (from 1958–1968) and, as a postgraduate, in Ulm (1968–1976), a newly founded university for medicine and sciences. In England, I did my clerkship (Royal Free Hospital, London in 1962 and paid visits to the Central Middlesex Hospital, London in 1970^{ies}). All this enabled me to learn about the progress of medicine in the wholistic sense that I refer to above: Arthur Jores (1960, 1981) in Hamburg, who had to defend his humanist beliefs to the Gestapo; in West Berlin in the spirit of the newly-founded Freie Universität (Free University); in Heidelberg Paul Christian (Christian and Haas 1949), who, together with Peter Hahn (1976, 1988), represented the tradition of Viktor von Weizsäcker (2005) and Ludolf Krehl (1929).

In Ulm my supervisor, Thure von Uexküll (1963, 1979, 1997, 2016), was liberal-minded and an important representative of wholistic medicine in the Central-European sense. He was chiefly responsible for the replacing of the old German-Prussian training regulations of 1865 with a new one (License to Practice Medicine). This applied to Germany and it introduced, in particular, psychosomatics, psychotherapy, medical psychology and medical sociology, with the requirement for the teaching to be “patient focused”.

With the co-operation of my open-minded colleague H. Heimpel, internist, haematologist, it was also my good fortune to be able to introduce to the Ulm Medical School an adapted version of the clerkship that had been developed in Rochester (New York) by William Morgan and George L. Engel and (1968) whom I had visited (Universität Ulm 1974).

3.6.1 The Power of the Symptom: Not Feeling but Sensing

The university in Ulm was founded in 1967. One of the founders was Thure von Uexküll, Professor of Internal Medicine and proponent of integrated psychosomatics. He continued the tradition of the internist Gustav von Bergmann (1936), who, together with the internist Ludolf Krehl Siebeck, followed the tradition of “medicine in movement”: they considered that functional illness could develop in the course of an active life into clearly-defined organ disease. Thure von Uexküll asked J. J. Groen (1982), the Dutch internist, diabetics researcher and asthma specialist, to assist as guest professor with the setting-up of integrated medicine in Ulm. J. J. Groen was pleased to oblige. Under his aegis and later that of his co-worker Pelsler (Paulley and Pelsler 1989) it was possible to pursue the “Power of the Symptom” (Freud 1914).

Groen often made references to the importance of Boerhaave and stressed Boerhaave's discussion of clinical findings, that is addressing the importance of the symptom. Groen was an emeritus professor of internal medicine at the Hadassah University in Jerusalem when his former pupil and co-worker Jan Bastiaans, later head of psychiatry at the university of Leiden, helped him to establish a research unit. Groen and Uexküll encouraged me to implement patient-centered teaching. Von Uexküll had me work with patients who were handicapped by functional physical disturbances, and some of whom were permanently disabled and unfit for work. According to the medical terminology in use at the time, there was "NOTHING" wrong with them, i.e. they had no anatomically verifiable complaint, and none that were verifiable in the usual general physical-chemical sense either (Dubois-Raymond, see above). Groen showed me how to deal with asthma sufferers. He explained how these patients suffered because of their compulsive ambivalence. The Swiss Rolf Adler, former research assistant to G. L. Engel, taught us the latter's anamnesis technique. In this centre of contemporary European psychosomaticians, I learned about the power of the symptom. I valued this power as "via regia" (royal road) on the one hand, but on the other hand, I feared it as a threat, and – combining the two – I admired it as a *supremely valuable* creation of the organism. In this way I learnt not to enquire about feelings but about sensations: by not feeling but sensing. In the case of Dr. E., this implies that he senses inch by inch when I follow the N. ischiadicus downwards, and he reports to me on the quality of the sensations as observed under my palpating fingers. He felt ashamed that he did not correctly judge the time he needed to reach the Wartburg Dialogue punctually. Sensing and feeling are different qualities of perception and they should always be discriminated.

3.6.2 *Transference and Countertransference*

As a junior doctor, I had felt that it also concerned me as a person, or even more as an individual, when a patient asked me for medical help. In fact, I had already felt this when I was still a student, so before I qualified, and had to stand in for Sheila Sherlock's (1963) the hepatologist's "houseman" at the Royal Free Hospital in London. The reference is not to an impersonal "someone", but to the personal "I" – I have to stand in and I have to make decisions. In the NOW (here) we are dealing with "I-messages". I had not yet (in the late 60^{ies}, early 70^{ies}) read the following passage in Freud, that I now regard as of central importance:

"We have only made it clear to ourselves that the patient's state of being ill cannot cease with the beginning of his analysis, and that we must treat his illness, not as an event of the past, but as a present-day force."

Sigmund Freud, SE XII: 147–156 (my emphasis in bold).

Freud outlines four steps for this that are, in my opinion, of great significance:

1. *"Finally there evolved the consistent technique used today in which the analyst gives up the attempt to bring a particular moment or problem into focus. He*

contents himself with studying whatever is present for the time being on the surface of the patient's mind, and he applies the art of interpretation mainly for the purpose of recognizing the resistances which appear there, and making them conscious to the patient.

2. *"From this there results a new sort of division of labor: the doctor uncovers the resistances which are unknown to the patient; when these have been got the better of, the patient often relates the forgotten situations and connections without any difficulty."*
3. *"If we confine ourselves to this second type in order to bring out the difference, we may say that the patient does not remember anything of what he has forgotten and repressed, but acts it out. He reproduces it not as a memory but as an action; he repeats it, without, of course, knowing that he is repeating it."*
4. *"This state of illness is brought, piece by piece, within the field and range of operation of the treatment, and while the patient experiences it as something real and contemporary, we have to do our therapeutic work on it, which consists in a large measure in tracing it back to the past."*

It is clear that Freud looks more at the behavior of the doctor and at his decisions than at the patient with the symptoms. There are reasons for this: Doctors are instructed to *eliminate* the symptoms, both while they are students, and then in their further training. This was also how I was trained. Now I had to *change both this thinking and this behavior* in order to *understand* the power of the symptom, instead of challenging it.

Freud speaks of an "interspace" between the illness and life that can help to achieve the transfer from the former to the latter. He says the following:

One must allow the patient time to become more conversant with this resistance with which he has now become acquainted, to work through it, by continuing, in defiance of it, the analytic work according to the fundamental rule of analysis. The doctor has nothing else to do than to wait and let things take their course, a course which cannot be avoided nor always hastened. If he holds fast to this conviction he will often be spared the illusion of having failed when in fact he is conducting the treatment on the right lines

(Man muss dem Kranken die Zeit lassen, sich in den ihm unbekanntem Widerstand zu vertiefen, ihn durchzuarbeiten, ihn zu überwinden, indem er ihm zum Trotz die Arbeit nach der analytischen Grundregel fortsetzt. Erst auf der Höhe desselben, findet man dann in gemeinsamer Arbeit mit dem Analysierten die verdrängten Triebregungen auf.... Der Arzt hat dabei nichts anderes zu tun als abzuwarten und einen Ablauf zuzulassen, der nicht vermieden, auch nicht immer beschleunigt werden kann)

The same is valid today. Freud wrote these passages with reference to psychological phenomena. He discussed this treatment in connection with the interpretation of dreams. Then as now, the interpretation of dreams must start with the manifest content of the dream. That is what is on the surface. Merleau-Ponty once said that nothing is so deep as the surface. This is true. The prerequisite is: take the symptom and see it as the manifest content of the dream i.e. as a PICTURE. The unhurried exchange about this picture, e.g. a painful shoulder, a racing heartbeat, an unpredictably metastasizing cancer, can facilitate the discovery of what is behind these manifestations. The picture may begin to move. In dreams it is the so-termed

latent dream-thoughts. In the picture it is childhood memories. They are part of the shoulder pain, the racing heartbeat, the unpredictable cancer. I can make progress if I ask more and more questions about how the patient sees the first pictures of his illness, when and how they started and in what circumstances. Finally, I ask when the patient last felt “full of the joys of spring”. I made progress 95% of the time, even when dealing with the most serious organic illness, or chronic functional complaints that made it impossible for the patient to hold down a job.

3.6.3 A Generation-Dependent View of the Symptom

In 1976, I had more good fortune: when I was appointed chair of psychosomatic medicine at the Philipps-University of Marburg in conjunction with the headship of the psychosomatic clinic and polyclinic, my colleagues and I already had a scientific concept. Both the chair and the headship were within the framework of the new plans but so far they were only on paper. They had to be put in place within a traditional, director-led clinic for internal medicine. Over the following years, it gradually developed into a department system. This type of system, consisting of internal medicine, pediatrics and psychotherapy, was familiar to us from Ulm, where we had also established a research program called “The designation and evaluation of affective learning objectives in the study of medicine” (Schüffel 1983a, b). The aim of this program was to research the process of becoming a doctor. The program was financed by the Deutsche Forschungsgemeinschaft (DFG; German Research Foundation), and we were able to transfer it from Ulm to Marburg.

Nevertheless, it was not an easy start. Just nine years earlier there had been an outbreak of a type of Ebola in the local Behringwerke, the well-known pharmaceutical company based in Marburg. Infected laboratory animals had infected employees. In the above-mentioned clinic there were now beds designated for the treatment of psychosomatic patients. Marburg’s Medical School is proud of its solidly based scientific reputation. Emil von Behring (1854–1917) who, in 1901 was the first winner of the Nobel Prize for Medicine, worked in Marburg. He was awarded the prize for his work in immunology and the resulting serum therapies (e.g. diphtheria, tetanus). His many honors included membership of the American Academy of Arts and Sciences, and officer of the French Légion d’Honneur (Legion of Honor). The Director of the clinic, Gustav Adolf Martini supported the development of our small department through the difficult early years. It is thanks to him that our patients were allocated beds on medical wards. But it is also thanks to Thure von Uexküll (Giessen; later Ulm) that the anamnesis groups in the clinical context continued to develop, first in Ulm, then in Marburg and subsequently in other parts of the country.

The correct English term for anamnesis groups is Peer Groups on History Taking; usually abbreviated to “Peegrohit” (Schüffel 1983; 83a). – Why do I refer to their existence? Why anamnesis groups? The answer is simple: we can identify

with young people going through a new stage in life because we have experienced this ourselves. In the specific case of the anamnesis groups, young medical students want to learn how to talk with patients. At the same time, they want to relate what they experience here to what they experience during their time as students (cf. Interview, English and German versions; www.schueffel.eu). The focal point of their interest is how to deal with the power of the symptom and how to connect this with medical pathology and how from there they can approach healing. Thus the salutogenic aspect (Antonovsky 1987) gains in importance. This again is exemplified by Dr. E.'s sciatica: He is ashamed that he arrived late at the Wartburg Dialogue despite his efforts to be punctual. It is hurt pride that he cannot talk about at the moment.

Students of varying ages who take part in the anamnesis groups may be in their first or second year, i.e. preclinical years; or their third to sixth years, i. e. the clinical years. They have two basic experiences that remind me of the experiences of the readers of the Luther Bible in the sixteenth century: They believe they understand what the symptom means for the individual patient. They then discover that there are as many opinions about the meaning of the symptom as there are members of the group.

There then follows a lively, often intensely affective discussion that fortunately does not end in a Thirty Years' War, but frequently in a thirty-year feeling of connection, sometimes based on the consensus achieved in the group and sometimes on the way differences of opinion are tolerated. These students were to be found more and more frequently in the hospital wards in Marburg, as had previously happened in Ulm. The ward physicians had to enter into discussions with the students, the students spoke to the patients on the ward and the patients began to talk about the interpretation of their symptoms. This resulted in a new kind of reflection in the clinic, first of all for the doctors, then the nursing staff, and later the general public outside the clinic. The doctors had to concede that the symptoms described by the patients were capable of varying interpretations often depending on the age group of the doctor. In other words the interpretation of symptoms has to be seen as generation-dependent.

3.6.4 The Anamnesis Group as a Basic Medical Experience

The doctors in the clinic recognized that the students' questions were legitimate and that they had not previously been accorded proper consideration. Most of them had been students in 1968 themselves and had encountered young people, not only in Germany, who found the post-second-world-war situation in Europe unacceptable (this was the time when Joschka Fischer, later to become German Foreign Minister, threw stones at the police and the student Benno Ohnesorg was shot dead by police in Berlin). Doctors began to show interest in the Balint groups that were not well known at the time. In this atmosphere, the "torch" of the anamnesis groups could be passed on. Up to the present time, at least 30,000 German speaking students (Federal

Republic of Germany, Austria, parts of Switzerland) have taken part in them (Köllner and Loew 2012; Bender 2012; Merkle 2012). The former students have turned into experienced general practitioners (cf. Herrmann, chapter 11), senior consultants and head physicians (Köllner, Loew, Bender, Merkle), outstanding researchers (Egle and Hofmann 1993; Egle and Zentgraf 2013), Lord Mayor (T. Spies 2012). They know how to lead controversial discussions: in each of them are the male and female doctors that Samuel Shem describes in his book “House of God” (Shem 1980). The functioning of those groups within the medical curriculum has recently been described (Keifenheim et al. 2014, 2015). The basic philosophy has been described by Schüffel (1983a, b); Schüffel and Pauli (1997).

They have in common an awareness that the primary concern in medicine is how to establish psychosomatic medicine as an approach.

3.6.5 *The Start of Scientific Psychosomatics*

At this stage, I would like to give an explanation for seeing Psychosomatics in Europe as a scientific approach.

I have illustrated how Freud described a new kind of approach for medicine. He referred to the power of the symptom that must be discussed and shaped *in the present*; this should be done *economically*. In other words: Doctor and patient value the meaning of TIME. It is the task of the doctor to communicate this necessity to the patient.

This process follows the four criteria described above. In other words: Until 1914, when Freud’s work was published, this was not recognized as a process that could be guided. Psychosomatics revealed it however. *It becomes the subject of a mutually co-operative activity and thus available for scientific examination.*

Freud wrote “Remembering, Repeating, Working Through” at the end of what Hobsbawm termed “the long century” (Hobsbawm 1994). That was in 1914, the start of World War I. At the same time, the USA and Japan were dealing with the transformation process described above. We have seen how the appalling effect of what Hobsbawm termed “the short century” i.e. the period from 1914–1989, influenced the further development of psychosomatic medicine in Europe. The two wars and the period between them lasted from 1914 to 1945. This can often be termed the second 30 years’ war.

The population of central Europe, traumatized, exhausted but relieved after two world wars, now had to start rebuilding.

There were two ways of doing this: people used the situation to incorporate new ways of thinking into existing structures, or leaped into the piles of rubble, clearing them before they had come to their senses. The United Kingdom used the first option and reformed its health system radically. The British National Health Service was set up in 1946.

- It guaranteed free basic health care to every citizen of the UK
- Patients were entered into the GP’s (General Practitioner) list

- the GP became the “gatekeeper” for referrals to specialists, who were based in hospitals.
- The GP’s are basically paid per head (capitation).

The development in Germany was different (as it was in Austria, Switzerland, and also the Netherlands):

- every citizen was guaranteed basic health care through an insurance company of their own choosing
- there is no doctor’s list but entrance to the surgery is free.
- the doctor is paid according the service provided
- the GP is NOT the gatekeeper

This represents the continuation of what Büchner described as the development of two medicines in Europe. This emphasizes the rhythm of centuries: on the British side of the Channel was a permanent employment contract expressed through a list and on the continental side of the Channel a loose alliance that is very much situation-dependent.

In the course of the next three decades, from 1945 to 1975, the representatives of the two medicines began to look back at their respective pasts. Major national differences became apparent that were related to different collective memories. I refer now to the past of the central European, mainly German speaking, medicine, while not forgetting how closely the two medicines are also connected to each other.

3.7 Democracy: Upheaval, Psychiatry of the Persecuted, Trauma Awareness: Generations and Genders

3.7.1 The Upheaval: “Oppenheim has been Overturned”

Is the formulation of E. Fischer-Homberger (1975) in her remarkable book on Traumatic Neurosis (1975) on Hermann Oppenheim (1858–1919) who was a neurologist in Berlin. He described the complaint that is known today as post-traumatic stress disorder (PTSD) (1889a, b, 1916). Oppenheim was overturned during WW I. The opinion was expressed that the complaint of traumatic neurosis he described was basically a form of hysteria and not an illness. This view became one of the principles of both German medicine and Austrian medicine. During the First World War, the insults went so far as to declare that traumatic neurosis was a Jewish invention. This hostile attitude was internalized between 1915 and 1964 (see below). At the same time this attitude was generalized and there was a strict denial of all psychological influences on the body. I describe elsewhere the story of an Auschwitz survivor with cardiac arrhythmia (Schüffel 2009:434–437). He had to spend more than 15 years pursuing his claim for reparation through the courts. As an expert witness, I realized that other respected medical experts had, without exception, refused to see a causal connection between persecution and complaint. My findings were

that the symptoms were, beyond doubt, verifiably subjective (anamnestic) and psycho-physiologic (stress ECG; clinical condition with breathlessness bordering on pulmonary edema).

3.7.2 Psychiatry of the Persecuted: Becoming Aware

A Heidelberg team of psychiatrists was able to counteract this attitude: Ritter von Baeyer, Häfner, Kisker with the publication “Psychiatrie der Verfolgten” (Psychiatry of the Persecuted) (1964). This team, that included Venzlaff (Göttingen) and later W. Blankenburg (Marburg), speaks rather of “Ausdruck eines echten erlebnisreaktiven Persönlichkeitswandels” (The expression of a true reactive personality transformation; 1964, III). At the time, influential voices began to express the need to rethink psychosomatics, and they had an effect: Viktor von Weizsäcker (2005), Paul Christian (Christian and Haas 1949; Jores 1960, 1981), Thure von Uexküll (1963), Kütemeyer (1963). The following are of great importance because they make reference to traumata: Mitscherlich, Mielke: the Nüremberg Medical Trial (1949); Mitscherlich, Mitscherlich-Nilsen: “Die Unfähigkeit zu trauern” (the inability to mourn) (1967).

Gradually it was possible to return to earlier times. In 1936, Wittkower at the Charité in Berlin wrote a book that is full of detailed research results in scientific psychosomatics during the 1930s (Wittkower 1937). The book describes 500 patients in medical wards and in the outpatient department of the Charité Hospital in Berlin. His work is based on a co-operation between the Charité and the Department of Medical Psychology at the University of London. Interestingly, it is dedicated to Professor His of Berlin and Professor Cannon of Harvard, both leading Internists of their time. Gradually, people were starting to read publications of this kind again. This was due to the above-mentioned state legislation that introduced the four “psycho-social” disciplines into medical training and also to the “Zeitgeist” after 1968. Fortunately, Wittkower who had to flee to Canada in the 30’s was able to follow up this change.

3.7.3 Trauma Consciousness, Generations, Genders and Their Interaction

In 1974 the Deutsche Kollegium für Psychosomatische Medizin (DKPM; German College of Psychosomatic Medicine) was founded. The Deutsche Gesellschaft für Psychosomatische Medizin and ärztliche Psychotherapie /German Society of Psychosomatic Medicine and Medical Psychotherapy was established in 1993. There is a tripartite further training system: in 1976, the subject “psychotherapy” was introduced as a three year training program for physicians of all disciplines, that

made it possible for all physicians to gain the psychotherapeutic knowledge and expertise necessary for their everyday requirements. In 1988 an 80-hour course in psychosomatic basic care was introduced into the further training courses. It was mandatory for GP's and gynecologists. In 1993, the specialist discipline "Psychosomatic Medicine and Psychotherapy" was established on par with psychiatry and internal medicine.

From 1974 to 1997, I was a board member of the DKPM and was secretary and treasurer during this period. In 1999 I was made an Honorary Member.

Now after all those years, I find myself asking: where did all the time go? How could I have only just discovered, seventy years after it happened, that 15,000 people were murdered in Pirna, in the psychiatric hospital that had been founded by Heinroth the humanist mentioned above? This same Pirna is my birthplace. Are these events still too close for us to be able to remember them? Neil MacGregor (2014) says something similar in his description of the fourth trauma, the Holocaust trauma.

I commented to my friend Benyamin Maoz of Beer Sheva (Maoz 2014), formerly Kassel/North Hesse: "We will need to develop *parallel worlds*" (Schüffel 2014). There we must discover how to develop our own culture so that we can use it to approach representatives of other cultures. This may start with the statement of the historian Fritz Stern who said: "1989 was the brightest moment in Europe's darkest century" (in: P.Watson 2010: XII). Now we have to see how the last and the present century can be bridged, allowing for coherence between generations and gender. In my opinion those persons are Joannes Juda Groen and Oliver Sacks.

J.J. Groen (1903–1990) (1982) was an eminent researcher and a gifted teacher (see above). He survived the German occupation of the Netherlands by living in the underground. But it is less known that he was a follower of the Dutch-Jewish philosopher Baruch Spinoza (1632–1677) who taught that all perception is an integral part of a whole. It follows that there cannot be categorical differences between energy and matter nor between body and soul. The whole is something we feel, we perceive, and we sense whenever we are happy; some call it God. This condition of happiness only takes place in a community.

JJ Groen loved to discuss this outlook on life and he lived it for himself and for us whom he met. After he and Denis Leigh founded The European Conference on Psychosomatic Research in 1956 (Schüffel 2013) he encouraged his former co-workers and friends to found ICPM. He supported its members to form a worldwide community with the aim of introducing a psychosomatic approach in medicine. It started with Erich Wittkower as President, followed by Maurice Knobel Morton Reiser, Yukihiko Ikemi, Adam Krakowski, Jan Bastiaans, Chase Kimbal (Antonelli, Rome, 1975), Cairns Aitken.

Thanks to JJ Groen (1982) I can now see how to cope with G. L. Engel's request to reject seventeenth century philosophy in medicine (Engel 1988, 1997). This can be done by taking the patient's history (Morgan and Engel 1968) within a *community* and working it through in the presence of the patient and doing it on the basis of a combined Groen-Spinoza Understanding.

The problem is how the community, i.e. the group, can be formed. This will be the topic of the next and last section. Oliver Sacks will help us.

3.8 Culture: On the Move – The Moving Seminar

(I, William Harvey,) raised my standard against King Galen”, (Swift 2014:32) London, 2014:32.

Looking back I can see that Don Lipsitt was moving towards the community we need. It was at the time of the Dartmouth Conference, Hanover, 1972 (Lipsitt 1977). I complained that “... we put into separate compartments the psychological and the physical care of our patients”. Don Lipsitt called me a “disgruntled psychosomatian” (p. 605). I looked the word up in Oxford Dictionary: “grunt ... low guttural sound made by a pig”.

I learned my lesson. I tried to be civilized. Don told me we have to bring culture to medicine. He explained: “... a greater emphasis (*is needed*) in medical school on humanistic, experimental aspects of medicine, *learned through interaction with patients and faculty*” (op.cit. p. 607).

It is a fact that changes in medicine occur over many generations, i.e. they are extremely slow This is well expressed by Graham Swift (op. cit.), Booker Prize winner. He demonstrates that very basic feelings are involved that are related to intergenerational development. They may be transferred over generations as demonstrated in the short story “Haematology”. This story concerns Harvey and his cousin Edward Francis. It takes place seven days after the revolution that resulted in the execution of the king in 1649, whose personal physician Harvey was. His cousin is an influential supporter of the Glorious Revolution. Harvey realizes that he caused a revolution himself. It resulted in the death of Galen’s medicine. He wonders how it will affect him.

3.8.1 *What We May Learn from Oliver Sacks: On Wholistic Medicine in Europe and Worldwide*

This question is posed in the year 2019, 370 years after the death of Charles I. In 1649 and 362 years after the death of Harvey. In my introduction, I expressed my intention to use a phenomenological approach to describe the history of psychosomatics in Europe.

Whichever one of the seven perspectives as formulated in the introduction is followed, the focus is always on the desire and ability of two individuals to take the next step together. The aim is to promote health from conception to the end of life.

I did this casuistically, on the basis of an example. This was often with reference to the history of Dr. E. during the Wartburg Dialogues. I emphasized that his history reflects the history of many men and woman in Central Europe.

We now need to see how a European culture of psychosomatic procedure, a wholistic medical approach, not only fits into a global psychosomatic culture, but is also prepared to help *shape* it.

It seems to me that the best example for casuistry is what happened to the physician, neurologist and author Oliver Sacks (1933–2015). I will develop further the thoughts I expressed briefly in the introduction and explain this assessment by examining Oliver Sacks's life (Sacks 2015). I go back to the *four-stage group work* that I discussed in the introduction: the *primordial* experience in the peer groups on history taking, the participation in group work "*at any time*", the pursuit of a *utopian ideal* (rhythm in the change of generations, gender equality as a cornerstone of democracy, empathetic coexistence as a characteristic of culture), *transcultural approach* (recognition of other cultures).

The primordial experience Oliver Sacks was born in London, a European cultural metropolis. He experienced the first years of his life as warm on the one hand and as very threatening on the other (Sacks 2015). Both his parents were respected doctors who loved their four sons. However, Oliver was traumatized early. He felt he had been abandoned when, at the age of six, he was evacuated from London to escape the German Blitz and sent to a boarding school (cf. Rudyard Kipling) where he was ill-treated by a sadistic headmaster. He remained there until 1943. He experienced his worst trauma as an adolescent when he came out as a homosexual and his mother told him she wished he had never been born. He had already confided in his father who betrayed his confidence by telling his mother. He sensed that he ought to have been dead (Sacks 2015:11). This is the deepest of all imaginable primordial sensing (cf. Section 5). It is understandably directly linked to the wish to stay alive, to take the next step, to move, to breath, to make sure these functions were still working. I have deliberately included the function of breathing here. After birth, it is put to one side as an elementary function of movement. This happens both in fantasy and in reality. Reference is made throughout to this primordial sensing and it runs through the whole work. In order to grasp it, the reader must keep engaging with the NOW (here). Oliver Sacks has the firmly fixed feeling of being dead. I owe the formulation of the NOW (here) to Otto Rank, a former associate of Freud.

Oliver Sacks's main work is "Awakenings"(Sacks 1973). Here he describes how patients with chronic encephalitis were awakened out of their apparent apathy and brought from death to life. This is about basic feelings that are an integral part of the individual. It is this that is spoken about at an early stage in the history taking groups. It is described in English and German on my homepage (www.schueffel.eu).

"At any time" this is a formulation that is also taken from the interview. It refers to the fact that physicians can take part at any time in the basic psychosomatic care groups and have the opportunity to have this primordial experience. I refer to these in Section 5. The reference is to the reading of the Luther Bible in the sixteenth century and again in the 21st. There was no change to the differing interpretations of the last supper. According to the King James Bible "the word was made flesh and dwelt among us" (John 1:14). We can make an analogy with Oliver Sacks.

In 1955, he spent a summer in a kibbutz in Israel where he profited physically from the welcome loss of 60 of his 250 pounds. He was healthy and according to his BMI almost of normal weight. However, he went back to London to his parents, at an age where most people have left home and started a family of their own. He regained his former overweight when living with his parents. Then, in 1960, he decided to go to Canada and from there to the USA – something I would interpret as absconding rather than emigrating. This absconding/emigration would last for the next fifty years.

3.8.2 *The Utopians Face a Dilemma: “Being Revered/Beheaded” or “Being Published/Punished”*

It is Oliver Sacks’s autobiography that prompts my somewhat radical description of the dilemma. His successes in the treatment of his patients brought him the lay public’s admiration. A film of “Awakenings”, directed by Penny Marshall and starring Robin Williams and Robert de Niro, achieved world-wide success, but was ignored by the medical press. It was as though his mother’s wish had been retrospectively fulfilled. I associate this with the historical event mentioned above, where Henry VIII does not thank his moral advisor Thomas More but has him beheaded.

Oliver Sacks describes his own association thus: in every action of publishing, he experiences a kind of “punishing”. There is always the sense of imminent danger in the air.

My associations are of a similar kind. I can see Büchner in despair, fleeing from Hesse and finding asylum in Zürich. That is where he wrote *Woyzeck*, whom he describes as a desperate creature who has been forsaken by his lover. He stabs her with a knife and kills her. The play was performed decades later in Vienna before the outbreak of the first world war. Sleepy sickness (encephalitis lethargica or Economo’s disease, an epidemic between 1915 and 1926) was prevalent in Vienna at the time, similar to the situation Oliver Sacks found in London and in New York. The play was a resounding success. It was described as follows by the young Viennese Paul Elnbogen, who was later to become a refugee himself and who later joined the US film industry:

We young people knew the play very well from Franzos’s publication. A German actor, Albert Steinrück, rude and rather brutal, played Woyzeck. I sat in the gallery of the little Kammerspiele. Four rows behind me sat Alban Berg, whom I greeted as I came in because I had known him very well for years. They played the drama for three hours without the smallest interruption in complete darkness. Indescribably excited and enthusiastic I stood up amidst wild applause, met Alban Berg a few steps behind me. He was deathly pale and perspiring profusely. “What do you say?” he gasped, beside himself. “Isn’t it fantastic, incredible?” Then, already taking his leave, “someone must set it to music.” (Elnbogen 1993)

That was how the opera was born. A short time later, Europe found itself at the most critical point in its history. What is sometimes termed the second Thirty Years War. This was the period when Schiele painted his striking picture of a mother with

a child in the womb. Full of hope, he said “the war is over” and then, aware of his condition, added “but I am dying”. The situation cannot be more vividly described. The picture is on display in the Ludwig Museum in Vienna. In the Dresden exhibition in 2013, “Die Erschütterung der Sinne” (A Shock to the Senses), there was a presentation showing the historical events leading up to this event. The exhibition focused on four painters: Constable, Goya, Delacroix and Caspar David Friedrich (Bischoff and Tuymans 2013).

In Berlin, Wittkower, the pioneer of psychosomatic medicine, had developed an instinct for the people of his time and engaged in psychosomatic medicine as a scientific discipline within the academic program at the university. He emphasizes the work of Georg Groddeck (1923; 1949) who was a close follower of Freud. This tradition was taken up in England immediately after World War II. An empathetic translation of Groddeck’s “ES” was published in England with a sympathetic introduction by Lawrence Durrell (1949).

Oliver Sacks takes up this tradition completely, although he does not mention the names referred to here. However, they only appear to be “forgotten”, they live on in his work. He describes how he went to a psychoanalyst twice a week for about fifty years. He thus reveals himself. He became increasingly aware of the “present-day force” of the illness that showed itself in the symptom.

Wittkower (1977) now shows, in the new North-American location, how the perspectives have developed before and after 1964.

3.8.3 *Exterritorial Publications Today?*

I found it exceptionally helpful to discuss the film “Awakenings” in a Balint group of experienced physicians. We focused on the situation of Lucy with Oliver Sacks. He discovers that Lucy catches the ball that he throws towards her. Until that point, he and his colleagues had assumed that the patients were unaware of their surroundings, in the same way patients with locked-in syndrome were. However, the nursing staff had long held a different opinion, namely that the patients had an inner life. It is now becoming clear to me that the encephalitis-lethargica patients after the first World War are the psychosomatic patients of today.

The experiences in psychosomatics as an approach based on a new phenomenology give me the impression that the ball game with Lucy was nothing other than a consistent grasping of the symptoms of those who were seeking medical help. It makes the primordial experience of the whole possible, as pursued by the Spinoza-adherent Groen. It facilitates the exchange between the old and the young, in the way a fruitful discussion can take place in the democratic sense and in the way a new culture can develop. It demonstrates what a transcultural approach can be like; one that for us in the twenty-first century can grow into a concrete utopia.

When we think about the development of psychosomatic medicine in Europe, it can help us to continue in the footsteps of Oliver Sacks, as Billy Hayes comments in his article in the New York Times of 26.08.2016 (Hayes 2016).

The scene is in a gay bar in New York in November 2014. Oliver Sacks is a highly respected man, no longer persecuted for being homosexual. Indeed, he had been awarded a CBE (Commander of the British Empire) by the Queen. Together with Billy, his partner, he was attending an event in his honor, he was walking with a stick, he was approaching death.

After an hour, Oliver Sacks said, “it is GOOD. It is PERFECT.” He leaves the bar with Billy, to whom he has dedicated his autobiography. It is this culture whose values underpin our medical care in Europe (Zipfel, Herzog, Henningsen, Kruse; 2016). The moment a reflection of this kind is expressed, it begins to be a concrete utopia. This contribution is still published exterritorially in the USA, but American texts are also read in Europe, and thus the word is spread. The Word dwells among adherents of a kind of medicine that has absorbed the word “psychosomatic”.

With that the third country mentioned by the editor in his questions has been touched upon, the USA. Is the “spontaneous experience” we refer to possible there? – At least Oliver Sacks answers this question unmistakably positively. – He, too, indirectly describes the “special meaning” the three rivers have for Dr. E. The meaning lies in the fact that the rivers represent ourselves in our environment: A Rhine and an Elbe will always flow together where our self is. We ourselves can be compared to a Danube. That is the “special meaning” that makes Dr. E’s recovery possible in the course of the Wartburg Dialogues.

Finally, a cautionary observation on the wholistic request made by pre-Socratic Empedocles, who showed at the beginning of our European cultural history how human beings develop between the two temperaments of love and destruction and how they deal with the four elements of water, air, earth and fire. – the air, now with an excess of CO², and all the other elements heating up with global warming (Schellnhuber 2019). How about our two temperaments being part of Empedocles’ thinking?

3.9 Summary and an Exposition with Three Conclusions

The history of psychosomatics in Europe is presented phenomenologically as the history of sensibility and of the symptom within the relationship between two individuals. Four essential phenomena are specified here that exert their influence NOW (here), in the present, past and future, and relate closely to particular realities. The realities are classified under the four phenomena, which are:

- a *primordial sensibility from the NOW (here) of the year 1830 (!)*,
- an obligation to consistently self-reflect *at-any-time*, descending from the year **1530**,
- a notion of sensibility and symptoms taken from the still-existing present of the year **1930**, *the leitmotif* and finally set in
- the context of the year **2030 (2130)**, therein the sensibility and striving for the *protective shelter of a concrete utopia, the dwelling*.

The seven classified realities (also referred to as value horizons) are called *pro-scenium*, *stage* (primordial); *context*, *background* (self-reflection), *rhythm*, *democracy* (notion of sensibility and symptoms), *culture* (concrete utopia).

3.9.1 *Two Time Points: How Büchner Summons us to Reflect on the Marburg Colloquy*

The years 1830 and 1530 frame a time period. Around 1830, the German dramatist Georg Büchner (1813–1837), in exile in Zürich, becomes aware of the fact that in Europe there are “two national medicines”, a French-English and a German. In his inaugural lecture in Zürich (1836), he takes a strong stand on this and perceives it acutely as a primordial experience. He wrote the drama “Woyzeck”, which Alban Berg later based his opera “Wozzeck” on (world premiere in Berlin, 1925).

The year 1530 follows after the Marburg Colloquy (1529) whose significance gradually extended beyond Europe. This dialogue, initiated by Landgrave Philipp the Magnanimous of Hesse, took place between the leading Protestant figures of the times and, on the one hand, demonstrated to the Catholic Church that they considered themselves a unified body. This understanding made the pursuit of individuation as professed in Humanism possible. On the other hand, they disagreed in their self-perception: The Lutherans believed that in the Eucharist, bread and wine are truly transformed to body and blood of Christ, whereas Zwingli and his supporters (later the Calvinists, too) viewed the Eucharist as a symbolic act: “*esse* versus *symbol*”.

The participants did indeed agree upon 14 of 15 articles; they could not, however, reach a consensus on much needed discussion about their dissension. Instead, their emotions met head-on. It came to an epochal division within the Protestant movement which held on over the next centuries and affected nearly all cultural areas, including the media. Not until 300 years later was Büchner able to stimulate reflection through a form of primordial experience.

3.9.2 *The Esse, the Symbolic, Humanism: The Origin of Psychosomatics as a Science, School, Practice*

The year 1930 serves as the start of a *currently (including 2019, the year of Brexit!)* passing present. The present oversees the retro- and anterospective. After the first Thirty-years War (1618–1648), a second thirty-year war takes place (1914–1945) in the midst of Europe; alongside it the Holocaust.

The *retrospective* reaches back to the year 1630. Under the protective and inspirational cloak of humanism, then the Enlightenment, then a so-called third Renaissance, European medicine developed in a (time-ordered) interaction from Italy (Padova) to England (Oxford), the Netherlands (Leiden), the Holy Roman Empire of the German Nation (Vienna), France (Paris), and finally Germany (Berlin, Leipzig). – The year 1630, chosen for mnemonic reasons, indicates the time period William Harvey’s (1578–1657) epochal achievements between England, Italy and Germany were published. His discovery of the (blood) circulatory system in humans and other mammals enabled modern European medicine in its two forms (according to Büchner) to develop over the next three centuries. Even today, occidental philosophy has **ignored** Harvey’s significance. Possibly for this reason, G. L. Engel found medicine has not strayed from a seventeenth century philosophy.

During the first half of the nineteenth century, the German branch of European medicine assimilated social and especially psychological elements by including personality development (Heinroth), the unconscious (Carus), the salutogenetic-macrobiotic aspect (Hufeland), sensory perception (Müller) in its subjectivity. This is where the *esse* came into effect. – This changed in the second half of the nineteenth century, especially in Germany. Here mechanistic, natural scientific medicine began to dominate, which, among other developments, brought forth seminal advances in bacteriology (Tb) and immunology (tetanus, diphtheria vaccinations) (Watson 2010). In reaction formation to the “romantic medicine” before, the organism was henceforth seen as a mechanically steered machine.

This was a phase in medicine that disregarded an individual’s inner change, yet enjoyed worldwide recognition. In the natural course of things the period of de-individualization took hold and was enthusiastically received as medical progress. Because the individual was neglected, medical pseudo-progress soon set in.

The *anterospective* view as of the year 1930 departed from *psychoanalysis* and Freud’s description of transference/countertransference. He did not see himself as a psychosomatic physician, yet his description of what occurs in countertransference can be considered the beginning of scientifically based psychosomatics. For the development of modern medicine he reaches a level of significance equal to Harvey. Through Wittkower and his references to the internist Wilhelm His and the physiologist Walter Cannon, scientifically-based wholistic medicine is henceforth founded.

It very soon occurs that Wittkower and other pioneers of psychosomatics are persecuted by the Nazis. They are either murdered or forced to escape, primarily to the USA. The Nazis prevent any form of empirical treatment for (psychological) trauma. Disorders caused by trauma, whether to feelings or to physical health, are treated medically without regard for the origin and according to the diagnostic code in effect around 1930. Even the most serious traumata are considered pathogenetically irrelevant (e.g., in coronary diseases) well into the twentieth century. Not until the 1960s does isolated resistance form, at first against the “silence”. Today it is a matter of overcoming the silence and actively communicating between generations, for example, about how to detect trauma. We detect the history within ourselves (Lloyde deMouse 1997). And meeting the patient we may undergo the *experience* that “...narrative – and evidence – based approaches ...” (Herrmann-Lingen 2017) can be combined.

3.9.3 Sensibility and Striving for the Protective Shelter of a Concrete Utopia

We have chosen the year 2030 to design models capable of dealing with trauma in a salutogenic way. We aim at the year 2130 in the knowledge that grieving can be considered effective only after being carried across generations.

Oliver Sacks is a personality who brilliantly demonstrates how even the most critical traumas can be treated. He fulfills a kind of “beacon function” that makes a utopia concrete. Sacks gives us a glimpse into his relationship with his mother. The moment she learns he is a homosexual, she says, “I wish you had never been born,” (Sacks 2015:9) and he is “haunted” to the end of his days by those words contrived “to wish me dead” (Sacks 2015:11). – He dies at the age of 86 and had heard the words when he was 19. If we look at Oliver Sacks as a beacon, then we can comprehend that he not only survived his mother’s rejection. With his death approaching, in his partner Billy Hayes’ presence, and in the best known gay bar in New York City he was also able to say to his environment and to his life, “It is GOOD. It is PERFECT.”

This illustrates an ultimate situation (Jaspers, 1946) that each and every person can enter in the face of existential threat. To what extent a person believes s/he is in line with the own sensibility and with the sensibility of the environment naturally differs. Speaking for myself: As the director responsible for the Wartburg Dialogues I have regularly observed that people will become involved in a discussion about the existential issues of health. Specifically, I have regularly observed that participants felt capable of supporting my dialogue partner and myself in such a way that the Next Step was ALWAYS formulated. What was imperative was that I kept these three aspects of my actions in focus; I myself was therefore a fourth aspect. This is why I feel entitled to call Oliver Sacks the most eminent psychosomatic physician of our time.

In retrospect I understand that an *INVOLVEMENT* takes effect that allows for both a symbolic act and an *esse*, and for oscillating between the two. Beyond all ideological-religious issues, the controversy during the Marburg Colloquy thus becomes a greatly significant and meritorious endeavor of our times and of 2130. A shelter can serve as a notion in which the concrete utopia takes shape. As the family physician Dr. E. worded it for his practice: “Within this shelter I conduct health dialogues each day.”

Dedication *This paper is dedicated to Shân. Over the last 50 years she has helped me to bridge the two sides of the English Channel. This made me feel at home in different cultures*

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Chapter 4

European Perspectives in Psychosomatic Medicine: Integration Through Interaction and Networking



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and Ramiro Verissimo

Abbreviations

ACPM	Asian College of Psychosomatic Medicine
APM	American Academy of Psychosomatic Medicine
APS	American Society of Psychosomatic
C-L	Consultation/Liaison
CBT	Cognitive behavioural therapy
EABCT	European Association for Behavioural and Cognitive Therapies
EAPM	European Association of Psychosomatic Medicine – The European Association of Consultation-Liaison Psychiatry, Psychosomatic Medicine and Integrated Care
ENPM	European Network of Psychosomatic Medicine
ICPM	International College of Psychosomatic Medicine
IJBM	International Journal of Behavioural Medicine
ISBM	International Society of Behavioural Medicine
JPR	Journal of psychosomatic research
Psychother Psychosom	Psychotherapy and psychosomatics

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4.1 Introduction

The importance of psychosomatic medicine has increased in both research and health care.

In Research

It is obvious that in the last century medicine has described several mechanisms of the etiology of different diseases along with new treatments. The scope of psychosomatic medicine has grown and been spread into new dimensions.

Psychosomatic scientists need all the power and support they can get from research institutions and from collaboration with each other. In this way they can maintain a high research level in this field, which has changed dramatically during the last 50 years.

In Health Care

Mental disorders are highly prevalent in Europe and impose a major burden on individuals, society and the economy (European Framework 2016). About twenty years ago the diagnosis of emotional disorders and psychosomatic disturbances was rare. Now, individual expectations in terms of quality of health and the phenomenon of progressive, scientific, psychosomatic understanding of diseases has increased and led to a demand for practical use of psychosomatic medicine. Acceleration in the development of significant technological advances in the field of medical science has created hope for radical improvement in life expectancy and quality of health. While life expectancy has been extended, the progress in the quality of health is unsatisfactory, mainly due to chronic, persistent emotional disorders and psychosomatic symptoms.

This new interdisciplinary setting is a challenge for practitioners – physicians, psychologists, nurses, social workers and others – and for scientists in the psychosomatic field. Many of these professionals have their own scientific societies, not only in special research fields, but also in medical specialties and sub specialties. For this reason, over the course of time different international and national societies have been formed. Compared to specialist societies like gastroenterology or psychiatry, psychosomatic or behavioural societies have a broader scope. They focus on psycho-social conditions and mechanisms according to origin and course of all somatic, somatoform and psychological diseases and want to influence their conditions by psycho-social or other interventions.

Communication between all professions in the field seems useful. The idea was born that different international and European psychosomatic/behavioural societies should be able to communicate in special research, health care, and psychosomatic training questions. This could be facilitated through special networks for scientific exchange. All medical/psychological societies involved in a special psychosomatic issues should be able to cooperate to maximize their strengths (and their ability to write research proposals for grants) in the competition with genetic, biochemical, pharmaceutical, cardiology and other powerful research groups.

This chapter describes an attempt to increase communication between the professions involved in psychosomatic medicine. Beginning with the history of ECPR

*(European Conference on Psychosomatic Research), following with a description of the ENPM (European Network on Psychosomatic Medicine) aims and development, the combining of ENPM and EACLPP (European Association of Consultation Liaison Psychiatry and Psychosomatics) and the limited success of this cooperation (see below), future directions of the aims and ideas of ENPM are outlined at the end of this chapter.

4.2 History of European Conferences on Psychosomatic Research

The first of the European Conferences on Psychosomatic Research (ECPR) took place in London in 1955. These conferences brought together individuals from European countries interested in psychosomatics (Schüffel 2013). The first three Conferences took place annually; in London, Amsterdam, and Copenhagen. Then there were two bi-annual conferences in Hamburg and Madrid; after which there were conferences every three years, until 1970, with venues in Athens, Rome and Knokke in Belgium (Table 4.1).

Elected four years earlier among the community of European researchers, a well-known European researcher was the president and organizer of each conference. Interestingly, 60 years later we recognize distinguished psychosomatic scientists who were among these successive organizers of the ECPR's meetings e.g. Johannes J. Groen, Archibald Denis Leigh, Lennart Levi. A formal society did not seem necessary in those days, when communication was a very individualized process. The main goal of these meetings was to modernize the psychosomatic medicine focus from literature and philosophy into comprehensive research oriented toward acquiring better and sounder knowledge in psychosomatic. It seemed necessary by then to come forward with evidence-based findings obtained through experimental research and studies on the psychosomatic underpinnings of different diseases. Of relevance to this matter were the London group, D. Leigh, psychiatrists from Madrid, J. J. López Ibor and Italy, Ferruccio Antonelli, as well as internists from Amsterdam and Hamburg, J. Groen, Henk Pelsler, Arthur Jores. From the 1950's, the group was able to present, discuss and promote their own studies in the scientific journals "Psychotherapy and Psychosomatics" (1953) and "Journal of Psychosomatic Research" (1957).

At the time ENPM was founded five other societies were already involved in the "Psychosomatic field":

1. The American Psychosomatic Society (APS; Herrmann-Lingen 2017). With a tradition going back to the 1930s, founded in 1942 by a group of scientists: Edward Weiss, Helen Flandars Dunbar, Walter B. Cannon, Eric Lindemann, Harold G. Wolf et al., this society was mainly oriented toward psycho-biology into the detection of psycho-social mechanisms involved in somatic diseases. In later years it has become increasingly difficult for APS to host research, health care, and clinical practice under the main scope of this society. Consequently,

Table. 4.1 Presidents and locations of the European conferences of psychosomatic research (ECPR)

D. Leigh (London 1955)
J.J. Groen (Amsterdam 1956) ^a
V. Lunn (Copenhagen 1957)
A. Jores (Hamburg 1959)
J. Rof Carballa & J.J.Lopéz-Ibor (Madrid 1961)
G.S. Philippopoulos (Athens 1964)
F. Antonelli (Rome 1967)
R. Pierloot (Knokke 1970)
E. Ringel (Vienna 1972)
C. Aitken (Edinburgh 1974)
W. Bräutigam (Heidelberg 1976)
F. Askevold (Bodø 1978)
G. Koptagel-Ilal (Istanbul 1980) ^a
H. Pelsler (Nordwijkerhout 1982)
H. Wolff (London 1984)
G. Christodolou (Athens 1986) ^a
W. Schüffel (Marburg 1988) ^a
P. Tienari (Helsinki 1990)
(1992 in Dubrovnik cancelled due to Bosnian war)
M. van Moffaert (Gent 1994)
M. Bourgeois (Bordeaux 1996)
F. Creed (Manchester 1998) ^{a,b,c} , founding of EACLPP with common biannual and separated biannual meetings
U.F. Malt (Oslo 2000) ^b
G. Cardoso & A. Barbosa (Lisbon 2002) ^a
H.C. Deter (Berlin 2004) ^{a,c}
M. Talcic (Cavtat 2006)
A. Lobo (Zaragossa 2008) ^b
G. Schüssler (Innsbruck 2010) ^b
P. Fink (Aarhus 2012) ^{a,b,c} , founding EAPM with annual meetings
D. Dumitrascu (Sibiu 2014) ^{a,c}

Since 1986: ^aICPM member ^bEACLPP member ^cAPS member (limited information before 1986)

APS has renamed itself in the last years as “APS, dedicated to the integration of biological, psychological and social factors in medicine”. The journal of the APS “Psychosomatic Medicine”, was founded 1939, and now carries the subtitle: “Journal of Bio-behavioural Medicine”.

2. The International College of Psychosomatic Medicine (ICPM; Streltzer 2016). This society was founded by scientists from North America: Eric Wittkower, Morton Reiser, Zbigniew J. Lipowski (1977) and Adam Krakowski, South America: Maurice Knobel, Roberto Kertész, and Europe: Herman Musaph, Johannes Groen and others in 1970, and included representatives from Asia (Yujiro Ikemi), Africa (Henry Collomb) and Europe (Jan Bastians, Jules Angst, Thure v. Uexküll). It used to have a biannual meeting that alternated with the

European Conference on Psychosomatic Research. This society was more focused on the medical field as a whole and on a holistic perspective of medical practice. The stimulation of better psychosomatic clinical care in the broad medical field was equally as important as the level of research. George Engel (1977), from Rochester, was a mentor and keystone to this thinking. This society's affiliated journals include "Psychotherapy and Psychosomatics", "Journal of Psychosomatic Research", and "General Hospital Psychiatry".

Following the ideas of ICPM was the founding of an Asian College of Psychosomatic Medicine by Internal Medicine physicians from Japan (1984). They had founded their own Japanese Society 1959 (Ikemi 1963) and were also interested in the integrative perspective of Psychosomatics in the whole field of medicine (Murakami and Nakai 2017). Of the many societies (from Spain, Italy, etc.), the German College of Psychosomatic Medicine was one of the first national European societies, founded in 1974, and had ideas and activities closely related to those of the ICPM (Deter et al. 2017).

3. The Academy of Psychosomatic Medicine (APM; Psychiatrists providing collaborative care bridging the gap between physical and mental health) founded by psychiatrists interested in consultation-liaison (C-L) psychiatry and psychosomatic medicine 1953 (W. Dorfman, Z. I. Lipowski (1991)), APM maintained that psychosomatic medicine was very close to the clinical perspective and practice of psychiatrists working in the field of consultation-liaison activities in general hospitals. This overlaps the EACLPP conception (see below); but its tradition goes back to the 1950's. The APM (1200 members, 900 congress participants) is affiliated with American Psychiatric Association and publishes its official journal "Psychosomatics" since 1960.
4. The International Society of Behavioural Medicine (ISBM). Founded in 1990, by five national societies of behavioural medicine (Stephen M. Weiss, Irmela Florin, Kristina Orth-Gomér et al.), ISBM defined "behavioral medicine as the interdisciplinary field concerned with the development and integration of biomedical, behavioural, psychosocial, and sociocultural science, knowledge and techniques relevant to the understanding of health and illness, and the application of this knowledge to disease prevention, diagnosis, treatment, rehabilitation and health promotion" (Orth-Gomér and Schneiderman 1996). It focused on all-important behavioural, psychosocial and biological risk factors and had as its goal the detection of behavioural, psychosocial risk factors besides "biological mechanisms" in the social environment. With lesser emphasis on individual psychosomatic processes and more emphasis on public health, it was founded by both physicians and psychologists (Schneiderman and Orth-Gomér 1996; Orth-Gomér et al. 2005) and focuses mainly on sound empirical research. The integration of behavioural medicine with other scientific fields would lead to better and more successful research. ISBM is an umbrella organization and has 26 national or regional societies (representing many thousand individual members) over the whole world. Formerly, psychosomatic societies were based on individual membership. The journal of this society "International Journal of Behavioural Medicine" started in 1994.

5. The European Association of Consultation Liaison Psychiatry and Psychosomatic (EACLPP). Founded in 1998, it was an attempt to solve the problem, as some researchers saw it, of the loose structure underlying the organization of the European Conferences on Psychosomatic Research. The founding members meant to provide a means to work together more intensively within a society of their own. The starting point of the EACLPP was the 1987 decision of some consultation-liaison (C-L) psychiatrists in Europe to develop a closer collaboration to stimulate the development of the C-L field (Huysse 1991). Following this initiative, the European Consultation-Liaison Work group for general hospital psychiatry and psychosomatic (ECLW) was established. The group consisted of psychiatrists and psychologists working with patients referred to psychiatric/psychosomatic departments. These scientists designed a huge project, the ECLW study (Huysse et al. 1996), sponsored by the European Union. The study included 226 consultants from 56 psychiatric C-L services in 11 countries. The ECLW study required that a network of researchers and clinicians across Europe be established (Huysse et al. 2001). When the ECLW study ended, the EACLPP was established as a formal organization of the ECLW network. These researchers were mainly focused on “Consultation-Liaison diagnosis and care in a general hospital setting as applied by psychiatry and psychosomatic physicians (Leentjes et al. 2011). Additionally the C-L section of the European Association of Psychiatry organizes symposia and education in psychosomatic medicine, with emphasis on psychiatric aspects. The “Journal of Psychosomatic Research” became the scientific platform of EACLPP. There is little distinct difference in content of the various societies, they all try to integrate body and mind, but there are clear differences in methods, aims, objectives, and health care practice.
6. Other societies in the “psychosomatic field” – Societies of psycho-physiology, psycho-neuro-immunology, health psychology etc. were also interested in this approach to the medical area, while focusing on epidemiology, physiology, biochemistry and interventions for some special patient groups.
 - Special interest groups and organizations related to specific disorders or treatments also had their own societies: e.g. European Association of Palliative Care, European Work Group on Transplantation Psychology and Psychiatry, International Society in Dermatology, Psychiatry and Psychosomatics, International Society of Psychosomatic Obstetrics and Gynaecology with national branches, European Association of Communication and Health.
 - Psychotherapeutic societies and psychotherapeutic research in the psychosomatic field.

Also important are the developments that occurred in the psychotherapeutic scene which influenced psychosomatic medicine; namely the founding of the International and German Psychoanalytic Association (1910/1926) and the German Society of Psychotherapy (1926); which influenced the founding of APS. The International Federation of Psychotherapy, the Society of Psychotherapeutic Research and the different national societies of Behavioural Therapy also left their traces on the

psycho-social dimension of Psychosomatic Medicine interventions today, e.g. the European Association for Behavioral and Cognitive Therapies (EABCT).

It is an association that brings together 53 individual associations from 39 different countries. Each association is committed to empirically based principles and the practice of behavioral and cognitive therapy approaches in the health, social, education and related fields. They include studies on CBT in somatic diseases and of patients with somatic symptoms. Additionally, Germany has developed a medical specialty, the “German Society for Psychosomatic Medicine and Psychotherapy”, which was founded in 1990 (Deter 2004; Deter et al. 2017).

While two of the five international psychosomatic societies mentioned above were founded in the United States, the others had a European traditional background. The different developments of these international psychosomatic societies probably are an expression of the conceptual and psychotherapeutic (psychodynamic, psychiatric or behavioural) way of thinking of their members (Table 4.2). However, in the middle of the first decade of 2000, the time had come for a common interdisciplinary perspective and practice, free of ideological and professional “blind spots”.

4.3 Ideas, Aims and Progress of the European Network on Psychosomatic Medicine (ENPM)

The “European Network of Psychosomatic Medicine” (ENPM), dedicated to the integration of psychological, social and biological factors in health care”, was founded by colleagues from European countries, participating in the the joint 25th ECPR- EACLPP European meeting held in Berlin, in 2005 (July 8/9) as a forum for 21 delegates of many psychosomatic/behavioural/psychiatric/internists national societies to present their work*. It was open to all national and international psychosomatic societies and colleges, ECPR-organizers, EACLPP, ICPM, ISBM and others. The forerunner and important model for the ENPM was the ECPR.

*Members of the ENPM initiative 2004/2005 were:

Gunta Ancane (LV), Margarita Beresnavaitė (LIT), Antonio Barbosa (PT), Hans-Christian Deter (GER), Dan Dumitrascu (ROM), Kristina Dropowa (POL), Christian Facekas (AU), Giovanni Fava (IT), Per Fink (DK), Maria Koppf (HUN), Ulrik Malt (NOR), Gabriele Moser (AU), Kristina Orth-Gomér (SE), Carl Scheidt (GER), Gerhard Schüssler (AU), Tatjana Sivik (SE), Wolfgang Söllner (GER), Törres Theorell (SE), Ramiro Verissimo (PT), Ad Vingerhoets (NL), Bohdan Wasilewski (PL)

An important task was to promote scientific exchange and collaboration between members of different societies and medical fields. One impressive example of such cooperation was the “Task Force for European Guidelines in prevention of cardiovascular disease”. This was concerned with the formulation of rules and recommendations on how to prevent recurrences in heart patients. The group con-

Table 4.2 The old world meets the new. Origins of psychosomatic medicine: Concepts, scientific operationalisation and health care implementation in different psychosomatic communities

Societies	Membership special profile ^a	Research	Health care
European conference on psychosomatic research ECPR (inaugurated 1955)	European; interested physicians and psychologists on the biannual conferences, 450 participants, 250 posters; no society, no members. At the conferences one business meeting of ECPR participants	Research on psychosomatic diseases in a bio-psycho-social way and applying this knowledge into clinical practice; focused on clinical psychosomatic research, mechanism and interventions	Health care issues in the whole field of medicine
International College of Psychosomatic Medicine ICPM (inaugurated in 1970)	International; 120 individual members from 30 different countries around the world, professionals (physicians, psychologists, nurses etc.) in health care. Bi-annual meetings (600–1000 participants; 200 posters), president, board, advisory board, three committees ^b implementation of psychosomatic knowledge in clinical practice; focusing on doctor patient relationship and emotional aspects in psychosomatic medicine	Common clinical and philosophical questions of the whole clinical field, interventions	Practical issues of the whole field of medicine, many specialities, like general practitioner, internal medicine, gynecology.
International Society of Behavioural Medicine ISBM (inaugurated 1990)	International federation of 26 regional member societies around the world (14 European); about 20% physicians/80% psychologists and others. Bi-annual meetings (650–800 participants; 400 posters), president, executive committee, governing council, 9 other committees, 4 special interest groups ^b ; news letter. On one hand epidemiological, public health and on the other hand neuro-biological aspects of empirically found associations. Identification of four important phases: 1. Identification of the health problem. 2. Re-evaluation. 3. New methods to manage the problem. 4. Training of skills to maintain change.	Mainly focused on behavioural aspects of medicine; emphasis on cognitive behavioural intervention and prevention; recognition of behavioural mechanisms in public health. Health care politics.	Focusing on behavioural aspects in medicine, implementation in primary care and other specialties with scientific evaluation

(continued)

Table 4.2 (continued)

Societies	Membership special profile ^a	Research	Health care
European Association of Consultation Liaison Psychiatry and Psychosomatics EACLPP (inaugurated 1998)	About 100 individual members, mostly psychiatrists. Annual meetings (200 participants; 100 posters), president, board, working and special interests groups. Research in the field of consultation liaison psychiatry and psychosomatics with integration in hospital and clinical practice of psychiatry and the field of medicine	Clinical psychiatric/ psychosomatic research, interventions; development of the Care Complexity Prediction Instrument (COMPRI) and INTERMED as spin-off of the ECLW study (Huyse et al. 1999)	C/L psychiatry and psychosomatics, integrated care
European Association of Psychosomatic Medicine ^c EAPM (inaugurated 2012)	About 120 individual members, psychiatrists, psychosomatic specialty, psychologists. 10 European member societies. Annual meetings (250–400 participants; 150 posters), president, board, 1 working and 13 special interests groups ^b . Research in the field of consultation liaison psychiatry and psychosomatics, integration in the whole field of psychosomatic medicine, hospital and clinical practice.	Clinical psychosomatic and psychiatric research, interventions	Psychosomatic medicine, C/L psychiatry and psychosomatics, integrated care
American Psychosomatic Society APS (inaugurated 1942)	North American society; about 1300 individual members, psychologists, physicians, few specialties; with an international branch (about 12% from Europe); annual meetings (500 participants; 800 posters), president, board, 6 committees, 5 special interest groups ^a ; newsletter (twice a year)	Goals: Scientific excellence, clinical relevance; mainly focused on clinical psychosomatic research: Mechanism; intervention studies (RCT)	Interested in special psychosomatic fields: i.e. cardiologic, gastrointestinal, pain etc.

^aMember-, participant- and poster-numbers of this table are information, which authors got in conferences, newsletters, websites or in personal communication within the last years. They are not fixed on a special time point and roughly estimated. For exact information within a special time line, please contact the secretaries of the individual societies

^bTopics of the individual committees, special interest and working groups are shown on the individual society website: www.icpmonline.org (3); www.isbm.info (13); www.eapm.eu.com (14); www.psychosomatic.org (11); www.apm.org/clpsychiatry.org (26)

^cEAPM was founded in response to reorientation of the European psychosomatic development, to combine ideas of ECPR and EACLPP

sisted of representatives of several different societies – Cardiology, atherosclerosis, Diabetes, Hypertension, Behavioural Medicine, Family Medicine etc. The psychosomatic contribution of the organized work group for these Guidelines was truly international and interdisciplinary. Another form of activity, centered mainly in the area of Eastern Europe, was the activity appointed by ENPM in 1994 – European Training Center (ETC) on psychosomatic medicine, based in Warsaw. In cooperation with the Polish Psychosomatic Society and Psychosomatic Institute, ETC has implemented educational projects in cooperation with the Polish Ministry of Labour and Social Policy – a semester program of postgraduate training for more than 600 social workers. They were trained to recognize emotional and psychosomatic disorders and to participate in comprehensive treatment.

This network was meant to be open to all European and international scientists and clinicians, as well as psychosomatic, psychiatric and behavioural societies also interested and working in this field. The founding members attending this meeting were, in one way or another, also involved with the Psychosomatic Societies from Sweden, Poland, Latvia, Hungary, Romania, Portugal, Austria and Germany; all other European and International Societies were then invited to join the European Network for Psychosomatic Medicine (ENPM).

Communication among scientists was anchored in an ENPM Homepage (<http://www.enpm.eu>), which included hypertext links to the web-pages of all European Psychosomatic societies. The management of the Network website as well as the commitment of proposing a logo was assigned to R. Verissimo, from Porto University, Portugal. RV and HCD conducted the developmental work on computer tools and software, which have enabled us to implement the ideas of free and integrative scientific exchange of ideas, concepts, thoughts, results, and conclusions. An important aim was not to engage the members in any unnecessary administrative tasks. A new model of free scientific integration that will directly benefit the quality of our scientific work and personal competence is practiced. The model of psychosomatic medicine did not differ from those presented by other psychosomatic societies or associations, but the focus on communication over society borders was new. The German College of Psychosomatic Medicine assumed in turn to host an internet discussion forum on its homepage involving all members of the ENPM, and C. Scheidt was appointed as the first manager of this forum.

Perspectives of collaboration in education and research (Deter and Verissimo 2008):

- Recognition, discussion, and harmonization of students and postgraduate training in psychosomatic medicine was assumed to be one of the outmost important tasks for ENPM _ Promoting psychosomatic oriented health care in a European perspective, in general practice, and other specialties (dermatology, gynaecology, neurology etc.), was another important task considered.
- Psychotherapeutic training for medical doctors and psychologists, and their integration within the health care system (in private practice and at an inpatient level) was a topic of interest.

The need for common European actions in the field of Psychosomatic Medicine

- Psychosomatic medicine in Europe must deal with similar problems and themes, such as the relation between theoretical findings from different fields: biological, on one hand, from basic sciences, and progress in good clinical practice on the other.
- This means good bio psycho-social primary care, family and internal medicine and detection of psychosomatic mechanisms implicated in different chronic diseases.
- As we gain a better understanding of the mechanisms involved in these complex diseases, especially on the psycho-social influences, we should also develop strategies to promote this knowledge in each and every country, thus allowing its implementation into their medical practice. Research in psychosomatic medicine is often conducted in collaboration with medical colleagues, but to demonstrate psychosomatic interactions involved in some diseases we need good empirical background data in all medical domains. We have to provide evidence that special psychosomatic strategies of treatment are better for dealing with biological, psychological, and social aspects involved in these complex diseases; and we have to demonstrate, through randomized clinical trials, that the efficacy of these treatments is, at least, comparable to other commonly used treatments. Only in this way will it be possible to bring psychosomatic experiences and knowledge into a level of widely accepted national and international guidelines for these complex diseases.

This seems to be a program that can be independently adopted by many psychosomatic research centers. The interdisciplinary communication and integration of important ongoing studies that the European Network on Psychosomatic Medicine intended to foster combined ideas and actions and made the acquired psychosomatic knowledge available to the health care systems across Europe.

Aims of the network

- Bring together all psychosomatic and behavioural societies in the psychosomatic field
- Coordinate European research activities sponsored by the European Union
- Coordinate European exchange programs for students, postgraduates and other research fellows
- Discuss actual important psychosomatic/behavioral/CL questions
- Give support for developing psychosomatic national Societies

Health Care

- Sufficient psychosomatic care in all European hospitals
- Sufficient out-patient psychosomatic health care in all specialties

Prevention

- Successful strategies of disease prevention and health care with integration of a bio- psycho social perspective.

Discussions at the homepage: <http://www.enpm.eu>

- *Links* and contacts to all national and international Psychosomatic/Behavioural societies in Europe
- *Open discussion platform* for several questions in the psychosomatic field
- ENPM coordinators in all European countries, who give support for the ENPM

Topics for action

- Psychosomatic training and diploma in Europe
Coordinator: G. Schüssler, Innsbruck, Austria
- Psychosomatic/behavioural interventions in Coronary heart disease in Europe
Coordinator: K. Orth-Gomér, Stockholm, Sweden, European Guidelines in Cardiovascular Prevention in Clinical Practice.
- Psychosomatic/behavioural interventions in ulcerative colitis and Crohn's disease in Europe
Coordinator: G. Moser, Vienna, Austria, European evidence-based consensus on the diagnosis and management of ulcerative colitis (Van Assche et al. 2013)
- European exchange programs for students, postgraduates and other research fellows
Coordinator: Dan Dumitrascu, Cluj, Romania.
- Psychosomatic basic care in Europe
Coordinators: B. Wasilewski, Warsaw, Poland; H.C. Deter, Berlin, Germany

A program implemented in 1995 with the participation of the ETC, Psychosomatic Institute in Warsaw and the Polish Balint Association is a training program for Ukrainian doctors and psychologists in the field of doctor-patient communication and psychosomatic approach in medical and psychological practice (Wasilewski 2011). Under this program, implemented in cooperation from the Ukrainian side by Bukovinian.

State Medical University in Chernivtsi and the Association of Psychotherapists and Psychoanalysts of Ukraine, several hundred Ukrainian doctors and psychologists participated in training. An initiative to obtain EU-funding for research for "Communication in doctor-patient relationship" was initiated.

Meetings of ENPM included presentations, symposia, work-shops and business meetings between 2004 and 2015 at European, national and international Psychosomatic Conferences in Cavtat, Croatia, 2006; Zaragoza, Spain, 2008; Innsbruck, Austria, 2010; Aarhus, Denmark, 2012 (European Conferences on Psychosomatic Research (ECPR); and Sibiu, Romania, 2014 (EAPM). National meetings of the German College of Psychosomatic Medicine were held in Nuremberg, Freiburg, Mainz, Essen, Munich, Heidelberg, Berlin and of the Polish Psychosomatic society (English language in international sessions).

In 2008 a broad vision was presented. It was general and wide enough to include the aims of the ENPM and other psychosomatic/behavioural societies in Europe for the next 20 years (Deter 2008). The development of the ENPM was a practical organization process to frame those different and overwhelming aims. It

seemed unrealistic and out of reach to manage those aims without a proper structure of its own society.

4.3.1 Further Steps of the ENPM

In Innsbruck 2010, the ENPM decided to found a new society, the European Federation of Psychosomatic Medicine, with a president, treasurer, and secretary, to foster interaction between individual members and different European Psychosomatic societies that would include the above-mentioned basics. After the founding meeting in Innsbruck, the idea came up of merging the ENPM – an informal network of scientists and friends – with the much more structured society EACLPP. This was done after many, partly intense discussions, among colleagues and board members of ENPM and EACLPP at the meetings in Aarhus 2012 and Cambridge 2013.

The election of a European Association of Psychosomatic Medicine board took place. Since then five annual EAPM conferences (Sibiu, Nuremberg, Lulea, Barcelona, Verona) have been organized.

4.3.2 Commentary

There are many national and international scientific societies active within the psychosomatic field (Table 4.2). As compared to primary care, gastroenterology (Boye et al. 2008) or cardiology, where one powerful society is active (e.g. the European Society of Cardiology, with more than 20,000 participants at the annual meetings), the field of psychosomatic/behavioural medicine is broader. It is in contact with all societies that represent the different medical disciplines and sub-disciplines (Enck et al. 2016). The psychosomatic interest area (psychosomatic medicine, behavioural medicine) is also spread throughout many different scientific groups oriented or devoted to special aspects: psycho-social care/intervention, primary care or even special sub-disciplines like medical/clinical communication, psycho-physiology, psycho-neuro-immunology, psychosomatic public health, health psychology, and others. All these scientists are innovative and are working in important fields of psychosomatic, but mostly without cooperation with other members of different psychosomatic sub-disciplines. The scientific journals of each society give important and new information for psychosomatic scientists about progress and new events in a special field. But, it seems necessary to intensify and combine the activities of these diverse societies involved in psychosomatic medicine. In fact this is a very diverse field. The debates on its value for clinical aspects of diagnosis and treatment are so controversial that it was necessary to promote more intense

collaboration and discuss the different scientific questions raised in many groups, but also within a European Network on Psychosomatic Medicine.

This idea may be controversial within some individual professional groups, involving different disciplines as they attempt to engage with psychosomatics. The structure of each group is crucial for the aims, ideas, and self-confidence of the individual members of these groups. But the situation now may be good for the field of psychosomatic medicine and its researchers. The example of the third Task force of European Guidelines on cardiovascular disease prevention, where eight societies worked together for scientifically based high level recommendations for clinical practice, is instructive in that it encouraged us to organize a communication platform for psychosomatic and behavioural medicine in Europe (de Backer et al. 2003; Orth-Gomér et al. 2005).

4.4 European Network on Psychosomatic Medicine (ENPM) and the Attempt to Merge It with EACLPP

The question for the newly founded society EAPM was which way to go. This was not only a network activity for European researchers on the same level, but included now also a president, vice president, board, the EAPM members, and the associated societies of EAPM. What should be the targets and challenges of the new society in the area of European psychosomatic medicine? (Table 4.2).

Firstly, a clear definition:

In this chapter we describe “psychosomatic medicine” as bio-psycho-social medicine, as in G. Engel’s (1977) definition, on one hand meaning a holistic dimension of medicine and on the other explaining in a scientific way differentiated bio-psycho-social mechanisms of etiology and the course of somatic and somatoform diseases along with possible intervention options.

1. Psychosomatic medicine in research and health care may imply:

- (a) Psychological and social aspects of etiology and course of somatic diseases. This includes personality and behavioural aspects e.g. classical conditioning, operant conditioning: prevalence, impact on course/outcome. It also includes psychosocial interventions.
- (b) Psychological and social aspects of etiology and course of somatoform/functional disorders and other psychological syndromes with somatic symptoms. (Including personality): prevalence, impact on course/outcome. It also includes psychosocial interventions.
- (c) Psychiatric aspects of somatic, somatoform diseases and other psychological syndromes with somatic symptoms: prevalence, impact on course/outcome. It also includes psychological interventions. There is some controversy concerning whether psychosomatic medicine includes psychotic disorders or only non-psychotic disorders like anxiety and depression.

- (d) Psycho-neuro-pathophysiology, –endocrinology, – immunology of a, b and c.
 - (e) Population based studies on prevalence and incidence
2. In a holistic perspective the following important points have to be added:
- (f) understanding and improvement of communication and interaction between patient and physician or other care givers,
 - (g) critical view on rationale, structure and development of health care systems in a society and
 - (h) examination of health care systems under bio-psycho-social needs of patients and doctors

In psychosomatic practice, a tendency to focus on special aspects of clinical care, e.g. C-L psychiatry, psychotherapeutic medicine applied by physicians, or behavioural therapy in medicine, can be identified. Such limitations are not necessary and will not be widely accepted by others (e.g. ICPM, ISBM), they do not present the whole field. For the challenges of psychosomatic medicine, mentioned above, it seems important to focus on crucial points.

Our goal was to foster international and European psychosomatic/behavioural societies. How should they communicate and cooperate in research, health care and psychosomatic training questions? We saw the importance of establishing networks to combine the strengths of all societies working in the psychosomatic field.

We note that

1. There seems to be a high need to discuss strategies for psychosomatic research in the future in special disease networks. A small society like EAPM – focused on clinical research and care – does not fulfill those requirements and cannot give sufficient support for a big study like the EU funded Consultation-Liaison study (Huyse et al. 2001) or the Female Coronary Risk study (Orth-Gomér and Schneiderman 1996). We think this society is too small and, the perspective too narrow to organize, within scientific groups of somatic medicine, a big study or work together with large groups in a European Guidelines committee (de Backer et al. 2003).
2. The different challenges related to the level of health care and services are a second task. One individual society should focus on each care levels: e.g. GP-, clinical specialty- and CL psychiatric/psychosomatic service level, which have different clinical needs and scientific foci. Individual training and learning by doing, through the responsible GP's or physicians in the specialties, or through support from psychosomatic specialists are two kinds of psychosomatic care:

Responsible physicians in the whole clinical field as well as psychiatrists or psychologists working in general hospitals have to select and pursue different tasks.
3. A third point was the challenge to increase psychosomatic knowledge and skills in different professionals working in the field of psychosomatic medicine, e. g. specialists in internal medicine, psychiatrists, psychologists, nurses, and social workers. They have different needs. It is impossible for EAPM to sufficiently

influence the professional standards in one region, one country, or in the whole of Europe.

What happens with the aims of the former ENPM after the decision has been made to cooperate in one single society? EAPM started a really good process in developing by-laws and an exemplary administration, having now at the annual meetings delegates from 23 European countries, integrating ten national societies of C-L-psychiatry and psychosomatics (5) and Psychosomatic Medicine (5) as members; which was one of the goals in ENPM. EAPM could cooperate in the conferences 2014 to 2018 in common satellite symposia with ICPM or ISBM.

The founding of EAPM stimulated new ideas in the former EACLPP (to be more integrative, more interdisciplinary, and multi-professional), but the three main targets of the former ENPM (see above) have not been realized. Additionally the communication among scientists (4) was anchored in the ENPM homepage, which included links to the web pages of all European Psychosomatic societies. But the cooperation with other somatic medical societies, e.g. European Guidelines in different somatic diseases (5), giving support for psychosomatics in primary care (6), developing a psychosomatic diploma in European countries (7), or supporting European exchange programs for students, postgraduates and other research fellows (8) have not been attempted. ENPM-perspectives of collaboration in communication, research, care, and education and the results within the EAPM after four years of co-working are described in Table 4.3.

However we have to accept that the EAPM is a standard society with usual and accepted ways of thinking and acting, which is unfortunately resistant to open discussion and change.

- (a) Research: There are several successful national research projects, but there was no interest in international research initiatives, not on an EU- level, not on an NIH-level, or not even on a low level towards a common European proposal for funding in the clinical somatic field. Until now there has been no attempt, whatsoever, in any psychosomatic/behavioural society, to achieve common European Guidelines (perhaps a “transplantation group” or a “somatoform disorder in primary care group” will develop). The questions cannot be answered as to who will provide for qualified research – within or outside the society- or as what kind of support is needed. Who is in the best position to get high impact (Impact Factors) and obtain grant-money for the psychosomatic field?
- (b) Care: There was less interest in involving specialists in internal medicine, neurology, dermatology, and gynecology in the society or working together with their specialist societies, although it is within those specialties that most psychosomatic cases are diagnosed and treated. Most EAPM members had psychiatric training and their main interest was health care on a consultation-liaison level with a special interest in somatoform disorders. Additionally, physicians with German psychosomatic specialty training have become members, so the society which should prevent further atomization of medicine and support the psychosomatic approach as an integral part of each medical practice, rather leaves this activity to the specialists.

Table 4.3 Aims, discussions and actions developed in ENPM practising in the new founded society EAPM within 4 years

ENPM aims	EAPM, June 2016
Aims	
Bring together all psychosomatic and behavioural societies in the psychosomatic field	4 psychosomatic societies 1 primary care society 5 consultation/liaison/psychiatric societies 120 individual members
Coordinate European research activities sponsored by the European Union and influence decisions of national and European health care- and research politicians	None
Coordinate European exchange programs for students, postgraduates and other research fellows	Partly; 2015 academy for psychosomatic medicine was founded
Discuss actual important psychosomatic questions	Few, many are missing
Give support for developing psychosomatic national societies	For the Romanian society only
Discussions at the homepage: http://www.enpm.eu	http://www.eapm.eu.com
Links and contacts to all national and international psychosomatic/Behavioural societies in Europe	Yes, but very few to member societies
Discussion platform for several questions in the psychosomatic field	Open discussion platform not accepted, very few in the membership only section of the EAPM website
ENPM coordinators and discussion partners at the platform	23 delegates, open discussion platform not accepted
Actions, that promote the efficacy and the integration:	
Proposals for Marie curie grant of the EU, to promote the scientific process of co working in Europe and the eastern countries	Not until now
Common studies with EU-funding	No proposal until now
Combine common interests between national psychosomatic societies	No activity to combine common interests in psychosomatic medicine
Proposed first steps for discussion and actions	
Psychosomatic training and diploma in Europe	Partly, EAPM satellite symposium with ISBM and ICPM Academy for psychosomatic medicine No attempt for organization a psychosomatic diploma No attempt for e-learning activities within psychosomatic/behavioural societies
Psychosomatic/Behavioural interventions in coronary heart disease in Europe	This working group is active
European exchange programs for students, postgraduates and other research fellows	ERASMUS program is still working
Psychosomatic basic care in Europe	An new attempt for basic care has focused on: Pain and somatoform disorders in primary care

One question stood out already at the beginning of APS, ECPR and ICPM: Combining basic psychosomatic approaches in health care with a high scientific standard: Practitioners were interested in clinical aspects, but their symposium submitted to the latest psychosomatic conference was not accepted. It seems necessary to understand special psychological and biological conditions within the clinical practice domain, which cannot be easily grasped by conventional research concepts.

The society has to decide how much clinical practice description is acceptable at psychosomatic conferences and which methods used in psychosomatic research are effective. The time has come to look for new answers to deal with present and future conditions.

- (c) Training programs: Similar to the ideas and work of the American Academy of Psychosomatic Medicine, EAPM started an academy in 2015 aiming to teach psychosomatic techniques in countries without resources; which was one of the ENPM tasks (see above). There have already been several C-L psychiatry-courses e.g. in Berlin- and Manchester (Guthrie 2016), with the focus on psychiatry and somatic disease, but with large differences across European countries (Baessler et al. 2016). Previous discussions have focused on a European diploma in Psychosomatic Medicine obtained through special training courses (Fava 2011) or through an e-learning program in behavioural medicine and psychosomatics (Berman et al. 2016). Coordination was lacking, as was discussion and communication with other international psychosomatic organizations working in this field.
- (d) Common discussion forum at the website for all European scientists with and without EAPM membership. At the EAPM-website there are few links to national and international psychosomatic societies working in Europe, and the discussion platform, which is not very often used, is located in the membership only section. The special interest groups/working groups give only information about their activities in the membership only section, but there is no discussion with important European scientists in this field. Thus, our ideas about free and intense scientific exchange have not been implemented.
- (e) Organizational issues: In the long run, each society, working by itself, can only achieve relative success. This was one of the arguments for unifying and bringing together collaboration through communication and integration in the way meant by ENPM.

4.5 Difficulties to Interact

We want to propose target areas for EAPM activity, according to our earlier ENPM ideas. Different aspects require different solutions. One intervention that works for one target group may not work for another group. One reason is that at least three different professions are involved in psychosomatic care and research. They are psychiatrists, psychologists, and specialists in internal medicine or other specialties. Researchers have different interests and agendas: e. g. some research

has a bias towards psychological-psychotherapeutic and psycho-physiological aspects of diseases, others focus their research primarily on co-morbid mental and somatic diseases and how to intervene, including drug treatment (Tanum and Malt 2001). This implies that some will want to attend “somatic” and psycho-physiological meetings, while others may tend to attend psychiatric/psychological meetings. It is by no means obvious that a network at the beginning will include all those aspects, so these suggestions must be seen and developed much more specifically and focused. “One size fits all” will not work, but it seems important that a first step focus on co-working between groups and overcoming barriers between individuals and organizations.

In our experience, this has not been easy. After an intense discussion of these thoughts, the EAPM board minimized or declined (March 2016) to build an ENPM discussion forum at the EAPM-website (free part) with separate platforms for interested scientists in working and special interest groups and with links to European national and international psychosomatic societies or to elect one or two EAPM delegates/board members who would be responsible for continuous cooperation with the different psychosomatic and behavioural scientific groups/societies in Europe. Perhaps some of the EAPM members want to communicate with others, but it may be questioned to what extent they can succeed. The main difference between ENPM and EAPM remains the society structure, which was focused on the their own conditions/by laws and their own membership which tried to built a closed shop (not only on the web site). A specialist society for psychosomatic medicine should be the basis of EAPM. Members should inform “physically oriented care givers” in different specialties about the existence, origin, and treatment of psychosomatic disturbances (see above). EAPM members – CL psychiatrists/ psychosomatic physicians-are seen as specialists (it remains unclear if for all diagnoses mentioned above in all specialties of bio-psycho- social medicine or only for the limited diagnoses of anxiety, depression, somatoform disorders fall in the domain of CL specialists)). In this sense psychosomatic medicine is not the same as behavioural medicine (Orth-Gomér and Schneiderman 1996) and the main focus of this society certainly does not represent the “art of healing” applied by all physicians (Lown 1996).

4.6 Future Directions: Integration Through Interaction and Networking

We have detected different ways of understanding and interpreting the “medical field”

- The main difference between C-L Psychiatry and Psychosomatic seems to be the point of view: should we consider Psychosomatic Medicine separately as psychosomatic, psychiatric, or psychological experts in the field of medicine and regular care? Or, should we work as primary care physicians observing the

interaction with the patient and his or her subjective experiences from their respective fields (Fava and Sonino 2010)?

- Translating this view to the scientific concept level: Psychosomatic/behavioural perspective represent causality in a bio psycho social view and the C-L-Psychiatry main point of view is an issue of co-morbidity.
- A third important aspect is the severity of (mental) disease, which leads to different types of intervention procedures: the GP, internal medicine and specialized psychotherapeutic/psychiatric level.

All have to be evaluated.

- Physicians responsible for CL-psychiatry tend to focus on severe mental diseases in health care and research. They tend to forget the normality and next to normal variation. Severity of mental disease as well as severity of behavioural or sociological disturbances may influence psychosomatic mechanisms as the origin or course of somatic disorders. There seems to be a tendency to generalize and interpret one's own clinical view or research interest as the whole field of psychosomatic medicine.
- The competition for power and reputation among psychiatrists, specialty physicians, and among psychologists, psycho-therapeutic orientations, and psychopharmaceutical treatment options, render an open discussion in a network difficult.

In our experience from the last years of EAPM activities the main topics at conferences (Cambridge, Nuremberg, Lulea) have been health care and C-L Psychiatry. Cooperation with other psychosomatic/behavioural medicine societies, with somatic disciplines – internal medicine, gynecology, skin disease, etc. – remained small. Within two pre-conferences of the last three meetings, the main psychosomatic cooperation partner was the APM – a psychiatrist organization.

In Europe, C-L psychiatrists and some psychosomatic specialists have found a place to meet and discuss issues. Unfortunately, until now there has been limited success in integrating ISBM and ICPM delegates and symposia in EAPM conferences or vice versa.

For the field of psychosomatic medicine as a whole and for its researchers, the situation now is excellent: Psychosomatic/behavioural medicine has reached valuable basic results in a growing field. But, in psychosomatic and behavioural medicine there are competing societies and meetings, thus there is little chance to go to all meetings and it is difficult to choose. It is also a waste of resources. We had hopes for the development of a stimulating and easily accessed website – a sort of Psychosomatic Facebook page, but it took more time than we thought to achieve this. Our expectations to strengthen the psychosomatic movement by this unification have not been realized. Large research initiatives are difficult to organize successfully. The involvement in large empirical studies has been reduced due to the animosities between the interests of various groups who are dominating and push-

ing the common interest and importance of progress in knowledge into the background. It is still worthwhile to maintain outstanding standards of psychosomatic research, care, and training in cooperation or competition with other organizations.

In summary, we are on the right way, but we have forgotten some aims of the ENPM and we are not sure if EAPM, ICPM, ISBM or other societies involved in psychosomatic medicine are willing to follow. The scene looks very society-focused (EAPM, ICPM, ACPM, APS, ISBM) and does not easily integrate and coordinate research and health care activities in the psychosomatic/behavioural field.

4.7 Conclusion

We have developed a novel form of interdisciplinary and interactive collaboration. We did so in creating a website which serves only as a tool for linking societies together. The idea behind these efforts was to promote the exchange of scientific experiences across the society borders. We offered a common and easy access to the specific website, which was generously paid by one European national psychosomatic society.

Furthermore this form of exchange was completely non bureaucratic. With a multitude of societies of similar kind we expected little difficulties to finance our endeavor. All these scientists are innovative and working in important fields of Psychosomatic Medicine, but mostly without cooperation with other members of the different psychosomatic sub-disciplines.

Psychosomatic Medicine and Behavioral Medicine is also spread through different society groups or diverted to special aspects: psycho social care/intervention, primary care or sub-disciplines, psycho-physiology, psycho-neuro-immunology and psychosomatic Public Health.

The scientific Journals of each society provide important and new information for psychosomatic scientists. In fact is it a very diverse field. The debates on its value in clinical aspects of diagnoses and treatments were so controversial that it was necessary to promote more intense collaboration.

The ideas of ENPM are still valid: During the past decades research in the field of psychosomatic new knowledge has been reached. Therapeutic measures have been able to prolong lives and improve the general health status in certain countries and groups. The connection between mind and brain is being explored. The time has come to implement the spectacular findings of last decades. There is the possibility to communicate through websites and at conferences. Perhaps in the future younger members of these societies will pursue our ideas and proposals.

Questionnaire Response

**Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry
in your (or your chapter's) Country**

Please return this as an attachment to your email

Country on which you are reporting: Germany

Your Name: **Hans-Christian Deter,**

Berlin, Germany. Current telephone no 0049 3084452061

E mail: deter@charite.de

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?

Yes () No () In some sense ()

a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes () No ()

b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes () No ()

2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?

Yes () No ()

Is teaching of psychosomatic medicine in medical schools required by law or health care system in your country? YES () No ()

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?

Yes (x) No (x)

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes (x) No ()

a. If YES, which?

Psychosomatic Medicine (x) Consultation-Liaison Psychiatry (x)

Consultation-Liaison Psychosomatic (x)

b. If YES, the status of such certification is:

i. Independent Medical Specialty (x)

ii. Subspecialty of Internal Medicine ()

iii Subspecialty of Psychiatry ()

iv. An independent non-medical discipline, as Psychology, Social Work ()

v. Other (Specify):[]

• Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes (x) No ()

If YES, please list names of the organizations and the websites if available:

Deutsche Gesellschaft für Psychosomatische Medizin und Psychotherapie

5. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:

PpmP

ZPM

6. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in your country? Yes () No ()

a. If YES, where does it occur? Check all that apply:.

b. Medical School () Residency () Fellowship ()

7. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes () No ()

8. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)

a. It is insignificant ()

b. Some subgroups (e.g. ethnic, religious) practice it ()

c. A significant part of the general population practice it ()

d. Is the most prevalent healing method used ()

e. It is often used in combination with Western medicine ()

f. More widely used methods are as follows (Please list, e.g., spiritual healing, meditation, herbal, etc):

- meditation, herbal, homoepathy

9. Please add any comments to your response here:

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Chapter 5

Major Trends of Psychosomatic Medicine and Consultation-Liaison Psychiatry in the United States and Canada



Hoyle Leigh

5.1 Native American Roots

Long before Columbus “discovered” America (1492), Native Americans practiced forms of holistic medicine emphasizing man’s harmonious place as a part of nature.

There is general consensus that Native Americans migrated from Asia via Siberia and the now drowned land of Beringia that bridged the Bering Strait. DNA evidence indicates that Native Americans share some genetic heritage with Australian and New Zealand aborigines. There is recent evidence that Native Americans, ancient and modern, stem from a single source population in Siberia that split from other Asians around 23,000 years ago. After a stop of up to 8,000 years in Beringia, slightly shorter than some researchers have suggested, they spread in a single wave into the Americas and then split into northern and southern branches about 13,000 years ago (Balter 2015; Raghavan et al. 2015).

As with many indigenous cultures, there was no distinction between physical and mental illness, as most illness were thought to arise as a result of some supernatural forces as a consequence to behavior of the patient or that of a malevolent other (sorcery). Thus treatment was aimed at the supernatural forces by shamans who prescribed rituals, chants, and herbs as well as forms of physical therapy and talking therapy as described below. For obvious external causes such as fracture, bites, etc., immobilization and sucking were utilized as in modern medicine (Vogel 1990).

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5.1.1 *Medicine Wheels and the Sacred Circle (Mandala)*

The Asian ancestors of Native Americans who crossed the Pacific Ocean several times in the distant past, brought with them medical practices and tools (Appenzeller 1992; Gibbons 1993; Adams, et al. 2010). There are striking similarities between the ideas of Native American medicine and traditional Chinese medicine. Traditional Chinese medicine is based on the ideas of Yin and Yang, and the five elements. Most Native American medicine is based on four elements which represent the four directions – East, West, South, and North (Vogel 1970a, b; Gill 1983). The East represents the Spring, freshness, peace, light and understanding. The South represents the Summer, warmth, growth, fertility, and the power of life while the West represents Autumn, maturity, rain and thunder. From the North representing the Winter come the purifying cold winds, thus austerity, endurance, and the white snows and hair of old age. In addition, three other directions, Up (representing the Sky, grandfather, the Great Spirit) and Down (representing the Earth and grandmother), and the Center that represents the connection and unification of all the sacred directions, complete the mandala of natural healing. The Center is the spiritual essence of Self, so that every living entity is also a Center. The fact that Mandala, which means “sacred circle” in Sanskrit, is used by Native Americans may be yet another evidence of cultural diffusion from Asia, in this case the Indian subcontinent.



The Medicine Wheel in Bighorn National Forest, Wyoming https://en.wikipedia.org/wiki/Medicine_wheel

The medicine wheels are found throughout the northern United States and southern Canada, and represent Native American concepts of never ending circle of life. One of the prototypical medicine wheels is in the Bighorn National Forest in Big Horn County, Wyoming. This 75-foot-diameter (23 m) wheel has 28 spokes, and is part of a vast set of old Native American sites that document 7,000 years of their history in that area. Medicine wheels are also found in Ojibwa territory, the common theory is that they were built by the prehistoric ancestors of the Assiniboine people.

The wheels were constructed by laying stones in a particular pattern on the ground oriented to the four directions. Most medicine wheels follow the basic pat-

tern of having a center of stones, and an outer ring of stones with “spokes” (lines of rocks) radiating from the center to the cardinal directions (East, South, West and North).

Physical medicine wheels made of stone have been constructed by several different Indigenous peoples in North America, usually those of the Plains nations. They are associated with religious ceremonies as well as healing.

Like Stonehenge, many medicine wheels were originally built thousands of years ago (e.g. 4500), and they had been built up by successive generations who added new features to the circle. Due to the long existence of such a basic structure, the function and meaning of the structure may have changed over time. As with Stonehenge, some of the wheels may have astronomical significance, where spokes on a wheel could be pointing to certain stars, as well as sunrise or sunset, at a certain time of the year.(Eddy 1979; Vickers 1992–1993; Wikipedia, 2015b, c).

5.1.2 Theories of Causation

Throughout history, mankind in general attributed all illness to one of three causes: human agency, supernatural agency, and natural causes. Illness is generally understood by Native Americans to be less the result of pathogens or physiological changes and rather the result of supernatural interventions brought about through either one’s own spiritual missteps or malevolent intent on the part of others (Rivers 2001). Among the supernatural causes Native Americans believed in were sorcery, taboo violation, disease-object intrusion, spirit intrusion, and soul loss. Spirits of animals and natural objects may also take revenge on acts of slights or abuses. An animal ghost may cause trouble if respect was not shown to its body after it was killed. Witches may use magic to cause sickness. Omens and dreams had particular significance. It was firmly believed that whatever a person saw in a dream revealed desires that had to be fulfilled to cure sickness (Vogel 1990).

Malevolent intent on the part of others, on the other hand, involves sorcery or witchcraft: the deliberate calling forth of negative supernatural intervention in another person’s life (Vogel 1970a, b; Vogel 1972). Witchcraft often plays a central role in the causation of illness. As a result, illness is rarely viewed as transmittable; witchcraft is nearly always person- (or, occasionally, family-) specific. Witchcraft is considered to bring about general misfortune, financial problems, alcohol and/or substance abuse, relationship and personal issues, and, critically, ill health. Resolution of bad fortune, therefore, is also understood to require supernatural intervention, usually invoked through ceremonies and rituals. Medication, if required, is determined on the basis of supernatural direction rather than pharmaceutical benefit—for example, the smoking of blessed cigarettes is a common prescription within Native American healing (Mehl-Madrona 1997; Tooker 1997).

Taboo violation is exemplified by the following: When one is ungrateful to the water-animals, as a wasteful fisherman, he may become strangely ill. It is then the task of the Otter society, one of the many medicine societies, to seek a cure by sprinkling water on the patient (Vogel 1990).

Disease-object intrusion occurs when an object, such as a worm, a snake, or a small animal has entered the body and caused illness. The object may be eliminated by drumming and singing, sucking, and sometimes bitter medicines to make the body an inhospitable host. Spirit intrusion is akin to the “possession by devil” of the European Middle Ages. Another form of spirit intrusion is the return of the souls of the dead to live in the bodies of living relatives.

Soul loss may occur when the soul leaves the body and travels about, causing the body to die. Sometimes the soul may be stolen by malignant shamans, witches, evil spirits, etc. (Vogel 1990).

The Chumash believe that life and death are decided by the Sun and Sky Coyote (Jones and Klar 2005). Every year the Sun and Sky Coyote play a gambling game called ‘peon’ to decide if the year will be wet or dry. If the Sun wins, the year will be hot and dry, food and medicine will be scarce and many people will die. If Sky Coyote wins, the year will be cool and wet, food and medicine will be abundant and people will survive. The Sun is hot, dry and unforgiving to humans. Sky Coyote is beneficial to humans, and is seen in the sky as the North Star. Knowing the position of Sky Coyote in the sky helps prevent people from becoming lost. However, Sky Coyote is a trickster and cannot always be trusted and may sometimes cause floods and other disasters. The Chumash use ceremony and prayer to encourage the balance between the Sun and Sky Coyote each year. If the proper balance is achieved, health can be maintained.

5.1.3 Medicine Man or Woman

The Medicine Man, or Shaman (or Antap in the Chumash tribe, and in many other names depending on the tribe), occupies a central place in Native American medicine. The medicine man has been described as at once a healer, sorcerer, seer, educator, and priest. In some tribes, several classes of healers are distinguished. Among the Ojibwas, the highest in rank were the priests of the Midewiwin, or medicine society, to which membership was gained by initiation and payment. Next in rank were the Wabenos (“dawn men”), practitioners of medical magic, hunting medicine, love powders, etc., followed by the third rank, Jessakid, seers and prophets, revealers of hidden truths, possessors of a gift of clairvoyance received from the thunder god. Last were the Mashki-kike-winini, or herbalists, who were generally called medicine men (and women, as many herbalists were women) (Vogel 1990). Medicine societies existed in many tribes. Such societies performed rituals such as the sprinkling of water to banish disease and chanting in

unison. In essence, the medicine man or woman diagnosed the patient's condition based on the tribe's world view as well as practical observation, and prescribed a wide variety of treatments ranging from exorcism to herbal medicine to sweat lodges.

In the Chumash tribe, the medicine man (Antap) takes a detailed history from the patient and relatives. The appearance of the patient's eyes, tongue, face and affected areas can be used in diagnosis. The Antap may look intently into the patient's eyes since the Antap's eyes are mirrors that make patients see themselves and see the truth. This is to help patients tell the truth. Prayer is an important tool used by the Antap' in diagnosis and treatment.

The Antap may start with helping the patient breathe more efficiently, by having the patient sing or suck on *Salvia apiana* (white sage). Breathing keeps the body fluids moving. The Antap usually touches the patient to find the areas that are affected and the distant areas that may be causing the problem. For instance, if a patient complains of pain in the lower abdomen, the Antap may touch the back to find out if an imbalance in the back is causing pain in the abdomen. The purpose of medical treatment is to restore balance to the patient, since balance is health. A sprain resulting from too much heavy lifting may be treated with rest and casting the area with *Scirpus acutus* (tule).

5.1.4 Herbal Medicine

Herbal medicine was widely used by Native Americans, and some sixty-six herbal medicines were identified as being common in both Chinese and Native American medicine as exemplified by the Chumash tribe in California (Adams et al. 2010).

5.1.5 Sweat Lodges

The Chumash tradition is to bathe everyday in cold water before the sun rises.

Heat is, however, used as a remedy for disease. Sweat lodges, found in most Native American tribes, are heated with fire and steam to treat sickness, especially common colds, upper respiratory and pulmonary infections. A cold from swimming in cold ocean water may be treated by heat treatments in the sweat lodge (Adams et al. 2010). Indiscriminate use of the sweat lodge, especially with alcohol use, may be risky (Livingston 2010). Hot springs are used as baths to treat pain and illness, especially arthritis.

5.1.6 *Healing Touch/Manipulation*

Healing touch is used by the Chumash to comfort, cure and relieve pain (Blackburn 1975). Usually, the treatment of pain involves manipulation of non-painful body areas to relieve pain in distant sites. However, painful feet are usually directly manipulated. Manipulation may be performed by the hands or deer antlers that are applied to sites to relieve pain. The healer individualizes therapy to make sure the patient receives the proper treatment. The treatment may be gentle or intense, depending on the patient's condition. The areas that are treated to relieve distant pain are known to the healer from experience and from training by teachers. Manipulation with deer antlers can involve the rounded or pointed parts of the antlers, and may be applied with pressure, depending on the condition of the patient. The Chumash believe that if the flow of water is interrupted in the body, an area of inflammation and pain results. Healing touch is used to manipulate non-painful areas since touch produces vortices in the body water that flow like waves to help establish flow in congested areas. Chumash view power as incorporeal, not restricted to a body or object. Healing power can be transmitted to an object, such as a healing rock. Power can be transmitted by the Antap through prayer and treating the rock with powdered *Eriodictyon crassifolium* (yerba santa) leaves in eel oil. Once the rock has been given power, the rock is wrapped in white down and can be used to heal people. By touching a sick person with the rock, the Antap can heal (Adams et al. 2010).

5.1.7 *Talking Circles*

Talking circles, peacemaking circles, or healing circles, are deeply rooted in the traditional practices of spirituality of indigenous people as represented by the medicine wheel. In talking circles, members sit in a circle to consider a problem or a question. The circle usually starts with a prayer by the person convening the circle, or by an elder. A talking stick is held by the person who speaks (other sacred objects may also be used, including eagle feathers and fans). When that person is finished speaking, the talking stick is passed to the left (clockwise around the circle). Only the person holding the stick may speak. All others remain quiet. The circle is complete when the stick passes around the circle one complete time without anyone speaking out of turn. The talking circle prevents reactive communication and directly responsive communication, and it fosters deeper listening and reflection in conversation. In a primary care setting utilizing this technique with 1200 patients, participation in at least 4 talking circles resulted in a statistically significant improvement in reported symptoms and overall quality of life (Mehl-Madrona and Mainguy 2014).

5.2 Pre-scientific Western Medicine/Psychiatry

At the time Europeans, mostly from England, began to colonize America after 1600, the medicine/psychiatry they practiced was in essence no different from that of the Native Americans, based on medieval notions of “possession” and moral failings.

5.2.1 *Salem Witch Trials*

An egregious example is the infamous Salem Witch Trials which were a series of hearings and prosecutions of people accused of witchcraft in colonial Massachusetts between February 1692 and May 1693. The trials resulted in the executions of 20 people, most of them women. 12 other women had previously been executed in Massachusetts and Connecticut during the seventeenth century. Two daughters of Reverend Samuel Parris, ages 9 and 11, began to have behavioral changes including screaming, throwing things about the room, uttering strange sounds, and fits. They complained of being pinched and pricked with pins with no physical signs. Other young women then began to exhibit similar behaviors.

In Salem Village, in February 1692, Betty Parris, age 9, and her cousin Abigail Williams, age 11, the daughter and niece, respectively, of Reverend Samuel Parris, began to have fits described as “beyond the power of Epileptic Fits or natural disease to effect” by John Hale, the minister of the nearby town of Beverly.[30] The girls screamed, threw things about the room, uttered strange sounds, crawled under furniture, and contorted themselves into peculiar positions, according to the eyewitness account of Rev. Deodat Lawson, himself a former minister in Salem Village (Lawson 1692; Wikipedia 2015c).

The girls complained of being pinched and pricked with pins. A doctor, historically assumed to be William Griggs, could find no physical evidence of any ailment. Other young women in the village began to exhibit similar behaviors. When Lawson preached in the Salem Village meetinghouse, he was interrupted several times by outbursts of the afflicted.

The first three people accused and arrested for alleged sorcery were Sarah Good, Sarah Osborne, and Tituba. Good was a homeless beggar, known to seek food and shelter from neighbors. Sarah Osborne rarely attended church meetings. She was accused of witchcraft because the Puritans believed that Osborne had her own self-interests in mind following her remarriage to an indentured servant. Tituba, a black or Indian slave, likely became a target because of her ethnic differences from most of the other villagers. She was accused of attracting girls with stories of sexual encounters with demons from *Malleus Maleficarum*. Later, additional women were arrested for witchcraft.

Much of the evidence used against the accused was *spectral evidence*, or the testimony of the afflicted who claimed to see the apparition or the shape of the person who was allegedly afflicting them. Another type of evidence was the *witch cake*,

which “utilized” traditional English white magic to discover the identity of the witch who was afflicting the girls. The cake, made from rye meal and urine from the afflicted girls, was fed to a dog. According to English folk understanding of how witches accomplished affliction, when the dog ate the cake, the witch herself would be hurt because invisible particles she had sent to afflict the girls remained in the girls’ urine, and her cries of pain when the dog ate the cake would identify her as the witch. This superstition was based on the Cartesian “Doctrine of Effluvia”, which posited that witches afflicted by the use of “venomous and malignant particles, that were ejected from the eye”.

The most infamous employment of the belief in effluvia was the *touch test*. If the accused witch touched the victim while the victim was having a fit, and the fit then stopped, that meant the accused was the person who had afflicted the victim. The mechanism is supposed to be that the Witch by the cast of her eye sends forth a malevolent venom into the bewitched to cast him into a fit, and therefore the touch of the hand by sympathy causes that venom to return into the Body of the Witch again” (Hale 1696).

Other evidence included the confessions of the accused; testimony by a confessed witch who identified others as witches; the discovery of *poppits* (*poppets*), books of palmistry and horoscopes, or pots of ointments in the possession or home of the accused; and observation of what were called *witch’s teats* on the body of the accused. A witch’s teat was said to be a mole or blemish somewhere on the body that was insensitive to touch; discovery of such insensitive areas was considered *de facto* evidence of witchcraft (Kramer et al. 1487 (2010); Wikipedia 2015c).

The episode is one of the most notorious cases of mass hysteria in America, and has been used in political rhetoric and popular literature as a vivid cautionary tale about the dangers of isolationism, religious extremism, false accusations and lapses in due process (Adams 2009; Cooke 2009).

5.3 Enlightenment

Even in the enlightened eighteenth Century, theories concerning mental illness were pre-scientific and treatments were inhumane. Benjamin Rush, one of the signers of the U.S. Declaration of Independence, is often called “The Father of American Psychiatry.” He wrote the first systematic textbook on mental diseases in America entitled, *Medical Inquiries and Observations upon Diseases of the Mind*, published in Philadelphia in 1812. The book went into five editions through 1835 and served as the major such textbook for almost 50 years. Benjamin Rush believed that mental diseases were caused by irritation of the blood vessels in the brain. His treatment methods included bleeding, purging, hot and cold baths, and mercury, and he invented a tranquilizer chair (pictured) and a gyrator for psychiatric patients (Library of Medicine 2006).



Tranquilizer Chair invented by Benjamin Rush, from NLM

On the other hand, the Founding Fathers Adams, Jefferson, and others of the United States were strongly influenced by concepts relating to what was known as the “music of the spheres.” – The unique “American Enlightenment principles of a rational, ordered system in harmony with a divine cosmos. Among the early exchanges to occur between European explorers (then settlers) and Native Americans were diseases and medical treatments. In the New World, Europeans were not surprised to find Native American remedies effective as the sixteenth century “law of correspondence” held that remedies could be found in the same locales where diseases occur. In fact, Benjamin Rush recommended that colonists grow their own herbs, adapted from the traditional European folk remedies together with local Native American medicinal herbs He published a treatise on the importance of Native American remedies in 1774 and later advised Lewis and Clark in their expedition west (1803) (Micozzi 2015).

Negative attitudes towards mental illness nevertheless persisted into the eighteenth century in the United States, leading to stigmatization of mental illness, and unhygienic (and often degrading) confinement of mentally ill individuals.

5.4 Nineteenth Century and Systemization of Psychiatry

The American Journal of Insanity (AJI) was first published in June, 1844, by Amariah Brigham, Superintendent of the Utica (N.Y.) State Hospital. Brigham had published on mental illness prior to *AJI*. His book, *Remarks on the Influence of*

Mental Cultivation on Health (Hartford 1832), went into three editions. He believed that insanity often resulted from ‘moral’ causes such as worries and anxieties.

By 1844, 25 public and private mental hospitals had been established in the United States. The Association of Medical Superintendents of American Institutions for the Insane was organized in Philadelphia in October, 1844 at a meeting of 13 superintendents, making it the first professional medical specialty organization in the U.S. The objectives of the Association were “to communicate their experiences to each other, cooperate in collecting statistical information relating to insanity, and assist each other in improving the treatment of the insane.” The name of the organization was changed in 1892 to The American Medico-Psychological Association to allow assistant physicians working in mental hospitals to become members. In 1921, the name was changed to the present American Psychiatric Association.

Dorothea Dix (1802–1887), a school teacher, was the foremost advocate for the humane care of the mentally ill during the nineteenth century. Her efforts are credited with the establishment of 32 state mental hospitals throughout the United States (Library of Medicine 2006).

During the latter part of nineteenth century, there arose two major approaches to psychiatry in Europe – the descriptive tradition of Emil Kraepelin (1855–1926) and the psychodynamic tradition of Sigmund Freud (1856–1939). American psychiatry, mostly based in mental hospitals, was greatly influenced by the descriptive, disease model of psychiatry.

In terms of general medical therapeutics, Silas Weir Mitchell, a Philadelphia neurologist and novelist, advocated “West cure, rest cure, and nature cures” for recuperating from the illnesses of nineteenth Century civilization. Andrew Jackson’s election to presidency in 1828 was accompanied by the rise of the “common man” in the United States, which caused a backlash against the medicine of the elites. Various forms of natural healing, e.g., homeopathy by Samuel Hahnemann of Germany, an alternative natural healing system, “Thomsonian System” by Samuel Thomson, and John Harvey Kellogg (a Seventh Day Adventist and founder of Kellogg cereals who advocated vegetarianism and rest cure) found their followers (Micozzi 2015). During the Civil War (1861–1865), the South relied on herbal medicines due to the inability to obtain manufactured medicines because of the Union naval blockade. The medicinal plants included snakeroot, sassafras, partridgeberry, lavender, tulip tree, dogwood, and oak. Patent herbal medicines became popular after the war across the country, which included Dr. Pepper, Dr. John Pemberton’s Coca-Cola, and Dr. Hire’s Root Beer (Micozzi 2015).

The American Medical Association (AMA) was organized in 1847, at least in part as a reaction to the earlier formation of the American Homeopathic Association in 1842. **Homeopathy** held the principle of “like cures like”, i.e., that which can produce a set of symptoms in a healthy individual, can treat a sick individual who is manifesting a similar set of symptoms. Homeopathic treatments involved administering vigorously shaken extremely diluted drugs (Hahnemann 1842).

Nearly all the non-orthodox healing practices including herbal medicine, homeopathy, osteopathy, chiropractics, hypnotism, etc., eventually were seen to be “quackery” and would be excluded from legitimate medical practice as described in the next section. The term, “quack” derives from the German quacksalver meaning “quicksilver” or mercury. Mercury was widely used at the time for numerous conditions such as constipation, depression, child-bearing, toothaches, as well as a disinfectant (Mayell 2007).

5.5 Twentieth Century and Psychosomatic Medicine

5.5.1 *The Flexner Report*

The **Flexner Report** is a book-length study of medical education in the United States and Canada, written by Abraham Flexner and published in 1910 under the aegis of the Carnegie Foundation at the request of the American Medical Association. At the beginning of the twentieth century, there were 155 medical schools in North America which differed greatly in their curricula, methods of assessment, and requirements for admission and graduation. Flexner visited all 155 schools and generalized about them as follows: “Each day students were subjected to interminable lectures and recitations. After a long morning of dissection or a series of quiz sections, they might sit wearily in the afternoon through three or four or even five lectures delivered in methodical fashion by part-time teachers. Evenings were given over to reading and preparation for recitations. If fortunate enough to gain entrance to a hospital, they observed more than participated.” The Report called on American medical schools to enact higher admission and graduation standards, and to adhere strictly to the protocols of mainstream science in their teaching and research. (Flexner 1910; Wikipedia 2015a).

As a result of the Flexner report, all for-profit medical schools closed, as well as most schools of osteopathy, chiropractics, homeopathy, etc., which could not meet the now rigorous accreditation criteria and the quality of medical and psychiatric education improved based on scientific methods (Beck 2004). The American Osteopathic Association, however, was able to bring a number of osteopathic schools in compliance with the scientific rigor of the Flexner Report, and the osteopathic medical schools’ curricula became nearly identical to allopathic medical schools’ except for osteopathic manipulation.(Gevitz and Grant 2004).

The practice of **osteopathy** began in the United States in 1874. The term “osteopathy” was coined by Andrew Taylor Still, MD, DO. Still was a physician and surgeon in Kansas state and territorial legislator who founded the American School of Osteopathy (now A.T. Still University of the Health Sciences) in Kirksville, Missouri in 1892. Osteopathy holds that the bone, osteon, is the starting point from which the cause of pathological conditions can be ascertained. In 1898 the American

Institute of Osteopathy started the *Journal of Osteopathy* (DiGiovanna et al. 2005). Osteopathic manipulative treatment is the therapeutic application of manually guided forces by a practitioner, intended to improve physiologic function and/or support homeostasis that has been altered by somatic dysfunction.

As a result of the changes following the Flexner report Osteopathic medicine in the United States differs greatly in scope and approach from osteopathy as practiced in Europe and elsewhere. The USA recognises a branch of the medical profession called *osteopathic physicians*, trained and certified to practice all modern medicine, while in other countries around the world *osteopaths* are trained only in manual osteopathic treatment, generally to relieve muscular and skeletal conditions. (Crosby 2010).

The two world wars in the twentieth century facilitated rapid development of medical research as well as an influx of physicians and especially psychiatrists and psychoanalysts fleeing Nazi persecution.

Psychodynamic psychiatry and psychoanalysis gained dominance in American psychiatry at least in part due to the War Neuroses (PTSD) and the influx of distinguished European psychoanalysts (e.g., Franz Alexander, Karen Horney, Erik Erikson) as well as the emergence of American born psychiatrists such as Karl Menninger and Harry Stack Sullivan.

5.5.2 *Psychosomatic Medicine and Specificity Theories*

Franz Alexander (1891–1964) was a student of Sigmund Freud who emigrated to the United States and founded the Chicago Institute of Psychoanalysis in 1932. Alexander psychoanalyzed patients suffering from a variety of somatic illnesses, and formulated that there were seven diseases that were particularly psychosomatic: essential hypertension, peptic ulcer, thyrotoxicosis, ulcerative colitis, neurodermatitis, rheumatoid arthritis, and bronchial asthma. He postulated that specific psychological conflicts were associated with specific autonomic activation, resulting in psychosomatic disease (e.g., in peptic ulcer, repressed dependency needs stimulate gastric secretion causing ulceration). This is called the *specificity theory* of psychosomatic medicine.

Flanders Dunbar (1902–1959), a contemporary of Alexander, believed that psychosomatic illnesses were associated with certain personality profiles and constellations rather than specific conflicts.

5.5.3 *Alexithymia*

Peter Sifneos and John Nemiah (1971, 1996) proposed that psychosomatic disorders arose as a result of a difficulty in describing or recognizing one's own emotions, a limited fantasy life, and general constriction in the affective life, which they

called *alexithymia*. The concrete mode of thinking associated with alexithymia is called *operational thinking* or *pensée opératoire*. Alexithymia is postulated to be related to primitive defenses of denial and splitting, and may be associated with a disturbance in cerebral organization.

Psychological defense mechanisms have been shown to be essential in modulating psychophysiological arousal to stress.

During the latter half of the twentieth century, through the work of various investigators, specificity theory gave way to a field model of psychosomatic medicine in which biological constitution interacts with environment in the development of personality, which, in turn, interacts with current stress in health and disease (Mirsky et al. 1957; Leigh and Reiser 1992).

5.5.4 Studies on Stress

The American physiologist Walter Cannon (1871–1945) investigated the physiologic activation associated with the *fight–flight reaction* and the role of homeostasis in physiology. Hans Selye (1907–1982) systematically studied stress that led to the elucidation of the *general adaptation syndrome* through the activation of the hypothalamic-pituitary-adrenal (HPA) axis. Later in the twentieth century with the development of psychoneuroendocrinology and psychoimmunology, there has been an explosion of knowledge on the relationship between stress and all aspects of the human organism.

5.5.5 Biopsychosocial Model

George Engel (1913–1999), a well-known psychosomatic investigator, coined the term *biopsychosocial model* (Engel 1977), as an alternative to the prevailing disease model in medicine that he called the biomedical model. While recognizing the contributions that the biomedical model made to the development of modern medicine, Engel objected to the “dogma” of the biomedical model on the grounds that it is reductionistic, mechanistic, and dualistic. Utilizing a general systems theory approach, the biopsychosocial model proposes that psychosocial factors influence the pathogenesis of all diseases. The biopsychosocial model has found wide acceptance among psychiatrists and medical educators.

Even prior to Engel, Adolf Meyer (1866–1950) at Johns Hopkins University, had proposed *psychobiology*, which emphasized the biological, psychological, and social factors that contribute to a patient’s health and disease through the life cycle (Meyer 1957). Meyer utilized a *life chart* which he described as a type of ‘word picture’ of the patient’s history to understand the patient’s current situation (Christiansen 2007) Meyer served as Hopkins’ department chair for many years,

and produced many future psychiatry department chairs who propagated Meyer's comprehensive model further down into the future.

5.5.6 Behavioral Medicine, Integrative Medicine, Complementary and Alternative Medicine (CAM)

In late twentieth century, the terms *behavioral medicine* and *integrative medicine* appeared. Behavioral medicine is practically indistinguishable from psychosomatic medicine except that, in treatment modalities, it tends to incorporate more behavioral techniques such as biofeedback. Integrative medicine strives to incorporate within the biopsychosocial model approaches derived from nonorthodox medicine such as *alternative* and *complementary* medicine.

5.5.6.1 Mindfulness

Mindfulness, derived from a Buddhist meditation technique, is gaining a growing popularity as a practice in daily life and a legitimate, mainstream treatment modality for various conditions. Mindfulness is defined as moment-by-moment awareness of thoughts, feelings, bodily sensations, and surrounding environment, characterized mainly by “acceptance” – attention to thoughts and feelings without judging whether they are right or wrong. Mindfulness focuses the human brain on what is being sensed at each moment, instead of on its normal rumination on the past or on the future.

Mindfulness meditation is usually practiced sitting with eyes closed. Attention is drawn to the movement of the abdomen when breathing in and out, or on the awareness of the breath as it goes in and out the nostrils. If one becomes distracted from the breath, one passively notices one's mind has wandered, but in an accepting, non-judgmental way and one returns to focusing on breathing. Meditators start with short periods of 10 minutes or so of meditation practice per day. As one practices regularly, it becomes easier to keep the attention focused on breathing. Eventually awareness of the breath can be extended into awareness of thoughts, feelings and actions (Kabat-Zinn 2012).

According to a 2015 meta-analysis of RCTs, mindfulness-based stress reduction program (MBSR) and mindfulness-based cognitive therapy (MBCT) significantly improved depressive symptoms, anxiety, stress, quality of life and physical functioning compared to wait-list controls (Gotink et al. 2015). Further, mindfulness meditation appears to bring about favorable structural changes in the brain (Tang and Posner 2013) and may also prevent or delay the onset of mild cognitive impairment and Alzheimer's disease (Larouche et al. 2015).

The “Mindfulness Movement has entered the mainstream, mainly through the work of Jon Kabat-Zinn and his Mindfulness-Based Stress Reduction (MBSR) pro-

gram, launched at the University of Massachusetts Medical School in 1979. Since that time, clinical studies have documented the physical and mental health benefits of mindfulness in general, and MBSR in particular. Programs based on MBSR and similar models have been widely adapted in schools, prisons, hospitals, veterans centers, and other environments.

Many psychotherapies incorporate mindfulness as an ingredient, including Mindfulness-based Cognitive Therapy (MBCT), Dialectical Behavioral Therapy (DBT), Acceptance and Commitment Therapy (ACT), Mode Deactivation Therapy, etc.

5.5.6.2 Complementary and Alternative Medicine (CAM)

At least 30% of adults and about 12% of children in the United States use health care approaches developed outside of mainstream Western, or conventional, medicine (NCCIH 2015). If a non-mainstream practice is used **together with** conventional medicine, it's considered "complementary." If a non-mainstream practice is used **in place of** conventional medicine, it's considered "alternative."

Integrative medicine brings conventional and complementary approaches together in a coordinated way.

There are mainly two groups of complementary health approaches- natural products and "mind-body" practices (NCCIH 2012, 2015). Included in CAM, but not neatly classifiable into the two categories are traditional healers such as the Native American Medicine Man discussed at the beginning of this chapter, Ayurvedic medicine, traditional Chinese medicine, homeopathy, and naturopathy.

The term "naturopathy", suggesting "natural healing" based on beliefs in vitalism and self-healing, includes homeopathy, herbalism, and acupuncture, as well as diet (nutrition) and lifestyle counseling. Naturopaths utilize a holistic approach with non-invasive treatment and avoid the use of surgery and drugs. Modern naturopathy grew out of the Natural Cure movement of Europe. According to the Merriam-Webster Dictionary, the first use in print that can be found is from 1901. The term was coined in 1895 by John Scheel and popularized by Benedict Lust, the "father of U.S. naturopathy". Beginning in the 1970s, there was a revival of interest in the United States and Canada, in conjunction with the "holistic health" movement (Jarvis 2001; Micozzi 2015).

Many of the CAM practices in the United States may be confined to specific ethnic groups such as Native American sweat lodges, but others including Yoga and herbs have gained wide acceptance by the general population.

The U.S. Government agency, The National Center for Complementary and Integrative Health (NCCIH) was established in October 1991 within the National Institute of Health (NIH), as the Office of Alternative Medicine (OAM), which was re-established as NCCAM in October 1998. Its mission statement declares that it is "dedicated to exploring complementary and alternative healing practices in the context of rigorous science; training complementary and alternative medicine research-

ers; and disseminating authoritative information to the public and professionals.” NCCIH has funded numerous, and some controversial, studies on CAM.

Natural Products

This group includes a variety of products, such as herbs, vitamins and minerals, and probiotics. They are widely marketed, readily available to consumers as dietary supplements.

According to the 2012 National Health Interview Survey (NHIS), which included a comprehensive survey on the use of complementary health approaches by Americans, 17.7% of American adults had used a dietary supplement other than vitamins and minerals in the past year. The most commonly used natural product was fish oil (NCCIH 2012).

There has been a large number of research concerning natural products, but the efficacy of these products remains at best controversial.

Mind-Body Practices

Mind- body practices include a large, diverse group of procedures taught by a trained practitioner or teacher. According to the 2012 National Health Interview Survey, yoga, chiropractic and osteopathic manipulation, meditation, and massage therapy are among the most popular mind and body practices used by adults. The popularity of yoga has grown dramatically in recent years, with almost twice as many U.S. adults practicing yoga in 2012 as in 2002.

Other mind- body practices include acupuncture, relaxation techniques (such as breathing exercises, guided imagery, and progressive muscle relaxation), tai chi, gi gong, healing touch, hypnotherapy, and movement therapies (such as Feldenkrais method, Alexander technique, Pilates, Rolfing Structural Integration, and Trager psychophysical integration).(NCCIH 2012).

5.5.7 Evolution, Evolutionary Medicine, Memes

Charles Darwin (1809–1882) showed that species evolved through the process of natural selection (*The Origin of Species*, 1859). With modern advancements of genome analysis, it is now possible to calculate just how closely specific species are related. For example, humans and chimpanzees share almost 99% of the genes. An evolutionary perspective of human illness is shedding light on why illnesses arise. As natural selection confers advantage to traits only up to the reproductive age, healthy traits in the post- reproductive period are not selected for. The human body probably evolved so that it was best adapted for the Stone Age, when most adults died in their youth. With the prolongation of human life that came with the progress

of civilization and medical advances, the human body is living long past what it was adapted for (Nesse and Williams 1994). The Stone-Age adapted human body may be ill-adapted for modern life, with its abundance of food, lack of physical exercise, and mental stresses, especially in the post-reproductive age. Evolutionary perspectives also may explain why certain genes that may cause vulnerability to potential mental illness, such as panic, may be adaptive under certain conditions found in evolutionary history (e.g., survival value, as in an overly sensitive smoke-detector).

Richard Dawkins, in his book *The Selfish Gene*, postulated a second replicator comparable to the gene, the *meme*, which is information that is replicated through imitation (Dawkins 1976). Later, memes are recognized as being cultural replicators, which may be stored outside of brains such as books and electronic media. Memes are considered to be like cultural DNA, containing cultural information that undergoes Darwinian natural selection.

Leigh extended the concept of memes as information contained in the potentiated neural connections in the brain, which may be absorbed from culture or generated from experience (memory) or from genes (Leigh 2010). Leigh proposed that the environment does not affect genes directly, but mediated through these memes, and gene x meme x environment interaction is important in health and pathogenesis (Leigh 2012a, b)

According to this view, what we call “mind” is the brain’s processing of the memes. As both genes (making up “body”) and memes (making up “mind”) are replicating packets of information that can be translated into codes (e.g., binary code), the distinction between the mind and body seems to be reduced to that of patterns.

5.6 Modern Psychosomatic Medicine

Advances in molecular genetics and imaging technology have elucidated the role of genes in our constitution, brain morphology, and behavior. Psychoneuroendocrinology and psychoneuroimmunology have elucidated the mechanism by which stress affects the human organism. Health and illness is now conceptualized as a result of the interactions among genes, early environment, personality development, and later stress. This interaction is in no small measure influenced by salutary factors such as good early nurturance and current social support. It is also clear that all illnesses are the results of this interaction, that there is no subset of illnesses that are any more psychosomatic than others. Nevertheless, the term *psychosomatic* continues to be used to denote studies and knowledge that place particular emphasis on psychosocial factors in medical illness.

Some consider *psychosomatic medicine* to denote an interdisciplinary approach that includes internists, oncologists, psychologists, etc., in contrast to *consultation-liaison psychiatry*, which is clearly a field within psychiatry.

There are a number of national and international “psychosomatic” organizations such as the American Psychosomatic Society, Academy of Psychosomatic

Medicine, Academy of Consultation-Liaison Psychiatry, European Society of Psychosomatic Medicine, and International College of Psychosomatic Medicine, and English language “psychosomatic” journals such as *Psychosomatic Medicine*, *Psychosomatics*, *Journal of Psychosomatic Research*, and *Psychotherapy and Psychosomatics*. *General Hospital Psychiatry*, *International Journal of Psychiatry in Medicine*, and *Psychosomatics* are mainly consultation-liaison psychiatry journals. Most of the organizations and journals are interdisciplinary, participated in by members of various specialties and professions.

Unlike the United States, in Europe and Japan, there is often a department of psychosomatic medicine in medical schools, apart from the psychiatry department. Such psychosomatic departments mainly deal with patients with psychophysiological disorders, and may use complementary medicine techniques such as yoga and meditation.

In the United States, the term *psychosomatic medicine* is often used interchangeably with consultation-liaison (CL) psychiatry, and most CL psychiatrists practice in general hospital settings evaluating and treating psychiatric, emotional, and behavioral problems of medical patients. Research in the emotional aspects of specific medical patients gave rise to such fields as psychoneurology, psycho-oncology, and psychodermatology.

5.7 Consultation-Liaison Psychiatry Training and Subspecialty Branding Issues

In the early part of the twentieth century, formal training in CL psychiatry began in a number of U.S. general hospitals, most notably at the University of Rochester under George Engel’s direction and at the Massachusetts General Hospital (MGH) under Thomas Hackett’s direction. Other notable training sites included University of Cincinnati, Montefiore Hospital–Albert Einstein Medical College in New York, and Yale–New Haven Hospital. The Rochester model was psychodynamically oriented, and trained both psychiatrists and internists in “liaison psychiatry.” Liaison psychiatry emphasized the educational role, and the trainee was assigned to be a member of the primary medical team including making rounds together. The MGH model, in contrast, emphasized the consultation aspect of training. The training programs were usually one to two years in duration. The CL training programs thrived during the 1960s and 1970s with the support of the National Institute of Mental Health and James Eaton, then head of its education branch. With the advent of managed care, however, “unbillable” liaison activity has faded to a large extent.

In 2003, the American Board of Psychiatry and Neurology (ABPN) approved the issuance of certificates in *psychosomatic medicine*. The Academy of Psychosomatic Medicine, an organization of CL psychiatrists, had been advocating the recognition of a subspecialty for CL psychiatry for some time but ABPN insisted that the subspecialty be called *psychosomatic medicine* rather than CL psychiatry. The executive summary of the proposal submitted to the ABPN states:

This application is in response to the growing body of scientific evidence demonstrating the high prevalence of psychiatric disorders in patients with medical, surgical, obstetrical, and neurological conditions, particularly for patients with complex and/or chronic conditions (“the complex medically ill”), and the critical importance of addressing these disorders in managing their care. [Psychosomatic medicine] psychiatrists would, therefore, constitute a group of individuals in psychiatry who have specialized expertise in the diagnosis and treatment of psychiatric disorders/difficulties in complex medically ill patients.

Obviously, this is a description of CL psychiatry. It is ironic that psychosomatic medicine, rather than CL psychiatry, was now recognized as a subspecialty of psychiatry in the United States as this designation leaves nonpsychiatric “psychosomaticists” in a Neverland. This situation was eventually corrected as a majority of the members of the Academy of Psychosomatic Medicine voted in 2016 to change the name of the field from psychosomatic medicine to *consultation-liaison psychiatry*, which was then endorsed by the American Psychiatric Association, and in 2017, ABPN finally voted to change the name of the subspecialty to *Consultation-Liaison Psychiatry* as of January 1, 2018. The Academy of Psychosomatic Medicine also changed its name to *Academy of Consultation-Liaison Psychiatry* (Boland et al. 2018).

Significant changes in CL psychiatry has occurred with the implementation of the Patient Protection and Affordable Care Act (PPACA), commonly known as Affordable Care Act (ACA) or Obamacare, signed into law in 2010. ACA was intended to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of healthcare for individuals and the government. It introduced mechanisms like mandates, subsidies, and insurance exchanges. The law requires insurance companies to cover all applicants within new minimum standards and offer the same rates regardless of pre-existing conditions or sex (Bartels et al. 2015). Gallup reports that the percentage of adults who were uninsured dropped from 18% in the third quarter of 2013 to 11.4% in the second quarter of 2015 (Kafka 2015).

Unfortunately, with the advent of Donald Trump presidency (2017), many aspects of ACA are being chiseled away and the eventual fate of the gains is in doubt.

A significant feature of ACA is the establishment of patient centered Medical Homes, in which coordinated care of primary care and mental health care is encouraged (Ferguson and Babb 2013; Bartels et al. 2015). “Integrated Care” as exemplified by the IMPACT (Interprofessional Model of Practice for Aging and Complex Treatments) model has gained popularity as a cost-effective way of providing mental health care in primary care settings (Schoenbaum et al. 2002; Unutzer et al. 2005; Blasinsky et al. 2006; Davydow et al. 2015). The IMPACT model extensively utilizes physician extenders (care managers), usually nurse clinicians or other mental health workers, and the psychiatrist who is usually co-located with the primary care team, functions as an overall mental health supervisor/consultant (Tracy et al. 2013; Oishi et al. 2003; Unutzer 2013). In the “collaborative care” stepped up model, depression is detected in a population based screening program, and initially assessed by a care manager, who recommends to the primary care physician, in collaboration with the psychiatrist, an antidepressant, and the patient may be seen in group sessions. If the patient fails to respond within a specified period, the patient’s care is “stepped up” to the psychiatrist, who may

treat the patient directly with medications and/or psychotherapy, or further stepped up to hospitalization (Katon et al. 1999; Simon et al. 2001; Unutzer and Park 2012).

With “integrated care”, we may see a return of liaison psychiatry in a somewhat diluted form in the sense that the primary liaison work is usually done by care managers who are non-psychiatrists (Chen et al. 2018; Grunauer and Mikesell 2018; Huitema et al. 2018; Kennedy-Hendricks et al. 2018).

5.8 Conclusion

Current status of psychosomatic medicine in the United States may be summarized as follows:

- A. Classical psychosomatic medicine with emphasis on “psychogenesis” of physical symptoms has largely given way to the role of stress as a factor in pathogenesis, course, and recovery from illness. The role of stress in epigenetic changes is increasingly becoming a focus of attention as will be discussed in Part II.
- B. The practice of “psychosomatic medicine” has become comprehensive medicine in a biopsychosocial context. On the other hand, a subspecialty of psychiatry has arisen with the designation, *Consultation-Liaison Psychiatry* (formerly *Psychosomatic Medicine*), with an emphasis on *co-morbidities* between medical disease and psychiatric conditions. Formalized educational and certification programs have developed for this practice as described in Chapter 22.
- C. The Affordable Care Act (ACA), with its emphasis on primary care and cost-effectiveness, though now in jeopardy, may bring a resurgence of liaison psychiatry in a somewhat diluted form.
- D. Native American healing has become to a large component of Complementary and Alternative Medicine (CAM) especially practiced by Native Americans, some techniques being modernized as in “talking circles” in primary care.
- E. CAM has become quite popular and some of the techniques have been proven to be effective (e.g. Mindfulness) and have become mainstream medical practice, Other popular practices include dietary supplements, Yoga, and acupuncture.

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Chapter 6

The Concept of Body-Mind Relationship in the Context of Chinese Culture



Shuiyuan Xiao

Traditional Chinese culture holds a rather complicated understanding on mind-body relation. Generally speaking, mind-body monism dominates among the intellects groups consisting of thinkers, philosophers, officials and doctors, while mind-body dualism prevails more profoundly and extensively among folk people, which plays the key role in the status quo of psychosomatic medicine in China. This chapter aims to illustrate the mind-body relation and psychosomatic medicine under the Chinese culture background from three aspects: traditional Chinese philosophy, folk belief and traditional Chinese medicine (TCM).

6.1 Traditional Chinese Philosophy

Originated from a period of more than 2000 years ago, the so-called Spring Autumn and Warring States Period (770 BC–221 BC), under the chaotic and confusing social situation at that time, traditional Chinese philosophy boomed with a great amount of thinkers, and then cultivated hundreds of schools of philosophy. The most influential schools included Confucianism, Mohism, Taoism, Legalism, Agriculturalism, school of the Military, school of Logicians, and school of Naturalists. Though all of them had once influenced the development of Chinese culture at that period, later on since Han Dynasty (202 BC–220 BC), Confucianism and Taoism formed the two fundamental bases for traditional Chinese philosophy. Here presented is a brief introduction to the understanding of mind-body relation of Confucianism and Taoism.

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Roughly, Confucians are idealists with profound, far-reaching ideals, making effort to maintain the social order and aiming to save the people and the society. Meanwhile, Taoists take a critical and deconstructive side, making efforts to reflect on the society, culture and their “developments”. Important representative Confucians include Confucius (551 BC–479 BC) and Mencius (372 BC–289 BC), while that of Taoism are Lao-tzu (571 BC–471 BC) and Zhuangzi (369 BC–269 BC).

As early as before Spring Autumn and Warring States Period, there had been an overwhelming worship to gods and spirits in China, and activities such as divination, witchcraft, sacrificial ceremony, and praying were important parts of daily life. However, there had been no clear documentation for or references to mind-body relations in the works of Confucianism or Taoism; to be brief, Confucians and Taoists all agree that there is no “soul” detached from the body. As for the concept of “soul/spirit” derived under the name of Confucianism or Taoism, it will be illustrated later in this chapter.

Confucius, the chief founder of Confucianism, was not certain about the existence of gods or spirits, he required his disciples to keep away from such illusory things as gods or spirits albeit respectfully, and not to discuss or talk about them. For example, as quoted from Confucius Analects · Shu’er, Confucius said, “The subjects on which the Master did not talk, were-extraordinary things, feats of strength, disorder, and spiritual beings.” (Legge 2016a) Also documented in Confucius Analects · Xianjin, Confucius was asked about gods and spirits, and he answered, “While you were not able to serve men, how can you serve their spirits?” When one of his students continued to ask: “I venture to ask about death?”, Confucius answered: “While you do not know life, how can you know about death?” (Legge 2016b) When defining “wisdom”, Confucius stated: “To give one’s -self earnestly to the duties due to men, while respecting spiritual beings, to keep aloof from them, may be called wisdom.” (Confucius Analects·Yongye) (Legge 2016c). In Confucius Analects Bayi, it is stated that people have to worship gods or spirits as they were really present; it would be better not to perform the worship if the worship is not performed in person. Literally Confucius indicated that you may believe in the existence of gods, and you may not. But if you participate in a sacrificial ceremony, you’d better perform it as if you believe in the existence of gods and do it in person (Legge 2016d). In another case, when Confucius fell ill, Zi Lu, one of his favored disciples, wanted to pray for him, quoting ancient sayings to convince Confucius that praying was useful. Confucius just replied that he had done praying long before (Legge 2016e). In this case, Confucius meant to tell his disciples that he had prayed to recover earlier, but his prayers just failed to work, so everybody should just forget about it. The other key Confucianism representative Mencius inherited Confucius’ idea and almost never mentioned such things as gods and spirits (Wu 2015).

Taoism representative Lao-zi also avoids talking about the existence or non-existence of gods or spirits or soul. He stresses that when the world is governed with Tao, neither ghosts, monsters, gods, nor spirits will do any harm (Henricks 1989). Another representative Taoist Zhuang Zi often expresses his ideas via fables and tales, in which legendary things such as gods and spirits are frequently mentioned. However, like Lao-zi, Zhuang Zi refused to discuss about the existence of gods or

soul, and he furthered a viewpoint that sacred people may stay both positive and negative towards any existence beyond the world and should not make any definite comment. A case in point is that, when one of Zhuang Zi's friend came to mourn Zhuang Zi's wife's death, he saw Zhuang Zi beating a clay basin and singing a song. The friend felt Zhuang Zi's behavior was not humane and told him so. Zhuang Zi responded, "When my wife just died, how sorrowful I was to shed tear uncontrollably; but later, thinking carefully, I understand that my wife had not had a life at the very beginning, not only so, she even had no body; still more, she had no breath. In this way, amidst the illusionary existence and non-existence, the very original stuff begins to have breath, and then body, and then existence and life, through changes and evolutions; and now the life ends vice versa. Such change and evolution occurs naturally just like the rotating of the four seasons, so now my wife lies peacefully amidst the sky and the earth, how should I cry mournfully for this natural phenomenon? Should I be so stubborn?" (Waley 1994) This is a case in point showing that Zhuang Zi doesn't believe that there is after-death soul, and he holds that mind and body are integrated and indispensable.

6.2 Folk Belief

In contrast to the understanding of mind-body relation of traditional Chinese philosophy and traditional Chinese medicine (discussed below), the folk belief in China commonly holds that human beings have the soul which could be independent from body, and remains existent even after the body has perished. In China society, this mind-body dualism has been widely applied to explaining the nature and guiding and regulating people's behavior; meanwhile, the explanatory model for health and diseases and illness behavior are equally influenced by such folk belief, which is still popular even in the current twenty-first century.

Soul leaving the body According to Chinese folk belief human's soul could be captured by monsters or ghost alike, causing the death of human; when shocked or severely ill, man's soul may leave the body and wander around, as the so-called "soul parting from body". If not treated timely, a man who lost his soul would die soon. It is commonly believed that when a person dies, especially when it is an abnormal death, the dying person's soul has fled away from the body even before the person dies. What's more, "Soul leaving the body" is also a part of near-death experience; it is said that people will feel that they are flying away from their own body; more extraordinarily, in folk tales and historical stories, the soul of one person may be injected into another dead person's body, making the dead one come back to life.

The concept of "soul leaving the body" was widely used to explain death, mental disorder and chronic diseases in China, and correspondingly, various "spiritism" were used to treat diseases. For example, "soul calling" has been a common practice until recently. In rural areas, if a child is not recovered from a chronic ill for a period

of long time, people could attribute “*zou hun*”, that is, loss of soul, as the cause of his or her disease. In that case, a ceremony of calling the soul back will be practiced by a folk healer or the child’s mother.

Ancestor worship Ancestor worship in China is originated from the filial piety of Confucianism, which at the very beginning aimed to guide the people to respect and support their parents, and later it has evolved into an abstract discipline with general meaning, and become the core of morality. As discussed previously, both Confucianism and Taoism hold a suspicious view on such concepts as “soul”, therefore Confucius, Mencius, Lao-zi and Zhuangzi just all avoid discussing such concepts. However, the later Confucianists generalized filial piety, and believe that people should not only respect and support their live parents, but also their dead ancestors. Filial piety believes that although the dead ancestors have passed away, their souls are still in existence and need care, respect and worship; if the descendants behave improperly, the ancestors’ souls might punish them; otherwise, when in need, ancestors’ souls might bless them and even offer direct help.

In modern society of China, ancestor worship is still an important part of people’s life. People influenced deeply by this traditional belief are unwilling to accept cremation, because they believe that if they are cremated, there will be no where to place their souls after their death. It is quite popular to hold ancestor worship ceremonies in traditional festivals, such as Spring Festival and Qingming Festival, among population ranging from grass root laborers to prominent officials, eminent personages and even scientists. At the Spring Festival, the most important festival of Chinese people for family reunion, the soul of died ancestors will be greeted to home to join the family reunion, while Qingming is a festival specifically for people to commemorate ancestors. The government usually takes a comparatively positive attitude towards such worship activities, and giving several days off for people’s convenience to go to hometowns to do the worship, leading to enormous traffic jams in the Spring Festival and Qingming Festival of recent years all over the country. The ancestor worship ceremonies vary in different regions and places in content and agenda, but four main contents are universal. First, ceremonial visit to the ancestors’ final residence, usually the tombs; second, sacrificial ceremony, that is to invite the ancestors’ souls to enjoy fruits or meat at home or on the tombs. Third, to burn symbolic money and daily supplies (houses, wardrobes or even vehicles and recreational tools), and people are self-assured that their ancestors could get and use these stuffs. The fourth is the praying, including reporting to ancestors the performances of the descendants and pray for the blessing of the ancestors to the descendants. Besides the two major worship ceremonies held in Spring Festival and Qingming Festival, people can hold worship ceremonies at any time to fetch back their ancestors’ souls to seek for help when in need.

Many people believe that the soul of their ancestors could enter their dreams and communicate with them. Because it is likely that ancestors’ souls are unable to have direct contacts with their descendants, consequently the “spirit medium” emerged, and they claim they could help people to communicate with their descendants, or conjure the ancestors’ souls to their own bodies so that the living descendants could

communicate directly with their ancestors. This is mostly used to explain the descendants' illness or misfortune.

Animism There is also a belief that everything has a soul among Chinese folk people. It is believed that all kinds of creatures, animals, and plants, may all cultivate themselves into "spirits" if they live long enough, and these spirits are either friendly or hostile to human beings, and more often the latter takes place. These spirits may attach themselves to a human body, or summon a man's soul, or seduce a man to do evil things harming the family or the society. In either way, this can do harm to people's health or even life. Once it is believed that somebody is engaged by an evil spirit, people would use various ways, especially witchcraft to purify and lustrate the spirits.

Koro was once a prevailing cultural-bounded syndrome in Southern China and south-east Asia, and its occurrence and prevalence were based on two influential folk beliefs in Eastern society, one of which is that the penis is human being's very origin, and will become sick or die once invaded, and the other is that some spirits may need to take in male's semen during their cultivation. When people think that some spirit will take or has taken in their semen, they may become extremely frightened and worried that their penis might withdraw into the body after the semen had been absorbed and cause death consequently. At first this phenomenon was believed to only occur to male, so it was named penis panic in Chinese. However, later it was revealed that women also got engaged during the prevalence and were frightened that their pudenda and breasts might withdraw into their bodies. So this was renamed koro. The most recent koro took place in late 1980s in Leizhou Peninsula of Hainan Province in China, and hundreds of inhabitants there were influenced by koro and caused social panic (Mo et al. 1987).

6.3 Traditional Chinese Medicine

Originated from primitive times, the extensive and profound Traditional Chinese Medicine (TCM) has developed some important concepts and disciplines the period of Spring Autumn and Warring States Period (770 BC–221 BC). The first medical code <Inner Canon of Huangdi> is said to be written by Huangdi (Huang Emperor, 2717 BC–2599 BC) and named after him. Now it is widely agreed that this book emerged in Western Han Dynasty (202 BC–8 AD), and was the inheritance of previous generations of medical practitioners. The history of thousands of years has witnessed the combining and interactive development of Chinese culture and TCM. TCM is rooted from Chinese culture; meanwhile, it makes an important part out of it. Although the western medicine, introduced into China more than 100 years ago, has been taking greater and greater role in medical science in China, the theories and ideas of the experience-based TCM still has a wide influence on people's identification and explanation of illness and health, as well as the practice of Chinese people in healthcare, prevention and treatment. In addition, the Chinese government

provides official support to the development of TCM, and has constantly advocated “equal emphasis on Chinese and Western Medicine” as a national health strategy. There are dozens of TCM colleges cultivating TCM and Chinese herb medicine professionals, and western medicine-oriented medical schools also offer TCM courses to students; among all medical disciplinary classification in China, TCM may be the biggest one, with estimated nearly one million registered practitioners with licenses. As for institution establishment, the country has set up national TCM research institute, and there are similar institutes in province-level administrations. There are TCM hospitals in most counties in China, and many western medicine-based comprehensive hospitals also have TCM departments and wards. What’s more, TCM dominates in most community health centers, clinics and rural health agencies.

Compared with modern western medicine, TCM has three prominent features: (1) modern western medicine is established on the foundation of experiments, meanwhile TCM is experience-based. This is also why TCM has been frequently challenged in recent years. (2) TCM is based on holism, regarding human being as a whole and even take human being as an integrate part of the nature, which is in sharp contrast with biological reductionism in biomedicine-dominated western medicine; (3) TCM attributes human being’s mental and psychological behavior to the reflection of body functions, and is not affected by mind-body dualism.

Holism perspective It is the basis of all TCM concepts, theories and practices to take human, human-nature relations and human health and illness from a holistic perspective. Its fundamental point of view states that human is a product/outcome as well as a part of the nature or environment, so human’s health and illness has a close link with the natural and social environments in which they stay, and therefore, human’s regimen, health care and treatment should all take environment into account. In his <Invaluable Prescriptions for Ready Reference>, famous TCM doctor Sun Simiao wrote that best doctors take medical measures from the state level, ordinary doctors take the patient as a whole to treat and take medical measures, while the worst doctors just take medical measures to treat a single disease. This has apparently reflected his emphasis on human-nature holism.

The well-known theory of Yin-Yang and five elements, a case in point and specific reflection of holism, is first originated from Xia Dynasty (about 2000 BC–1600 BC) in Chinese history and it believes that the two opposite Qi—Yin and Yang—is the very beginning of everything in the universe. When Yin and Yang combine, everything begins to grow, and forms wind, cloud, thunder and rain in the sky, and hill, mountain, river and ocean on the earth; Yin and Yang can convert into each other, and they are dependent on each other as well. That is to say that each aspect of Yin and Yang can rely on another aspect as the foundation of its existence. Yang cannot exist without Yin, and vice versus. For example, the sun is Yang, and the moon is Yin; the external aspect of a matter is Yang, while the internal side is Yin; male represents Yang, while females refers to Yin; high temperature is Yang while low temperature is Yin; the upper is Yang and the lower is Yin; dry air is Yang while humid air is Yin, etc. In TCM theory, Yin and Yang concepts are widely

applied to distinguish parts of the body, such parts as the upper, front, external and exposable parts are Yang, while the lower, rear, internal and hidden parts of the body is Yin. When applied to body functions and illnesses, it is believed to have concepts such as deficiency and excess, exterior and interior, chills and fever, pathogenic and vital. For example, the major symptoms of Yin vacuity include dysphoria with smothery sensation, night sweating, sleepless, dry pharynx, dry mouth, yellow urine, red tongue with little white tongue coating, and thready rapid pulse; while the major symptoms of Yang vacuity include chills, pallor complexion, cold limbs, thin stool, clear urine in large amounts, weak and sinking pulse, etc. Correspondingly, the treatments are classified as nourishing Yin and tonifying Yang.

Five element theory takes the five common elements—metal, wood, water, fire, earth—of daily life as the foundation for the composition of the universe and various natural changes. The five elements have different natures and qualities, for example, wood is to grow and nourish, fire is to warm up and raise, earth signals peacefulness and existence, metal refers to destroy and constrain, and water is to cool down and moisturizes. The theory allocates the quality of everything in the world into the five aspects, while the five elements are believed to be dependent on one another, counteract and promote one another. In this way, TCM applies analogy with the five-element theory, follows the functions and features of different organs, and categorizes the different structures and composition of human body into five strings, and thus developed the viscera-state doctrine of TCM, forming a viscera and organs structure system. This system is centered by five major organs (liver, heart, spleen, lung, and kidney), coordinating with six viscera (gallbladder, small intestine, stomach, colon, bladder, triple-jiao (san-jiao)), holding the five body parts (muscle, vessel, flesh, hair, bone), inducing resuscitation by the five sense organs (eye, tongue, mouth, nose, and ear), flourishing in exterior appearance (hands, face, lips, hair and fur). Using analogy with five element theory, TCM categorizes related natural matters or phenomena, and correlates them with the nature of viscera and organs of human body, forming the holism viewpoint of correspondence between man and universe; it is believed that inside the body, the pathology of the five organs interacts and spreads through one another, the disease of an organ can be passed to another, and vice versus, which shapes the illness holism.

Mind-body monism perspective Traditional Chinese Medicine believes that the mental or soul of a man is integrated with the body, and there is no soul detaching from the body. TCM regards the mental activities of human as the function of the “heart”, one of the five organs. The so-called “heart in charge of mind and will” means that heart is the core of mind, sense and mental activities; while vital essence (Jingqi) is the material foundation for the mind (mental activities). Here please note that TCM’s “five organs” are not exactly the organs of human body in terms of modern anatomy, and therefore the heart, which TCM believes the organ of mental activities, is not exactly the concept of modern anatomy. The mind emerges with the body, the body carries the mind, and the mind reflects the body. The mind exists with the body and disappears with the death of the body. To sum up, the mind is the outcome/product of the material world, and is a natural phenomenon in the universe.

It is an interesting historic and cultural situation that the folk belief of mind-body dualism has not played influential role in the development of TCM in the long history run.

TCM stresses emotions and their effect on health. Man has seven kinds of emotions belong to mental activities, including such emotional changes as joy, anger, worry, sadness, sorrow, fear and shock. Usually change of emotion doesn't affect people's health, but extreme emotion fluctuation, or long-term negative emotions, may cause excessive or long-term tense and thus harms people's health, and bring about some illness. TCM holds that the seven emotions are closely related to the five organs of man, and interact with their pathological and physiological changes, that is, joy corresponds with heart, anger with liver, worry with spleen, sadness and sorrow with lung, fear and surprise with kidney. The seven emotional fluctuations may affect the balance and functioning of Yin and Yang, Qi and blood. Normally, the Yin and Yang within man is balanced to maintain the regular physiological functioning, while extreme emotional changes may break this balance, affect the operation of Qi and blood, thus to cause disorder of Qi and blood. <Plain Questions: On pains> points out: "any disease may be borne with Qi. Anger rises Qi, joy relax Qi, sorrow destroys Qi, fear lowers Qi, shock upsets Qi, worry messes Qi."

Cutting in from the emotions and psychological factors, TCM applies the seven emotions theory to the treatment of patients and has developed a lot of therapies, among them are medication that affects mental states, dietary therapy and sports therapy. What's more, the idea of "behave properly to improve one's character" introduced preventing illnesses and promoting health from psychological perspective.

TCM doctors have left us many legendary anecdotes in psychological treatment of patients. As recorded in <The Records of Three Kingdoms: On Hua Tuo>, once there was a governor who was severely ill and invited Dr. Hua Tuo for treatment. After diagnosing, Hua Tuo told the governor's son: "Your father is unusually ill and has blood stasis in his stomach. We have to make him very angry to vomit out the blood stasis to cure him. Otherwise he will die soon. You may tell me all ridiculous things your father has done and I will write a letter to irritate him." The governor's son said: "I have nothing that cannot speak out if only it could cure my father!" So he told Hua Tuo all his father's absurdities. Hua Tuo left the governor a letter of scolding and fled. The governor was very angry and ordered his soldiers to capture Hua Tuo but in vein. The governor was so angry that he vomited a large amount of black blood and then recovered. In this case, Hua Tuo grasped the mental characteristic of irritancy of powerful authority, and didn't prescribe medication, instead, he laughed at patient's shortcomings, using Yang emotional stimulation to treat the governor's Yin disease. In this way, "anger raises Qi", and blood followed the Qi to be vomited out, then the patient was cured.

In another popular case, Zhang Zihe (1156~1228), a famous Chinese doctor in Jin Dynasty (1115~1234), was said to be good at curing difficult diseases. Once someone named Xiang Guanling came to him, saying that his wife had a strange disease, and she didn't eat anything though she was very hungry; instead, she

shouted, screamed and cursed all day long. She had gone to a lot of doctors with numerous medications, but it all proved to be useless. After he examined her, Zhang Zihe called on two women to play the buffoon, making various kinds of clownish gestures and performance. The patient was pleased and then her sickness was reduced. And then, Zhang Zihe asked two voracious women to eat greedily in front of the patient, and the patient followed them subconsciously and began to eat food. Then the patient was cured in the end.

To sum up, as for mind-body relations, TCM holds the Holism and mind-body monism. However, during the thousands of years' history of TCM, TCM has not produced a specific psychosomatic medicine in the modern sense, furthermore, related fields, such as psychiatry and psychological therapy have also not been well developed, reflecting that Traditional Chinese Medicine take the body and the mind as a whole instead of separate structures.

Questionnaire Response

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry

Please return this as an attachment to your email

Country on which you are reporting:

Your Name: Xiao Shuiyuan

Institution: Central South University

City & Country (e.g. London, UK): Changsha, China

Name(s) and Country of Others who provided information:

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?

Yes (X) No () In some sense ()

- a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes () No (X)
- b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes (X) No ()

2. Is there a Department (or equivalent) of Psychosomatic Medicine in institutions in the country?

Yes (X) No ()

Is teaching of psychosomatic medicine in medical schools required by law or health care system in the country? YES () No (X)

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in the institution or other institutions in the country?

Yes () No (X)

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in the country? Yes () No (X)

- a. If YES, which?
Psychosomatic Medicine () Consultation-Liaison Psychiatry ()
- b. If YES, the status of such certification is:
i. Independent Medical Specialty ()

- ii. Subspecialty of Internal Medicine ()
- iii. Subspecialty of Psychiatry ()
- iv. An independent non-medical discipline, as Psychology, Social Work ()
- v. Other (Specify):[]

5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in the country? Yes () No ()

If YES, please list names of the organizations and the websites if available:

Branch of Psychosomatic Medicine, Chinese Medical Association. I don't think the Branch of Psychosomatic Medicine has a website.

Branch of Psychosomatic Medicine, China Association of Chinese Medicine, <http://www.psm2010.com/en/index.asp>

6. Please list the names of professional journals published, if any, in the country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:

No

7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in the country? Yes () No ()

a. If YES, where does it occur? Check all that apply:.

b. Medical School () Residency () Fellowship ()

8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in the country? Yes () No ()

9. Concerning traditional/folk/indigenous practice of healing in the country (please check all that apply)

- a. It is insignificant ()
- b. Some subgroups (e.g. ethnic, religious) practice it ()
- c. A significant part of the general population practice it ()
- d. Is the most prevalent healing method used ()

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Chapter 7

Psychosomatic Medicine in Indian Subcontinent: A Historical Perspective



Harjot Singh

7.1 Introduction

In this chapter, India refers to the Indian sub-continent. It includes the modern countries of India, Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan, and Maldives. In modern academia, the term South Asia is used to distinguish this region from East Asia and South East Asia. The region has been historically, culturally and geographically distinct and unique from other parts of Asia even though there have been exchanges going on through the millennia. The three examples of exchanges are – the spread of Buddhist and Hindu traditions into South East Asian countries, and the spread of Buddhism outside of India into East Asia and South East Asia, and the influx of Islam and Muslims into India from Central Asia and the Middle east.

The framework used to understand the history of psychosomatic medicine in India is that of medical anthropology (Oberoi 1994). This implies four basic tenets:

- (a) There is a patient
- (b) The patient has a problem as manifested by symptoms.
- (c) There is a Physician/Healer
- (d) There is a cognitive framework that describes the etiology of the problem and the cure proposed or done.

7.2 Traditional Medical Systems

Traditional Indian medicine is described first. This is the part of medicine where documentary evidence is available in the form of books and commentaries.

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7.2.1 *Ayurveda*

This system has the pre-eminent place in the history of Medicine in this region. The literal meaning of Ayurveda is Ayur (life) Veda (Knowledge). The medical tradition of Ayurveda represents one of the widest uses of thinking put to practical use in Indian society. General population broadly holds the views of body function and illness as described in Ayurveda (Marsella and White 1982).

Ayurveda is also the oldest documented medicine system from India. The three texts that are considered most authoritative are collectively known as “the great three” (brhat trayi). The first two are identified by the names of the physicians who are credited with writing them – Caraka Samhita by Caraka, and Susruta Samhita by Susruta. The third is Asthanga Hrdaya Samhita by Vagabhatta (Weiss 2015).

The texts are in ancient Indian language of Sanskrit. They trace their origins to divine sources; for example, the Susruta Samhita ascribes the origin of the text to the lord of medicine Dhanvantari, who appears on earth as Divodasa, the King of Kasi, and recites the text to his disciples (Bhishagratna 1907).

The Ayurvedic tradition in Sri Lanka traces its origins to the mythical King Ravana, and ascribes multiple texts to him (Inst. of Indigenous Medicine). It is estimated that the earliest of these texts was written between 200 BC and 400 CE. They likely documented a system of medical practice that had been taught orally several centuries before. The texts are difficult to date also because the present editions include piecemeal contributions over an extended period, reflecting a process of accretion and transformation (Weiss 2015; Bhishagratna 1907). Multiple commentaries on these texts, written through the centuries are also available.

The texts provide a rich knowledge of medicine of the time, and framework of how medicine and surgery were to be practiced, including how Physicians should conduct themselves and how training was to be provided to medical students. The most commonly used word for a physician in Ayurveda is Vaid or Vaidya. Apart from giving information on medical conditions and their treatment, they also provide valuable information on geographical, social, and economic conditions of India at the time (Bhavana 2014).

The mental (Manas) illnesses are mentioned at the outset of the text among the diseases that torment the humanity, and need to be addressed in the text (Bhishagratna 1907).

Before discussing illnesses, it is important to understand the basic framework of how Ayurveda is organized, and also the basics of etiology and pathology in Ayurveda.

The Ayurveda recognizes eight branches of Medicine (Ashtanga – lit. eight parts) (Bhishagratna 1907). These are:

- (a) Salaya-Tantram – Treatment by surgery. Susruta Samhita lays special stress on it and considers it to be the primary and oldest branch of Medicine.
- (b) Shalakaya-Tantram – Pertaining to the diseases of body organs above the clavicle
- (c) Kaya-Chikitsa – Treatment of general diseases including Insanity, called Unmada

- (d) Bhuta-Vidya – Diseases caused by spirits and demons.
- (e) Kumara-Bhritya – Diseases of children, including diseases caused by demons and spirits
- (f) Agada-Tantram – Diseases caused by toxins e.g. snakebites, poisons, other venomous animals
- (g) Rasayana-Tantram – pertains to rejuvenation of body and prolongation of life
- (h) Vajeeekarana-Tantram – Science of aphrodisiacs

In Ayurveda, the basic requirements of a treatment are the presence of four aspects of treatment (EasyAyurveda.com):

1. Bhishak – Physician (another word for Physician)
2. Dravya – Medicine
3. Upasthata – Attendant/nurse
4. Rogi – patient

The requisite qualities of each are described in the texts, e.g. the Physician is required to have extensive theoretical and practical knowledge, and to have dexterity and cleanliness.

The Ayurvedic systems recognizes that entire universe, including the humans, is made of five elements – ether, air, fire, water, and earth. The Ayurveda calls them – five Mahabhutas–Akasa (ether), Vayu (air), Tejas (fire), Ap (water), and Prithvi (earth). These five elements form the three humors (doshas) in the human body. The doshas in Ayurveda do not represent actual fluids such as blood or bile in Hippocratic medicine, but rather represent the balance of different elements that make up all parts of the body including the mind. They are highly unstable, and change with the time of the day, and with food. All five elements are present in all doshas.

The three doshas are:

- (a) Vata Dosha – composed of Akasa (ether) and Vayu (air)
- (b) Pitta Dosha – composed of Tejas (fire) and Ap (water)
- (c) Kapha Dosha – composed of Ap (water) and Prithvi (earth)

The harmonious balance elements in three doshas would signify a healthy body, whereas the disturbance on any one or more of the doshas would lead to illness. Appropriately, the treatment has to address the imbalance via multiple methods – medication, meditation, fomentation, dietary changes, prescription for rest or exercise, and sleep.

Charaka has defined *mind* as ‘Ateendriya’ or a super sense, ‘Sattva’ or essence and ‘Chetah’ or consciousness. The definition of mind is a practical one viz. presence of consciousness indicates presence of mind. Just as physical causes of illnesses are described with the theory of three doshas, the Psychological functions are described as Gunas (Balodhi 1987). This is a hard to translate word, and an approximate translation is quality. There are three gunas (Table 7.1):

- (a) Sattva
- (b) Rajas
- (c) Tamas

Table 7.1 The three Gunas

Sattva	Rajas	Tamas
Spiritual quality	Active quality	Material quality
Good and caring	Passion and desire	Hopes and illusions
Does work as a duty, knows right from wrong	Dominance of self-interest, there is distortion of right and wrong	Ambiguity, idleness, fantasy, and persistence.
Respect for teachers, nonviolence, meditation, kindness, silence, self-control, and purity of character	Full of attachments and wants fruits of action	Cautious, apprehensive, and revengeful, derives happiness which originates and ends in self-delusion and misconception

Based on the combination of doshas, Ayurveda describes seven types of people. And based on the gunas, Ayurveda describes sixteen types of personalities – seven types of Sattva, six of Rajas, and three of Tamas (Srivastava 2012).

The classical Ayurveda asserts that diseases of the mind originate from the heart, and not the brain. When the ducts carrying the doshas to the heart are clogged, it causes the diseases of the mind. The symptoms would depend on which of the doshas or all of them are affected. This theory of disease is somato-psychic in nature as opposed to a theory of psychosomatic origin of illnesses (Marsella and White 1982). The interdependence of mind and body is recognized. The problems in interaction between body and mind due to many factors lead to psychosomatic strain and discordance resulting in disease; examples of such factors are climate change, or transgression of the bounds of moderation and agreeability relatively to one's nature and capacity. Hence, explanations of mental illness refer either to internal causes, that is, imbalance of humors, or external causes, that is, either caused by or associated with features of various classes of spirits, ranging from deities to ancestors and demons (Weiss 2015). See tables below.

The term that describes insanity is Unmada, and it is described along with Epilepsy (Apasmara) – almost similar causes are proposed for both. The premonitory symptoms are called mada. Six different types of Unmada are described – one each from problems with one of the doshas i.e. Vitta unmada, Pitta unmada, Kapha unmada, the fourth Sannipattika Unmada which is from combined dosha problems that is considered very difficult to treat, Soka unmada from sorrow or grief, and the last one Visa unmada due to poison. The different symptoms of Unmadas are described in detail in the texts (Table 7.2).

However elsewhere within the Caraka Samhita, there is a different view – where psychological problems are attributed to confusion of intelligence or voluntary transgression. Jealousy, grief, fear, anger, vanity, hatred and other Psychiatric disorders are all due to voluntary transgression (Balodhi 1987).

The **treatments** of mental illnesses can be divided into three types:

- (a) Magico-religious treatment – incantations, sacred thread rituals, prayers, using certain gemstones, sacrifice, donations to Brahmins, astrological interventions, ritualistic procedures etc.

Table 7.2 Features of endogenous categories of mental illness (Nija Unmada)

Type	Cause or predisposition	Psychopathology	Somatic symptoms
Wind (Vata)	Dry, cold, or insufficient food Purgation Decay of body elements Fasting	Inappropriate laughing, smiling, dancing, etc. Emaciated and ragged	Reddish complexion Worse after eating
Bile (Pitta)	Foods that are indigestible, bitter, sour, or hot	Impatient, excited, threatening, agitated, angry Nudity Hallucinations	Yellow complexion Feeling hot
Phlegm (Kapha)	Fullness in the stomach	Slowed speech and action Excessive sleeping Favors solitude, avoids wife	Loss of appetite Nausea White fingernails Worse after eating

Table reproduced with permission from Weiss (2015), Data based on Caraka Samhita, 6.9.9-15

Type	Cultural association	Premorbid features	Symptoms	Onset
Deva	Gods – divine and authoritative	Pure, experienced in austerities and studious Moral Dressed in white	Placid gaze, serious, dispassionate No desire for sleep or food Scant sweat, urine and faeces Lotus blossom face	Suspiciousness, delusion, hallucination
Guru, Vṛddha, etc.	Teachers, elders, and respected persons	Bathing, purity Solitude Versed in scriptures and poetry	Behaviour, diet, and speech suggests a curse	Auditory hallucination “by curse”
Pitṛu	Deceased ancestors	Devoted to mother, father, teachers, elders	Dull gaze, undiscerning Excessive sleeping Eats inedible substances Poor appetite and indigestion	Visual hallucination
Gandharva	Celestial musicians associated with <i>sama</i> , love and gambling in Vedic literature	Likes singing, music, someone else’s wife, garlands, pleasant fragrances	Passionate, impetuous, serious Fond of music Dance, food and drink Red clothes Derides ritual	Touched (by Gandharva)

(continued)

Table 7.2 (continued)

Type	Cultural association	Premorbid features	Symptoms	Onset
Yakṣa	May be divine or demonic; ruins offerings to Ancestors	Intelligent, strong, handsome Likes humour, talks a lot	Sleeping, crying, laughing Fund of dance	Taken by Yakṣa Experience of being possessed
Brahma-rākṣasa	Ghost of unholy Brahma	Dislikes scriptures, austerities, discipline Either a fallen Brahma or claiming high status Frolics in temple waters	Dances and laughs loudly Hates gods, sages, and physicians May injure himself	Unspecified
Rākṣasa	Evil demon with sharp teeth; ruins ancestral rites	Lacking mental clarity Slanderous and lusting for women Deceitful and unpleasant Drinks and eats too much	Disturbed sleep, averse to food Fond of knives, meat and blood Threatening	Smell of raw flesh
Piśāca	Most evil and demonic; lurks in deserted houses, by waters, roads and trees	Lacking mental clarity, slanderous Lusting for women Deceitful, a braggart, hurts others	Abnormal thinking Behave improperly Dancing, singing, laughing, chattering Slept in filth Nudity running about aimlessly Memory loss	Experience of being possessed: “They mount his back making him see”

Data based on *Caraka Saṃhitā* 6.9.20-21

Table reproduced with permission from Weiss (2015), Data based on *Caraka Saṃhitā* 6.9.20-21

- (b) Medication therapy – food preparations, certain kind of butter or clarified butter, fomentations, herbs etc.
- (c) Behavior therapy – intimidation, terrorizing including threats of flogging or piercing the patient with sharp instruments, or putting the patient in a dry well with a cover over it, (Marsella and White 1982), or coaxing by giving gifts, and pacification. Scalding the patient with hot water, or branding with a hot iron is also discussed. Susruta recommends removing the cause of sorrow or grief in cases of unmada due to sorrow or grief.

The highest patronage to Ayurveda was given by the Buddhist kings (400–200 BCE), and with the spread of Buddhism, Ayurveda also spread to other South and Southeast Asian countries (Sharma 2006).

7.2.2 *Siddha*

This is the traditional ancient medicinal system of South India. Siddha literature is in Tamil and it is practiced largely in Tamil speaking part of India and Sri Lanka. The principles and doctrines of this system, both fundamental and applied, have a close similarity to Ayurveda (AYUSH1 – AYUSH is the acronym for Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa-Rigpa, and Homeopathy).

7.2.3 *Deshiya System*

This system deserves mention because this was the traditional system of medicine in the island of Sri Lanka before Ayurveda came with the advent of Buddhism from India. Over time, Deshiya became blended with the Ayurveda, hence the traditional medicine practiced in Sri Lanka is a mixture of both (Institute of Indigenous Medicine).

7.2.4 *Unani Medicine (Pronounced Yunani, Called Unani-Tibb in India)*

This is the medical system that came into India with the advent of Islam, around eleventh century. The name implies that it is Ionian and Greek in origin, even though it was largely developed in Persia and Arabia. Its roots are Greek, as writings of Hippocrates (460–370 BCE), called Buqraat in Arabic, and Galen (129–200), called Jalinus in Arabic, inspired the Persian and Arabian Physicians who developed it. Ayurvedic writings were also translated into Persian around 700 AD, and Arabic around 800 AD, and contributed to the development of this system (Mangathayaru 2013). Ayurveda is called Al'ayurfida in Arabic.

The most influential Physician in this system is the Persian polymath Avicenna (Ibn Sinna) (980–1037). His book, Canon of Medicine (al-Qanoon fi at-Tibb), a five volume medical encyclopedia, completed in 1025, commanded authoritative position in Medicine for centuries. There have been thousands of commentaries written about Canon of Medicine, and in the medieval world it was one of the most translated and studied books of Medicine. The other important developers of Unani system of Medicine are Rhazes (al-Razi) (854 CE–925 CE) from Persia, Al-Zahrawi (936–1013) from Muslim Spain, and Ibn-Nafis (1213–1288) from Egypt.

In Muslim sciences, the interpretation and treatment of psychiatric disorders are based on at least two different schools. Unani is the secular, and medically grounded theory and clinical practice that is being discussed in this chapter. It needs to be differentiated from a religious-spiritual understanding of not only psychiatric disorders but also almost all problems that humans face. This second system has many roots. The foremost is the *tibb-i-nabawi* (prophetic medicine), which is the collections and commentaries of the sayings of the prophet Muhammad, on hygiene and medicine. The others are the magico-religious practices of sufi rituals and the cult of sufi saints that became very popular in India. These are combined with other elements derived from esoteric sciences and folk beliefs (Speziale 2003). These practices are discussed in the next section of the chapter.

Unani system spread all over South Asia patronized earlier by the Muslim rulers. Its practitioners developed local treatments based on local flora and fauna. The practitioner is called a Hakeem, a word of Arabic origin, meaning a wise man.

In Unani system of Medicine, there are four elements, called four Arkan – Air (Hawa), Water (Maa), Fire (Nar), and Earth (Arz) (Azmi 1995). These elements not only constitute the primary components of the human body but also make up the rest of the universe. These elements make up four humors called Akhlat. The humors appear in Unani practice as blood (dam), phlegm (balgham), yellow bile (safra), and black bile (sauda).

When these different qualities of elements interact and react, then previous qualities become diminished and a new moderate quality is developed, called the temperament (Mizaj) – the literal meaning of Mizaj is intermixture or admixture, implying mixture of humors. For practical purposes, it means the metabolic composition along with the behavioral attributes of a person. Though the word temperament is often used in psychological sense, in medical sense it implies the blend of humors, i.e. biological constitution (Jabin 2011). In Unani system, the Mizaj “temperament” is a notion of primary importance, though a difficult concept as it indicates the properties of an atom, a molecule, a cell, a tissue, an organ and human body as a whole” (Ali et al. 2007).

The four essential temperaments are hot, cold, moist, and dry. Four more are compounded of those single temperaments – namely, hot and dry, hot and moist, cold and dry, and cold and moist.

According to the composition of these humors in a person, all human beings can be assigned a particular temperament – or a combination of temperaments – which are expressed as Damvi (sanguinous), Balghami (phlegmatic), Safravi (choleric), and Saudavi (melancholic) (Javed et al. 2009).

The Unani medicine recognizes six essential factors that affect the composition of temperament of human body. They are: (a) ambient air; (b) food and drink; (c) physical activity and rest; (d) emotions and feelings; (e) sleep and wakefulness; (f) retention of fluids and evacuation of wastes (Siddiqui 2009). The Unani Medicine recommends that the approach towards health and reinforcement of health should be individualistic and based on temperament (Jabin 2011). The disequilibrium in humors produces changes in temperament that leads to illness. For example, the dominance of phlegm or black bile determines the phlegmatic or melancholic char-

acters respectively. Excess black bile (cold and dry) induces depressive disorders. Excess of yellow bile (hot and dry) leads to hysteria and maniacal disorders (Speziale 2003).

The main aim of treatment is to restore the normal temperament of the person (Speziale 2003). There are three modes of treatment in Unani system (Ahmad 2007):

1. Regimental therapy (Ilaj bil tadbeer) – exercise, climate change, massage, venesection, leaching, cupping, diet therapy (Ilaj bil ghiza).
2. Pharmacotherapy (Ilaj bil dava) – using medications of plant, animal and mineral origin, either alone or in combination
3. Surgery (Ilaj bil Yad) – Surgery

In Unani system of medicine the psychiatric nosology is also a part of medical classification under the title of Amraze Nafsani, (diseases of the mind) where all the diseases are classified as syndromes rather than an individual disease entity. These diseases are categorized based on the theories and philosophies of several Greco-Arab physicians and philosophers (Ahmed et al. 2015).

Historically, the Unani medicine was practiced widely in India, alongside practice of Ayurveda, without any enmity between the practitioners of the two systems. Through the centuries, multiple books and treatise were written in India to adapt the Unani system to India, and to expand its uses (Verma 1970). For example, an Indian Physician Najabuddin Unhammad, in 1222, described seven types of mental disorders:

- (a) Sauda-e-tabee (Schizophrenia) – called Junoon if it becomes chronic
- (b) Muree sauda – depression
- (c) Malikholia-e-maraki (delirium)
- (d) Haziyan (paranoid state)
- (e) Ishk (delusion of love)
- (f) Nisyan (organic mental disorder)
- (g) Janoon – chronic schizophrenia (see above)

Methods of treatments included bleeding and purging, diet changes, massage, change of climate, being allowed the profession of choice, avoidance of fear and irritation, soft music, sympathy and kindness, and medications (Vyas and Ahuja 1999).

7.2.5 *Sowa-Rigpa*

Sowa-Rigpa commonly known as Amchi system of medicine has been practiced in Tibet, Mongolia, Bhutan, some parts of China, Nepal, Himalayan regions of India and parts of Central Asia. Sowa-Rigpa means the science of healing. The majority of theory and practice of Sowa-Rigpa is similar to Ayurveda. Tibet has a long history of translating Indian texts, and about twenty-five texts related to medicine are

also preserved in Tibetan literature. Gyud-Zi (also called Gyushi, or rGyu-bzhi), meaning the Four Tantras, the fundamental textbook of this medicine derives material from Indian texts, enriched in Tibet with its own folklore, as well as Chinese and Unani systems of medicine (AYUSH3). The system was formalized around twelfth century though it had been evolving for several centuries before. The fundamental concepts of five elements, called Jung-wa-lna, and three doshas, called Nespa gSum are similar to Ayurvedic system. The elements are called sa, Chu, Mai, rlung and Nam mkha, roughly translated as earth, water, fire, air, and, ether. The practitioners of this system are called Amchis.

Since in the traditional belief system, the fundamental textbook is believed to be taught by Buddha, it is heavily influenced by Buddhist philosophy. It is believed that all the living creatures on the earth are sick until they give up the root cause of sickness, i.e. ignorance. Due to ignorance, three mental poisons of anger, desire, and mental darkness are born within us, which act as the root cause of illness. The concept of three doshas being in and out of balance is similar to Ayurveda, however due to presence of 84,000 different types of afflictive emotions ascribed to Buddhist teachings, the number of disorders also goes up to 84,000, which are sub-classified into subtypes, that finally leads to a fundamental classification into two main types of disorders – hot and cold (Gurmet 2004).

7.3 Magico-Religious Systems

Any understanding of Indian psychosomatic medicine would be incomplete without understanding this part of people's lives. When the medical problems pertain to "possession", magico-religious healers are overwhelmingly contacted while traditional Practitioners are seldom approached (Chadda et al. 2001; Kapur 1979). In a broader context, Indian medical experience tends to be pluralistic where patients choose between different practitioners, even seeking more than one at the same time, e.g. in a 4-year study, fully 88% of patients who were hospitalized psychiatrically were also seeking help from a faith healer (Bathla et al. 2015), despite high levels of dissatisfaction at times (Schnover et al. 2014). A 3-month study showed the number to be 45% (Campion and Bhugra 1997). Post treatment interviews show that patients have divergent experiences in this pluralistic system, and each therapy was found by some to be helpful and by others to be ineffective. These findings suggest that a greater availability of distinct forms of therapy makes it more likely that an individual will find a therapy to which he or she responds well (Halliburton 2004). It is noteworthy that it is difficult to even find an Ayurvedic facility that would treat severe psychiatric problems (Bhattacharyya 1986). This kind of medical pluralism is not peculiar to South Asia. This pluralism assumes that the patients are capable of the idea that not only could there be multiple causes of an illness, but there could multiple parts of the treatment too (Leslie 1988). Anthropological studies show that medical personnel from all systems incorporate some form of religious language invoking divine help in India. The traditional practitioners believe

that seeking divine intervention makes their interventions more potent (Khare 1996). The magico-religious practice of astrology is included in Ayurveda as part of treatment. There are extensive parts of Ayurvedic texts that discuss the holy chants called Mantras, required for specific illnesses, including Unmada and Apasmara – insanity and Epilepsy (Alper 1989). A monograph from 2008, about a village just 1 hour away from the Bangladesh’s capital city of Dhaka shows that none of the people had heard of a psychiatrist or that there is a treatment available for “other illnesses”, i.e. mental illnesses. In the same study, the villagers were able to describe these illnesses, based on their own observations, of six types – insanity with varying degrees of it, possession by evil spirits, anxiety, congenital disability, epilepsy, and addiction. They also believed that the traditional medicine practitioners didn’t know how to treat it, and the only treatment that was possible was by the faith healers (Van der Geest et al. 2008).

This is the folk religion or the popular religion, also sometimes called the local religion, as applied to medicine.

There are obvious problems trying to write a history of this system. First, historically, most of these belief systems are not well documented for multiple reasons – the main one being that the majority of adherents have been uneducated village peasants and their families. They don’t have the skills or the penchant for documenting any of this.

Even in early modern Europe such records are scant. Second, these healers pass on information through oral traditions. Third, the early attempts to document these healing systems were made in around eighteenth–nineteenth centuries, particularly after the British came to India and started the documentation, and these were done by the elite, or the colonial administrators, who were biased and motivated by considerations of class. These healing practices were largely local and local people followed them regardless of the religion they ascribed to. However, all the major South Asian religions underwent a major transformation in the latter half of the nineteenth and first half of twentieth centuries. There was development of a western educated class that tried to define their religions as uniform, and religious practices distinct from each other; as opposed to locally practiced religions that defied such definitions (Oberoi 1994). This process of delineating created a view that these local and older practices were inherently wrong because it doesn’t make sense for people of all religions to follow and pray at the same shrine; and these practices were also seen as superstitious, backward and irrational.

This system has a pragmatic reason to exist, i.e. healing afflictions. DSM-5 stresses cultural formulation, and understanding these systems constitutes an important part of understanding the patient. The magico-religious healing practices of this system don’t follow the scriptural practices or codes, rather the focus is to deliver the results without any focus on analysis.

Now we look at what constitutes this magico-religious system in addition to what has been mentioned earlier within the context of Ayurveda and Unani. This system consists of miracle saints, goddesses, and village sacred sites, and belief in spirits and witchcraft. The belief system permeates all parts of life and it is as if the believers live in an enchanted universe (Weber 1962). The miracle saints generally

have a title that identifies what religion they may have followed or born in, e.g. a Hindu Saint may be called a Guru or a Sant, a Muslim saint would typically be a Pir or a Sain, and a Sikh saint would be called a Sant. Multiple miracles are attributed to them during their lifetime and the miracles include healing from illnesses of all kinds. When people of other faiths visit the shrines of these saints, they are not looking to be educated in the theology of that particular religion. The visits are clearly made for pragmatic reasons – healing, and attempts to solve other psychosocial problems (Oberoi 1994). There is a kind of specialization that also exists among these saintly shrines for who can heal what. Some Muslim sufi shrines called Dargahs, can have rooms for patients, where patients can stay for months or years, sometimes in chains. In the past, these shrines had patronage of rulers, but now they depend on the money collected from patients, and other worshippers. This has led to these shrines abandoning practice of Unani medicine and relying solely on faith healing (Speziale 2003).

Due to relative lack of scientific studies of this system from India, I present three anecdotal examples.

The first example comes from Macauliffe who was a British judge, and visited one such shrine of a very popular saint, Sakhi Sarwar (Macauliffe 1875). This shrine is in the state of Punjab in Pakistan. The healer at such a shrine is called a Mujawir, and the word used for the spirit is jin. The author describes a typical healing session in detail.

“Within a cordon of Mujawirs and musicians knelt several females who continues swaying their bodies and their heads from left to right to the sound of drums. The heads and faces of some were covered; the long hair of others streamed wildly over their persons, while their features looked weird and impassioned. I looked on for some time, but it soon became painful for me to see some of the wretched females, who had been for hours swaying their heads and bodies to the tune of drums... I was informed it was a ceremony for the exorcism of jins and evil spirits, by whom the females before me had become possessed and excited.... After a few hours of the strange bodily motions above described, the exorcising mujawir, standing before the female, commences in lawyerlike fashion by asking the jin’s name and tribe. The jin answers through the mouth of the female. Then the mujawir asks what induced the jin to possess the female. To this query different answers are returned, according to the circumstances and the designs of the mujawir and the female... The mujawir urges on her master the propriety of departing from the person. The jin is generally accommodating, and promises to leave for a certain consideration... Should the jin, either at the instigation of the female’s husband, or for any other reason, refuse to depart, the mujawirs have often recourse to torture. I was told the favorite system in such cases was, to tie the patient’s wrists together, so that the palms of the hands may touch; then insert pieces of wood between the fingers opened laterally, and squeeze their tips. The jin at this frequently relents and departs, saying that the female has been sufficiently tortured.”

Second example comes from a news report from PBS about treating mental illness with medicine and religion in India. This report is from 2014, about a shrine in the state of Gujarat in India. The shrine has centuries old tradition of healing people afflicted with possession that results in a variety of Psychiatric and psychosomatic symptoms. In this report, the shrine allowed the psychiatrists to open up their offices inside the shrine. They also trained the faith healers to look for telltale signs of mental illness (PBS 2014). This is rather a rare example of a cultural formulation co-

existing with modern medicine cooperating, and it ultimately benefits the patient. This approach is also completely opposite to what is typically done – opposition and scorn for faith healing practices that can alienate the patient.

Third example is about the blockbuster movie *Manichitrathazhu* (The Ornate Lock 1993) made in the language Malayalam, from the state of Kerala (available for viewing from YouTube: <https://www.youtube.com/watch?v=ExSmkZ43bIM>). The movie explores possession and dissociation, and how the competing ideologies of psychiatry and faith healing are portrayed in the popular culture. The movie has been remade in many other Indian languages with commercial success that speaks to the Indian people's real struggle with how to make sense of the clash between faith healing and modern Medicine, not just Psychiatry (Weiss 2015).

In this system of healing, the gods and goddesses have a place for prayers. However, as far as the diseases are concerned, goddesses have a prominent place. The best-known example till recently was Sitala – the goddess of Smallpox. She is largely a malevolent goddess that has to be kept cool otherwise her anger would cause the pox. The role of ancestor worship is similar to worshipping other spirits – however the spirits of the ancestors would be seen as benevolent and specific rituals have to be done to keep them happy.

7.4 Historical Development of Psychiatric Institutions in India

Most of the practice of psychosomatic medicine discussed so far, does not document the institutions where this medicine was practiced. The development and practice of psychiatry in India is discussed based on historical documents. Prior to European colonization of South Asia, the accounts of mental treatments based in institutions are scant.

According to the scribes of Asoka Samhita, as early as two–three centuries BCE, many hospitals were established for patients with mental illness (Nizamie and Goyal 2010) during the reign of King Ashoka, the great Buddhist king who ruled over much of South Asia, (265–238 BCE, also given as c. 273–232 BCE). There is reference to asylums during the reign of Emperor Mohammad Khilji (1436–69), and presence of a mental hospital at Dhar in Central India is documented, under the physician Maulana Fazulur Hakim (Sharma 1984). A curious part of this history is documentation of a tradition from the city of Gujarat in the state of Punjab in modern Pakistan. In this practice, children born with microcephaly, called Chuas (rat-people) were left at the shrine of a Sufi-Muslim saint called Shah Daula. These people with disability would become part of the shrine's system of blessings, and would ask or beg for money in exchange. The documentary evidence of this practice exists for at least 170 years (Miles 1996). Such institutionalization of people with mental illness and disability is common – for example, in the example discussed in the prior section about the collaboration between psychiatry and faith healers,

patients were left in chains at these shrines for some periods of time. At many shrines, there would be rooms within the architectural compound that the patients could rent and stay in for months or even years. In August 2001 a gruesome event occurred when fire broke out at one such shrine, in Yerwadi, in which 26 mentally ill people burned to death because they had been chained to prevent them from escaping (Thara et al. 2004).

The development of mental asylums in India starts with British India in the late eighteenth century and then leads to development of modern psychiatry and Psychosomatic Medicine in India, discussed in a separate chapter.

7.5 The Traditional Medical Systems in Current South Asia

Prior to the colonization of Indian subcontinent by European countries, the indigenous medical systems had widespread acceptance by the masses, and patronage by the royals. For example, during thirteenth–seventeenth century, Unani Medicine had its hey-day in India (AYUSH2). This system along with other indigenous systems including Ayurveda declined during the European colonization as modern medicine was introduced and gained ground. These systems saw a revival in early twentieth century, e.g. Unani system saw revival during the Indian freedom struggle especially as one of the Hakeems responsible for reviving Unani system, Ajmal Khan, was also a prominent freedom fighter.

After independence from the British Raj, all Indian indigenous systems have seen a revival, supported by many governments in South Asia.

In 1995, the Department of Indian System of Medicine and Homeopathy (ISM&H) was created by the government that was later expanded to include other systems in 2003, and renamed Department of AYUSH – acronym for Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa-Rigpa, and Homeopathy. A separate Ministry of AYUSH was formed on 9th November 2014. The ministry's objectives are to upgrade the educational standards of Indian Systems of Medicines and Homoeopathy colleges in the country, and to strengthen existing research institutions and to ensure a time-bound research, and to develop plans for promotion, cultivation, and regeneration of medicinal plants used in these systems, and to evolve pharmacopoeia standards for Indian Systems of Medicine and Homoeopathy drugs (AYUSH4). Traditionally, the systems have had a master-apprentice system of education, or a lineage system where the information was typically passed from a father practitioner to his son. Training in each of the systems has now been standardized and institutes for training and research have been established. For example, a graduate from an Ayurvedic school of medicine is called a Bachelor in Ayurvedic Medicine and Surgery. The graduation requires four and a-half years of training followed by 1 year of internship (Wikipedia1). Advanced training requirements and programs have also been established for practitioners of AYUSH. For

example, the National Institute of Unani Medicine in Bangalore, an autonomous organization under Ministry of AYUSH, established in 2004, awards post-graduate degrees in eight disciplines – Medicine, Pharmacology, Preventive and Social medicine, Obstetrics & Gynecology, Pharmacy, Basic Principles, Regimental Therapy, and Surgery (NIUM). The National Institute of Ayurveda in Jaipur, established in 1976, is considered the apex in research and training in Ayurveda (NIA). Statutory bodies have also been established to monitor the training programs e.g. the Central Council of Indian Medicine, established in 1971, monitors education in traditional Indian medicine.

The College of Indigenous Medicine was established in Colombo, Sri Lanka in 1929 with similar objectives to AYUSH. In 1977, it became part of University of Colombo, and was renamed Institute of Indigenous Medicine. It offers programs in Bachelor of Ayurvedic Medicine and Surgery, and Bachelor of Unani Medicine and Surgery, as well as advanced degrees.

The Bangladesh Board of Unani & Ayurvedic Systems of Medicine is the regulatory body to standardize training and research programs in Bangladesh (BBUASM), and Nepal Ayurvedic Medical Council provides similar functions in Nepal (NAMC)

Similar trainings are offered in Universities in Pakistan (Wikipedia2).

7.6 Conclusion

There is a rich tradition of psychosomatic medicine in the Indian subcontinent. This tradition is a deep part of culture and modern practitioners of medicine have to be aware of it, not only in India but in the West as well. These practices are part of complementary and alternative medicine (CAM) taking roots in the West. For example, one of the interventions with evidence is mindfulness-based stress reduction. Its effectiveness is well documented for chronic pain, anxiety, stress, and psychosomatic conditions (MBSR). At the same time, a google search for “dosha” returns multiple sites with a checklist that not only diagnoses you, but recommends treatments as well. A cursory walk down the supplement aisle of any supermarket or drugstore shows formulations sold for turmeric, cinnamon, and garlic with benefits promised based on ancient Indian medical texts. At the same time in 2008, a National Center for Complimentary and Integrative Health funded study examined the content of 193 Ayurvedic products purchased over the Internet and manufactured in either the United States or India. The researchers found that 21% of the products contained levels of lead, mercury, and/or arsenic that exceeded the standards for acceptable daily intake (NIH). This knowledge will help medical practitioners to be aware of the usefulness of some of these practices, e.g. adding mindfulness based stress reduction to a regimen for a pain syndrome. At the same time, this knowledge can help open up trustful conversations with the patients about the potential harm of these practices and products.

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Chapter 8

Major trends of Psychosomatic Medicine in North Africa and Middle East



Tarek A. Okasha

8.1 History

8.1.1 *Mental Disorders in the Pharonic Era*

Little is known about the cultural differences in psychological adjustment and perception of illness. Illness perception is a culture dependent factor and appears to influence psychological adjustment very differently. The cultural impact on illness perception does not only affect the clinical presentation of the illness, but also the psychological coping mechanisms, the most appropriate lines of management, and the patients' expectations from their therapist.

Ancient Pharonic Egyptian medicine, interestingly, did not recognize the specificity of mental disorders. They attributed all mental phenomena to disorders in the heart or the uterus. There was no differentiation between psyche and soma and hence there was no stigma for mental illness.

Nearly 1000 years before Hippocrates used the term hysteria, ancient Egyptians in the Kahun papyrus (a papyrus for uterine diseases), described a series of morbid states, all attributed to the displacement of the uterus. They ascribed these morbid states to the "starvation" of the uterus from its upward displacement, with consequent crowding of other organs leading to different bodily symptoms.

The earliest recorded sources of medicine emanate from the two great centers of culture, Egypt and Mesopotamia. Of these the Egyptian records are very important, especially the information available from surviving papyri (Okasha and Okasha 2000b).

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A few authorities have attempted to summarize our knowledge on ancient Egyptian medicine. A medical perspective was presented by Prof. Ghalioungui at the Faculty of Medicine of Ain Shams University in Cairo (Ghalioungui 1963). He posed various questions: what was the nature of that medicine? Was it sorcery or rational practice? What was valid in it? What influence did it exert on the medicine of the Greeks who claimed to have borrowed from it? His book also draws several comparisons between the popular therapeutics actually practiced in Egypt today, which no doubt have been directly inherited from ancestors, and the treatments prescribed in hieroglyphic documents.

The main sources for studying medical knowledge in ancient Egypt are the surviving papyri, which first required transliteration into modern languages. Furthermore, inscriptions on mummies, statues, and paintings have been studied.

Ancient Egyptian books were rolls of papyrus made from the plant *Cyperus papyrus*, a sedge that grows wild anywhere in Egypt. All these papyri have been translated and annotated (Grapow 1954).

8.1.1.1 Egyptian Beliefs and Health

In ancient Egypt, the philosophy of life and death centered upon the idea that these were part of a continuous cycle, hence the belief in life after death demanded elaborate funeral ceremonies and complex rituals in preparation for it. This belief emphasized the psychology of the dead and the personality of the hereafter.

The individual was considered to be composed of three integral parts. The *Khat* represented the body. The *Ka* was the soul of the individual's double, represented and symbolized by uplifted arms, whose main function was to protect the deceased body. The *Ba*, which was symbolized as a flying bird carrying the key of eternity, was believed to leave the body after death and reside in heaven, periodically visiting the burial place of the mummified body.

Death, as opposed to life, did not exist in the Egyptian mind. Ancient Egyptian language had no sign to express it. Death was nothing but a further step in life during which his soul or *Ba* could return from yonder to reinvest his body and resume with it his interrupted life. The primary duty of preserving the shape of the deceased was to allow the *Ba* to recognize it before reanimating it. One of the worst outrages that could be inflicted on a dead person was to let the body decay, to erase the name, or to disfigure the body beyond recognition.

The custom of embalming continued until the first centuries of the Christian era. At first it was limited to Pharaohs, notables and priests, but it slowly spread among the people. The ceremony took 40 days under the supervision of one or more priests, wearing gods' masks and singing prayers.

As much as Ancient Egyptians cared for the spirits of the dead, they feared them. It was thought that diseases were either due to evil spirits or the wrath of the gods, but organic causes were also described. Hence the art of healing was part of the ancient religious practices (Harris 1971).

The most important of the healing gods was Thoth, who was represented at times as a monkey, but generally as an ibis, or as a man with the head of an ibis surmounted by the solar disc and the lunar crescent, and often holding the Seshet or inkstand and reeds, symbols of the scribe. He personified the moon and was related to the sun. Thoth was also called 'the measurer', and was held to be the inventor of the exact sciences, of mathematics, arts, theology, occult sciences and magic and the author of the secret healing formulae. He became the scribe of all the other gods and partook of their work, and, since he was also believed to be the owner of the secret books, he was considered to be the god of wisdom. He was revered as an author of books on medicine and served as physician to the gods and protector of all who were ill. His silhouette is the logo of the Egyptian Psychiatric Association.

The god "Thot"



The silhouette of the god “Thot” is the logo for the Egyptian Psychiatric Association (EPA)



It is in this fertile soil that Freud’s long standing interest in Egyptology was rooted. Among the 2300 or so antiquities collected personally by Freud in his life-time, some 600 objects are Egyptian. Out of 35 figures on the desk at the time of his death, 22 are Egyptian, mainly bronzes dating from 600 BC.

It can be argued that prehistorical Egyptian imagery and configurations underpin Freud’s own self-analysis, and are pivotal to both pre-Oedipal and Oedipal issues. That he chose to focus on Greek legends in his theoretical writing can be seen as a “defensive” function and a secondary process structure of historical Oedipal development (Bernfeld 1951). Freud clearly knew the details of the legend of Osiris and Horus since he possessed both volumes of Wallis Budge’s *Osiris* and the *Egyptian Resurrection* (Leff 1988). Having related the Osirian story, we can compare it with Freud’s Oedipal myth. The most striking surface difference is that whereas the Oedipal situation is triangular (mother/father/child), the Osirian introduces a fourth term, that of the brother (maternal/paternal or sibling).

8.1.1.2 Medicine in Ancient Egypt

Perhaps the first hospital system in the world was found relatively recently in the excavation at North Saqqara: a side gallery leading into a new wing consisting of a main passage with a vast maze of complicated lateral galleries branching off on

either side (Budge 1911). These side galleries, averaging 3 meters high by 2.5 meters wide, were completely filled with thousands of sealed pottery jars similar to those found nearby in 1964, which contained wrapped mummified ibises. The jars, however, proved to contain the mummies of falcons, many of them most beautifully shrouded. These were probably destined for worship and for the treatment of sick people lying in separate rooms.

There is no known physician's title in pharaonic times to suggest specialization in mental diseases, although psychic and mental symptoms are mentioned in many clinical observations, mainly in the Book of the Heart (Emery 1971). In Ebbell's translation of the Ebers papyrus, the words 'heart' and 'mind' occur in 14 prescriptions. Indeed, personality types were attributed according to the color and shape of the heart, e.g. long-, short-, white-, and black-hearted. It also seems that the lay assumption of white-hearted individuals originated from ancient Egyptian beliefs (Ebbell 1937).

Discrimination against mental illness in Ancient Egypt was unknown. The terms soma and psyche did not exist. The heart was believed to be the center of physical and emotional life, of the will and the intellect (Bryan 1930). The heart controlled actions of the arms, the legs and every part of the body, as well as such functions as vision, hearing and breathing. It made decisions and the tongue proclaimed what the heart has conceived. Wear and tear on this essential organ brought about senility.

All the feelings, conditions of the soul, traits of character and temperament were expressed by various idioms referring to the heart, and all mental disorders were treated as diseases of the heart. For example, being happy was described as 'long of heart' and depressed as 'short of heart'. A confident person was called 'he who fills the heart'. 'To drown the heart' meant to hide one's thoughts, and 'to wash the heart' was to satisfy one's desire. 'Dryness of the heart' referred to forgetfulness, which was said to be the result of thrombosis.

Because mental disorders were considered to be somatic diseases of the heart, the issue of stigma because of mental illness was irrelevant. Mental patients were just patients like any other (Okasha 1999).

Breasted (1930) drew attention to what appears to be the first reference to the brain itself used anywhere, in the Smith papyrus of about 1600 BC (Posener 1936). Until then, the earliest discussions of the brain had been found in Greek medical documents, some 2000 years later. The Egyptian treatise describes the external appearance of the brain as like the corrugations arising in metallic slag.

Breasted also wrote that the earliest observations showing that the brain is a center of nervous control are contained in the Smith papyrus. The surgeon noticed that injuries to the skull and brain disturbed the normal control of various parts of the body as far away as the feet (Breasted 1930).

The same source also refers to convolutions of the brain, localization of functions within the brain, the brain as the source of control of movements, the connection of the brain with nervous system and tetanus after brain injury.

8.1.1.3 Dreams

Premonitory dreams in temples were regarded in late Egyptian history as orders. The interpreters of such dreams were the lector priests. Some of the temples were in fact sanatoria (e.g. Kom Ombo and Dandara). The patients were received and prepared by prayers, sacrifices, bathing and oiling and then left to sleep. Dreams were then interpreted and treated accordingly. Gardiner translated the earliest book of dreams, probably from the 12th dynasty (2000–1790 BC), which contains interpretations of all possible dreams (Breasted 1934).

Good dreams included a man seeing himself eating lotus i.e., he will enjoy something; killing a serpent means that he will quench a controversy; crossing in a boat means that he will avoid controversy; climbing on a tree means the abolition of all his evils.

Examples of bad dreams included a man seeing his bed on fire, which means that his wife will leave him, or pricking his body with a needle meaning he will tell a lie.

8.1.1.4 Hysteria

The oldest of the papyri, Kahun Papyrus – dating back to about 1900 BC – deals specifically with the subject of hysteria. It is lamentably incomplete, only fragments having survived. The fragments were evidently part of a small treatise describing a series of morbid states, all attributed to the displacement of the uterus. Most of these diseases are defined clearly enough to be recognizable today as hysterical disorders: a woman “who loves bed, she does not rise and does not shake it”; “who is ill in seeing, who has pain in her neck”; “pained in her teeth and jaws, she does not know how to open her mouth”; “aching in all her limbs with pain in the sockets of her eyes, she cannot hear what is spoken” (Okasha and Maj 2001).

These and similar disturbances were believed to be caused by the ‘starvation’ of the uterus by its upward displacement with a consequent crowding of other organs. As treatment, the genital parts were fumigated with precious and sweet-smelling substances to attract the womb, or evil-tasting and foul-smelling substances were injected or inhaled to repel the organ and drive it away from the upper part of the body where it was thought to have wandered. As a final measure to cause the womb to go back to its place, an Ibis of wax was placed on charcoal and ‘let the fumes thereof enter the vulva’. This merits a special comment as it introduces a magico-religious element to the otherwise entirely rational basis of treatment. The Ibis was the symbol of the God Thoth. The use of these ordeals to repel or attract the uterus would suggest their belief in uterine displacement as a cause of these ailments, contrary to the statement that the idea of the wandering womb did not originate from Egypt (Gardiner 1934).

These methods were still carried out in recent times. Strong-smelling herbs such as Valerian and Asafoetida in the form of aromatics, sedatives and antispasmodics were still recommended as specifically anti-hysterical remedies in medical textbooks as recently as the beginning of the twentieth century.

8.1.2 Islamic Culture and Mental Disorders

In the Islamic culture, the humanitarian interaction with a doctor is valued as much, if not more, than his or her technical ability or scientific knowledge. The humanitarian nature of this interaction depends on the way the doctor deals with the patient and his or her family and the extent to which the doctor expresses respect for and acceptance of local cultural and spiritual norms (Okasha 2000).

In Traditional Eastern cultures, social integration is emphasized more than autonomy; that is, the family, not the individual, is the unit of society. Dependence is more natural and infirmity is less alien in these cultures. When affiliation is more important than achievement, how one appears to others becomes vital and shame, rather than guilt, becomes a driving force. In the same manner, physical illness and somatic manifestations of psychological distress become more understood and acceptable and evoke a caring response; in contrast, a vague complaint of psychological symptoms may be disregarded or be considered to indicate that the patient is “soft” or worse, “insane”, or lacks faith (Okasha 2004).

In some cultures, and we argue that Arab and Islamic culture is one of them; the collectivity of the community is valued rather than the individuality of its members. Decisions are made not at an individual level but at a familial, tribal, or communal level, in the best perceived collective interest.

These differences are the mainstream norm and not an absolute description of a stereotyped behavior. Cultural diversity may influence the implementation of ethics in different societies. In traditional societies, the family is an extended one, decision making is group and family oriented, Western attitude regarding individual autonomy does not exist. In traditional societies the concept of external control, dependence on God with regard to health and disease, and attribution of illness and recovery to God’s will all maintain a healthy doctor-patient relationship, which makes trust, confidence, and compliance characteristic in traditional societies as shown in Table 8.1.

Islamic culture includes traditional beliefs in devils, jinn, the evil eye, and so on (delusional cultural beliefs). The family structure is characterized by affiliated behavior at the expense of differentiating behavior. Also, rearing is oriented toward accommodation, conformity, cooperation, affection, and interdependence as opposed to individuation, intellectualization, independence, and compartmentalization. The extended family helps in managing intergenerational conflicts. Young individuals vacillate between two worlds, one following the values of Western societies and the other following the values and beliefs of traditional societies (Okasha 2004).

Families in some traditional societies take pride in looking after their mentally ill relatives. In these societies, it is shameful to the family if it is discovered that a mentally ill family member is homeless.

The approach of Islam to mental illness can be traced to two main sources:

Firstly, the Holy Text (the Koran), where the most common word used to refer to the mad person, i.e., insane or psychotic in the Koran is “majnoon”. This is mentioned five times in the Koran to ascribe how prophets were perceived.

Table 8.1 Comparison between Traditional and Non-traditional societies (Okasha 2000)

Traditional societies	Non-traditional societies
Family & group oriented	Individually oriented
Extended family	Nuclear family
Status determined by age, position in family and care of elderly	Status achieved by one's own efforts
Relationship between kin is obligatory	Relationship between kin is a matter of individual choice
Extensive knowledge of distant relations	Knowledge of close relatives only
Family decision making	Individual autonomy
External locus of control	Internal locus control
Physician's decision making is respected	Doubt in doctor-patient relationship
Rare suing for malpractice	Common suing for malpractice
Deference to God's will	Self determination
Trust in doctor patient relationship	Mistrust in doctor patient relationship
Individual can be replaced, pride is in the family	Individual is irreplaceable, pride is in self
Pride in family care of mentally ill patients	Community care of mentally ill patients
Illness and recovery attributed to God	Self-determined recovery

Secondly, common convictions at the popular level: The same word is used by the masses to describe the perceived eccentricity of all prophets when they attempt to guide their people to enlightenment. It is sometimes coupled with being a magician or a teacher. In a sense, there seems to be a positive connotation to madness that would flatter the antipsychiatry concept of madness, which flourished in the mid-sixties.

The word "majnoon" is originally derived from the word "jinn". The word "jinn" in Arabic has a common origin with overlapping words with different connotations and can be traced to refer to a shelter, screen, shield, paradise, embryo and madness. The current belief that the Islamic concept of the insane is that the person is possessed by a "jinn" should not be confused with the concept of the Middle Ages. In Islam, the "jinn" is not necessarily a demon, i.e., an evil spirit. It is a supernatural spirit, lower than the angels, and has the power of assuming human and animal forms, that can be either good or bad. Some jinn are believers, listen to Koran and help human fairness. Moreover, Islam is not devoted to human beings, but also to the spiritual world at large. In the Koran, almost always, the jinn and the human being are mentioned together. This has altered the concept and the management of the insane, although they may be perceived as being possessed because the possession may be by a good or a bad spirit. Consequently there is no place to generalize punishment or give to condemnation unconditionally.

Apart from the concept of the insane as being possessed, Islam has another positive concept where the insane is taken as the one who dares to be innovative, original, and creative or attempts to find alternatives to a static and stagnant mode of living. It is also to be found in various attitudes towards certain mystics such as Sufism, where the expansion of self and consciousness has been taken as a rationale to label some of the Sufis as psychotic. The autobiographies of some Sufis reveal the

occurrence of psychotic symptoms and many mental sufferings in their paths to self-salvation.

The third concept of mental illness is the consequence of the disharmony or constriction of consciousness, which non-believers are susceptible to. It is related to denaturing of our basic structure (Al Fitrah) and disruption of our harmonious existence by egoism, detachment or alienation, partly presented by the loss of integrative insight.

The prevailing concept of mental illness at a particular stage in the Islamic World usually depended on the dominance of enlightenment or deterioration of prevailing Islamic thought. During times of deterioration, the negative concepts of the insane as being possessed by evil spirits dominates, whereas during periods of enlightenment and creative epochs, the disharmony concept took precedence.

Islam also identified the unity of body and psyche. The psyche (Elnafs) was mentioned 185 times in the Koran as a broad reference to human existence, meaning at different times body, behavior, affect, and/or conduct i.e. a total psychosomatic unity.

The first Islamic hospital appears to have been established by the early ninth century in Baghdad (705 AD) followed by Cairo (800 AD), Damascus and Aleppo (1270 AD) and then with the Arab and Islamic influence in Seville, Spain (1409 AD) and from there is spread to the rest of Europe. Among the hospitals that appeared throughout the Islamic world, perhaps the most famous one was that created in Cairo by the Egyptian Sultan al-Mansour Kalaoon in the thirteenth century (Dols 1992 and Okasha and Okasha 2000a). The hospital had sections for surgery, ophthalmology, medical and mental illnesses, i.e., it had a separate ward for psychiatric patients in a general hospital. Contributions by the wealthy of Cairo allowed a high standard of medical care and provided for patients during convalescence until they were gainfully occupied. Two features were striking: the care of mental patients in a general hospital, and the involvement of the community in the welfare of the patients, an attitude which foreshadowed modern trends by six centuries (Baasher 1975).

The Egyptian historian al-Maqrizi, who wrote in the early fifteenth century, gives a full description of the Bimristan al-Mansuri, sometimes called the Bimristan of Kalaoon or simply Dar Ash-Shifa (= house of healing). Al-Maqrizi says that the reason for the sultan's foundation was that in the year 1276, when he was a prince fighting the Byzantine, he was attacked by a severe colic in Damascus and the doctors treated him with medicines brought from the Nur ad-din hospital. Al-Mansur recovered and went to inspect the hospital; he admired it and vowed that, if God made him King, he would build such a hospital. Soon after, he became Sultan of Egypt in 678/1279, and he began the construction of his hospital (Okasha and Okasha 2000b).

According to Al Maqrizi, 'When the building was finished, al-Malik al-Mansour endowed it with the revenue from several properties in Cairo and other places that amounted to about a million dirhams a year. He fixed the expenditures for the hospital, the mausoleum, the school and an orphanage. Afterward, the sultan secured the drugs, doctors, and everything that was necessary for the sick in the hospital. He appointed attendants of both sexes to serve the sick, male and female, and established their fees and he set up beds with mattresses and everything that was needed

by the sick. He set apart a special place for each kind of illness. Thus, the four alcoves of the hospital were designated for those with fevers and similar illnesses. He assigned a hall for the oculist, a hall for the surgeon, a hall for those with diarrhea, a hall for women, and a place for those who had a cold temperament (i.e. the insane), who were divided into two sections, one for men and the other for women. He had flowing water installed in all parts of the hospital and places were designated for the kitchen, medications, potions, and preparing electuaries, collyria, eye powders, and similar things as well as places for storing these products and for distributing the drugs and drinks. He also made a place in the hospital for the head of the physicians for the reading of medical texts. The number of admissions to the hospital was not fixed; all had access to it, without distinction between rich and poor. Besides, the duration of treatment was not limited, and the sick received even at home the medications that they needed' (Dols 1992).

By the ninth century, Muslim physicians were writing medical textbooks. The Arabic medical profession was cosmopolitan and sophisticated, open to members of all faiths. The illustrious Arab physician Rhazes was a brilliant clinician who gave excellent descriptions of illness, including mental ones. Apparently he used psychotherapy in a primitive but dynamic way. Avicenna the most brilliant of Arab physicians, wrote the Canon Medicine, which was used as the medical bible until the sixteenth century. The eleventh century physician Ibn Jazlah described melancholia with delusion, manic depression, and psychosis, although he attributed these disorders to humors.

Arab scientists produced a number of drugs. A thirteenth century work listed 1400 drugs. Avicenna used rauwolfia in the treatment of acute mental symptoms. The teaching of the great clinician Rhazes had a profound influence on Arab as well as European medicine. The two most important books of Rhazes are "El Mansuri" and "Al-Hawi". The first book consist of ten chapters and includes the definition and nature of temperaments, the dominant numerous and comprehensive guides to physiognomy. Al-Hawi is the greatest medical Encyclopedia produced by a Moslem physician. It was translated into Latin in 1279 and published in 1486. It is the first clinical book presenting the complaints, signs, differential diagnosis and the effective treatment of illnesses. One hundred years later, "El-Canoon in Medicine" (The Law in Medicine) by Avicenna was a monumental, educational, and scientific medical book with better classification

After the fourteenth century magic and superstition began to creep back into the medical works of Muslim writers which some authors call the dark ages of Islam, where the scientific approach in thinking was replaced by magic, superstitious beliefs and sorcery.

Religion plays an important role in symptom phenomenology, attribution (God's will), and management. Psychological symptoms are attributed to weakness of personality, lack of faith, lack of conformity, laziness, or other factors, hardly factors that entitle an individual to a right of choice. Statements such as "if God is willing," "I seek refuge in God from the accursed Satan," "God is the healer" are widespread in the Muslim world, indicating a belief that the final decision is made where no human has control and, therefore, that human choice is a marginal variable in the determination of the final outcome (Okasha 2000).

8.2 Transcultural Aspects and Research in the Presentation of Some Psychiatric Disorders

8.2.1 *Emotional Expression (EE)*

Emotions can no longer be considered private intrapsychic or psychobiological phenomena. Emotions, no less than other attitudes, beliefs or behaviors, are mediated by culture and cannot be examined except in their context. Normal emotional expression in Anglo-Saxon culture may suggest a schizoid reduction of emotional response in a Mediterranean culture (Okasha et al. 1994). Emotional Expression may take the form of overprotection, critical comments, inner hostility, positive regards and warmth.

Critical comments in different cultures were associated with more relapses in schizophrenia and depression; English studies: Two critical comments (Vaughn and Leff 1976) USA Studies: Three critical comments (Hooley et al. 1986), Los Angeles: Six critical comments (Montero et al. 1992), Egyptian studies: Seven critical comments which explain the high tolerance of Egyptian families (Okasha et al. 1994).

Level of family criticism in traditional cultures is higher than in the West. High EE can be viewed as a desirable social trait, criticism can be a sign of care and concern in traditional families. Little is known about the role of warmth and positive remarks in family life and patient outcome and clinically significant levels of warmth could protect the patient against relapse.

The cultural and religious heritage absorbs many features, which would otherwise be considered symptomatic of a psychiatric disorder. Judging disability in a cultural context is a more sensitive and valid indicator of the need for treatment than diagnosis (El-Islam 1980).

8.2.2 *Suicide in the Pharonic Era and Islam Era*

References to suicide are very rare in Ancient Egyptian sources and have not been dealt with in Egyptology more than marginally. Wilson, in his book 'The Burden of Egypt', quoted an Egyptian sage, Ipu-wer, who witnessed a period of common peril and disaster during the first and second Intermediate Period during the nineteenth dynasty (1850–1450 BCE): 'Crocodiles sink down because of what they have carried off, for men go to them of their own accord.' (Gardiner 1934).

One of the most difficult and interesting texts named 'The dialogue of a man with his soul', most probably from the same period, makes suicide the central question. The man argues with his soul that he would be much better off if he were to commit suicide. In the course of eloquent and beautifully composed arguments, the soul succeeds in convincing the man that suicide, and particularly the burning of the corpse, would mean disaster for both of them. By destroying the body (instead of having it embalmed according to traditions and nourished by offerings), the soul

would lose the house into which, according to the Egyptian belief, it must return every night in order to be renewed and reborn the following morning at sunrise, so as to live eternally.

Here we are confronted with the very essence of Egyptian ethics. The Egyptians felt that not only the Ba (soul), but also the whole body and its organs came under the responsibility of the gods and were the dwelling places of the divine powers. The question whether suicide is sinful and thus subject to eternal reprobation becomes irrelevant, if preserving the corpse by embalming it and supplying it with offerings suffices to keep the soul alive. It apparently does not matter much if man reaches death by committing suicide or by awaiting it deliberately, as long as the corpse itself is not extinguished by fire or drowning. Apart from Cleopatra's suicide, this problem was not an issue in Ancient Egyptian literature.

Islam means submitting to God. This submission entails that at the end it is God who decides everything. It follows that everything that happens carries with it a certain wisdom or rationale. Even if the individual fails to grasp that wisdom, Islam demands that a Moslem believe in their presence and in God's final judgment. Suicide is prohibited by Islam like other religions. It is "*haram*". The logic behind the prohibition is that it is an act that manipulates something that is meant to be only God's concern i.e. life. Furthermore it indicates lack of trust in God making things better. However, "*haram*" also means acting in a way that is unjust to self and unjust to others.

Feelings of hopelessness and the intention to kill oneself are rare among Moslem depressed patients where losing hope in relief by God and self-inflicted death are considered blasphemous and punishable by eternal hell fire in the after-life. Although the wish to die is not uncommon among Moslem depressives it usually remains at the level wishing that God terminates their lives and does not progress to the wish to kill themselves (Okasha and Lotaif 1979).

Suicidal behavior drops markedly in frequency during the Holy month of Ramadan. However, rates of suicide attempts (parasuicide), which are more likely to be intended to elicit care, have no significant associations with religiousness among Moslems.

Studies of Moslem depressed patients suggest that symptom frequencies and expressions used in depressed Arab patients differ considerably from Western-derived definitions (Hamdi et al. 1997; El-Islam et al. 1988). The Hamilton Depression Rating Scale was used in different Moslem communities (Hamdi et al. 1997; El-Islam et al. 1988; Pfeiffer 1968). There was a higher incidence of retardation, somatic anxiety and hypochondriasis and a lower incidence of morning worsening of symptoms, suicide, guilt and delayed insomnia.

The WHO Atlas on Mental Health (2005) compared suicide in different regions in the world and found that the Eastern Mediterranean Region; mostly a Moslem population; had the lowest incidence of suicide in in all WHO regions, and suggested that adherence to religious beliefs about suicide in Islam may have an effect. Similarly, lower suicide rates were also found in Catholic countries most probably for the same reasons (Okasha and Okasha 2009).

8.3 Research in Somatoform Disorders

8.3.1 *Presentation of Pain in the Arab World*

In Arab countries “Pain” is the main indication of illness. It is usually attributed to a neighboring organ (e.g. headache, tightness of chest etc...) Emotional and behavioral problems are not perceived as a mental illness. Sometimes they are explained in terms of delusional cultural beliefs, low level of endurance or low level of patience. The Arabic language tends to be overemphatic and hyperbolic. It expresses emotionality at the expense of rationality. Patients and relatives exaggerate their verbal reports of distress. Somatizers are usually young, more histrionic, and exposed to a multitude of stress factors (Okasha 2003).

Demographic factors have been suggested as determinants of the prevalence of somatization. Rural and urban dichotomies proved irrelevant to the prevalence of somatization. This is especially the case in those countries, where urbanization of the country-side and ruralization of cities are taking place. Gender and population studies of prevalence has shown that female patients outnumbered males in the presentation of somatoform disorders (Katon et al. 1991).

The authors argue that the higher prevalence of women among somatizers may be explained by a female pattern of help-seeking behavior. Expectations from housewives and mothers would attribute more respect to a somatic complaint than a psychological one. While the former is frequently respected, the latter is frequently discarded as irrelevant. They have found that almost 60% of the high utilizers of primary health care suffered from less severe forms of somatization (Katon et al. 1991).

8.3.2 *Somatization*

Okasha and Okasha (1998) studied 120 Egyptian patients (84 men and 36 women) with ages ranging between less than 20 years and over 60 years of age (27). Symptom clusters involved CNS symptoms (90%), gastrointestinal symptoms (87.5%), pain and headache (80%), fatigue (90%), chest symptoms (82%), cardiovascular symptoms (72.5%), genito-urinary symptoms (52.5%) and muscular symptoms (52.5%). Diagnoses given to the 72 inpatients were as follows: depressive disorder (31.9%), schizophrenia (29.1%), anxiety and phobic disorder (13.8%), delusional disorder (12.5%), somatoform disorder (8.3%) and acute polymorphic psychotic disorder (7.1%). Among the 48 outpatients 25% had depressive disorder, 25% had somatoform disorder, 25% had anxiety and phobic disorder, 18.75% had bipolar manic disorder and 6.25% had neurasthenia.

Somatizers in primary care are usually characterized by low level of psychological distress, are less introspective, show less concern about having an emotional problem, and are less likely to attribute their suffering to psychological causes. They

show little use of mental health services, and are usually unable to talk about personal problems and are less likely to seek help for anxiety or sadness (Okasha and Okasha 1999; Okasha 2005).

8.4 Conclusion

There are important lessons to be learnt from the examination of beliefs and practices relating to mental disorders that exist in various cultures throughout the world. In many non-western cultures, native practitioners, to whom modern psychiatry is unknown, treat emotionally disturbed persons. The examination of the emotional attitude and interpersonal elements in these various forms of psychological treatments offers the psychiatrist a broad perspective from which to understand the basic components of our own present day systems of psychiatry and psychotherapy.

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Chapter 9

Psychosomatic Medicine in Sub-Saharan Africa



Bernard Janse van Rensburg and Nkokone S. Z. Tema

9.1 Introduction

In this chapter, the main mental health care indicators on Sub-Saharan countries, as listed in the World Bank's different African regions, will be considered in an attempt to identify a possible proxy measure for the level of development of Consultation-Liaison Psychiatry (CLP) in the region. This is followed by an overview of different concepts of mind-body functions and of psychosomatic medicine in CLP service delivery, training and research. Considering the available information in the literature on training programs and on the content of postgraduate curricula in the area, the chapter concludes by discussing the common psychiatric disorders and problems to be included in training in terms of a "generalist" versus a "sub-specialist" approach to CLP.

9.2 Sub-Saharan Africa

9.2.1 Overview of the area

The sub-Saharan African region, as classified by the World Bank, represents well over 80% of the countries in Africa and is usually further divided into five sub-regions (Table 9.1), (World Bank 2015; United Nations 2015). The particular

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Table 9.1 Countries listed by the World Bank as SSA countries, per region

Central Africa (Middle Africa)	Burundi, Cameroon, Central African Republic, Chad, Democratic Republic of the Congo, Equatorial Guinea, Gabon, Congo Brazzaville, Rwanda, São Tomé and Príncipe, South Sudan
West Africa	Benin, Burkino Faso, Gambia, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Liberia, Mali, Niger, Nigeria, ^a Senegal, ^a Sierra Leone, Togo
East Africa (Horn of Africa)	Djibouti, Eritrea, Ethiopia, ^a Somalia
Southeast Africa	Kenya, ^a Rwanda Kinyarwanda, Tanzania, Uganda ^a
Southern Africa	Angola, ^a Botswana, Comoros, Lesotho, Madagascar, Malawi, Mauritius, ^a Mozambique, ^a Namibia, South Africa, ^a Swaziland, Zambia, Zimbabwe

^aSSA countries with organized associations of psychiatrists

cultural and territorial divisions in the Sub-Saharan African (SSA) region which have led to diversity and conflict, and which continue to exacerbate political difficulties in the continent even today, resulted to a large extent from the inaccurate political boundaries drawn by the colonial masterminds at the time (Meredith 2005).

Meredith (2005) alludes to European negotiators at the end of the nineteenth century bargaining over separate African spheres to control, often resorting to drawing straight lines on the map, taking little account of the myriad of traditional monarchies, chiefdoms and other African societies that existed on the ground. It is in this context that some of these countries still spent a significant portion of their national fiscus on military hardware in armed conflicts, to the obvious detriment of humanitarian development and upliftment instead. The sub-continent has also been plagued by drought, famine and communicable diseases, that have further often undermined development in the SSA region. As a result, most countries in the sub-continent are still classified by the World Bank as low-income countries, with a few middle-income countries scattered in between (United Nations 2015).

9.2.2 SSA Countries in the Five World Bank Regions with Organized Associations of Psychiatrists

The World Psychiatric Association (WPA) is an association of psychiatric associations, currently with 135 association as full members and a number of affiliated associations (Word Psychiatric Association 2016a). According to the WPA, only thirteen of these Sub-Saharan countries have organized professional groups, or societies of psychiatrists who are members of the WPA (Table 9.2) (Word Psychiatric Association 2016b), leaving most countries only with individual psychiatrists and other mental health care workers, often with a very unfavourable distribution rate of psychiatrists across the population.

According to Okasha (2002), who reviewed the role of the WPA in mental health in Africa, noted that the whole African Region at the time only had about 1200 psychiatrists for a population of about 65 million (average 0.05/100,000 population, compared to 9/100000 in the European Region. The WHO's Mental Health Atlas in

Table 9.2 SSA Countries with organized associations of Psychiatry in terms of WPA African Zonal area

WPA Zone 11 – Northern Africa	<u>Algerian</u> Psychiatric Association; <u>Egyptian</u> Psychiatric Association; <u>Ethiopian</u> Psychiatric Association; ^a <u>Libyan</u> Association of Psychiatry, Neurology and Neurosurgery; <u>Moroccan</u> Society of Psychiatry; <u>Sudanese</u> Association of Psychiatrists; ^a <u>Tunisian</u> Society of Psychiatry
WPA Zone 13 – Central and Western Africa ^a	<u>Ghana</u> Psychiatric Association; Association of Psychiatrists in <u>Nigeria</u> ; Society of Psychopathology and Mental Hygiene of <u>Dakar (Senegal)</u>
WPA Zone 14 – Eastern and Southern Africa ^a	<u>Kenya</u> Psychiatric Association; <u>Mauritius</u> Psychiatric Association; <u>Mozambican</u> Association of Psychiatry and Mental Health; <u>South African</u> Society of Psychiatrists (SASOP); <u>Uganda</u> Psychiatric Association

^aCountries in SSA area according to World Bank categorization (World Health Organization 2014)

2011 still estimated the median rate of psychiatrists working in the mental health sector in the WHO African region to be 0.05 per 100,000 population (World Health Organization 2011). While in 30% of countries the majority of all psychiatrists at the time worked exclusively in mental hospitals, 24% of countries had no or less than a quarter of all the psychiatrists in the country working in mental hospitals. From the 2014 WHO Mental Health Atlas, the distribution of psychiatrists in Sub-Saharan Africa has been summarized in Appendix 1 (World Health Organization 2014).

9.2.2.1 WPA Northern Africa Zone (Zone 11)

Most of the North African countries listed in the WPA's Zone 11 (Northern Africa) are not listed as part of the World Bank's SSA region, while it is only Ethiopia and Sudan who are having organized associations of psychiatrists with WPA membership (Table 9.1).

Ethiopia which is the most populous in the region, has benefited from a number of global mental health collaborations that seemed to have propelled the development of psychiatry, although the proportion of psychiatrists to the population has not been recorded regularly (World Health Organization 2014).

Sudan on the other hand has the highest number of training institutions in the region, although very little is published on mental health and mental health services in Sudan (or South Sudan). The Sudanese Journal of Psychiatry, however, provides a platform for most of the work done in mental health in this region (Salah et al. 2013). The proportion of psychiatrist per 100,000 population in Sudan was recorded as 0.03, according to the WHO Atlas (World Health Organization 2014).

9.2.2.2 WPA Central and Western Africa Zone (Zone 13)

The countries listed in the World Bank's West Africa region of SSA countries, forms one of the bigger groups of SSA countries, although only a few has an established psychiatric association (Tables 9.1 and 9.2). These are Ghana, Nigeria and Senegal, which also seems to be the more progressive, or more documented countries in this

region, regarding the development of mental health care services. Most of the literature on this region are from Nigeria, with less from Ghana and little published by, or about, the rest of the countries in the WPA Central and Western Africa Zone.

Nigeria Hospital-based studies in Nigeria suggested that the paramedical personnel in general hospital wards of developing countries could be taught psychosocial intervention techniques necessary in the management of emotional complications of physical disorders and alluded to the need for earlier detection of psychiatric morbidity associated with physical illness so that referral in the early stage can be undertaken (Abiodun and Ogunremi 1990; Oyewole 2016). The proportion of psychiatrist per 100,000 population in Nigeria was recorded as 0.1, according to the WHO 2014 Atlas (World Health Organization 2014).

Ghana Read and Doku (2012) identified several important areas for investigation in a literature review on the mental health research in Ghana, including clinical disorders, suicide and self-harm and substance misuse. In a recent study in adolescents, Glozah and Pevalin (2016) reported that psychosomatic symptoms in this study group were positively associated with common mental illness, but age and gender did not moderate this association. The proportion of psychiatrist per 100,000 population in Ghana was recorded as 0.06, according to the WHO 2014 Atlas (World Health Organization 2014).

Senegal Considering perspectives and attitudes towards mental health in rural Senegal, Monteiro et al. (2014) noted that staff members encounter many patients with emotional/psychological problems or mental illnesses, and highlighted the need for more training to address and diagnose mental health problems, especially severe psychiatric illness. The proportion of psychiatrist per 100,000 population in Senegal was recorded as 0.14, according to the WHO 2014 Atlas (World Health Organization 2014).

9.2.2.3 WPA Eastern and Africa Southern Zone (Zone 14)

East Africa represents one of the smallest of the five World Bank SSA regions, while seven countries have established organized associations of psychiatrists, including Uganda, Kenya, Mauritius, Mozambique, Botswana, Namibia and South Africa (Tables 9.1 and 9.2).

Njenga's (2002) review of psychiatry in East Africa, included Uganda, Kenya and Tanzania. Most of the psychiatric services in this area were developed during the colonial period but were left to deteriorate when conflicts also affected these countries. They have, however, recently all embraced necessary changes that would move the discipline of psychiatry forward (Njenga 2002). Uganda, Kenya and Tanzania, all previous colonies of the British Empire, attained their independence in the early 1960s (Njenga 2002). In recent times, these countries have again experienced another commonality in being home to an estimated 1.5 million refugees

from surrounding countries, in particular from Somalia, Sudan, Ethiopia, Burundi, Congo, Malawi and Mozambique (Njenga 2002). Tanzania is not included as a country with an organized professional association, and in 1998 was noted to only have 14 psychiatrists in the country (Ngoma et al. 2003). By 2001, this had declined to 10 psychiatrists working in the public sector, of whom 4 are at Muhimbili, the main teaching and referral hospital (Ngoma et al. 2003).

Uganda With only 30 psychiatrists for a population of just less than 40 million, Uganda at the time faced similar challenges with regards to shortages of mental health care specialist as most countries in the continent (Njenga 2002).

Kenya with a population of approximately 30 million, reportedly had 5500 doctors during the late 1990's of whom 47 were practicing psychiatry. Half of this number practiced in Nairobi, a city with a population of 3 million, leaving the rest of the country to share 25 psychiatrists. Kenya is, none the less, one of the best resourced countries in African, in terms of available psychiatrists (Njenga 2002).

Mauritius is a higher middle income country on the one hand is the least populous countries in the region and enjoys the highest ratio of one psychiatrist per 100,000 population in the African continent (World Health Organization 2014).

Mozambique Similar shortages of psychiatrists and other mental health care workers have been reported in Mozambique, with emphasis on bridging the treatment gap with task shifting strategies (Dos Santos et al. 2016).

South Africa may have made most progress of all the countries with an organized association of psychiatrists in the Southern Region of World Bank SSA countries. Like countries in Eastern Africa, it owes most of the development in psychiatry to the previous colonial period, although an integrated cultural approach was mostly disregarded at the time (Minde 1974a, b; Tema and Sodi 2014). Since the first democratic election in 1994, significant developments has taken place with regard to legislation and policy development on mental health, such as the Mental Health Care Act, Act no 17 of 2002 (South African Government 2002). This legislation, amongst other, ensures the protection of mental health care users' human rights, aiming at psychiatric care in the least restrictive environments.

9.2.3 SSA Countries in the Five World Bank Regions with Training Facilities for Mental Health Care

While all countries with organized associations of psychiatrists discussed in the preceding paragraph, have been reported to have medical schools training undergraduate and postgraduate students in Psychiatry, countries in this grouping may at least have training facilities for mental health care workers, with only some of these for general practitioners (World Health Organization 2014). Because of the small

Table 9.3 SSA Countries who may have training facilities for mental health care, but no organized associations of psychiatrists

Central Africa (Middle Africa)	Burundi, Cameroon, Central African Republic, Chad, Democratic Republic of the Congo, Equatorial Guinea, Gabon, Congo Brazzaville, Rwanda, São Tomé and Príncipe
West Africa	Benin, Burkino Faso, Gambia, Guinea, Guinea-Bissau, Ivory Coast, Liberia, Mali, Niger, Sierra Leone, Togo
East Africa (Horn of Africa)	Djibouti, Eritrea, Somalia
Southeast Africa	Rwanda Kinyarwanda, Tanzania
Southern Africa	Angola, Comoros, Lesotho, Madagascar, Malawi, Swaziland, Zambia, Zimbabwe

numbers of psychiatrists working in these countries, they have therefor also been documented not to have organized associations of psychiatrists (Table 9.3). This division was proposed as a proxy indication of the different levels of development of specialist CLP in these regions, but while an attempt was made to obtain more data from individual medical schools in these countries on the content of their undergraduate and postgraduate training curricula, this information was unfortunately not readily available. An overview of these countries' populations and ratio of psychiatrists per 100,000 is listed in Appendix 1.

The population of these countries are generally characterized by a high prevalence of poverty, communicable diseases – particularly HIV infection, as well as various forms of civil unrest (World Health Organization 2014), making it fertile ground for many psychosocial problems. Health care, and in particular mental health care in most African countries is still underfunded and mental health care probably the most affected despite its contribution to the top five global burden of diseases (Okasha 2002). The competing priorities of poverty and a high rate of communicable diseases have seen mental health care relegated low on the list (Okasha 2002). While efforts have been made by the World Health Organization (WHO) to establish mental health policies and improve service developments in many of the countries in the region (World Health Organization 2000).

Lund noted that international development policy has neglected mental health and its relationship with poverty, particularly in low- and middle-income countries (Lund 2012; Lund 2015). Charlson et al. (2014), noted that significant population growth and ageing will result in an estimated 130% increase in the burden of mental and substance use disorders in Sub-Saharan Africa by 2050. Lund et al. (2012), reported that the majority of people living with mental disorders in low- and middle-income countries do not receive the treatment that they need, but despite an emerging evidence base for cost-effective interventions, little is known about how these interventions can be delivered in routine primary and maternal health care settings. While Skeen et al. (2010), noted that mental health is a crucial public health and development issue in sub-Saharan Africa (SSA), little progress has been made towards achieving the Millennium Development Goals.

9.3 Mind-Body Concepts

To consider whether the interpretation of mind-body concepts in the SSA region may have a similar meaning than elsewhere, some clarification may be required of the general understanding and developments regarding the experience of symptoms experienced and presented by patients, of patients' personal and cultural belief systems, of models for the explanation of illness and affliction, as well as of the interpretations of such complaints by attending physicians, within the context of the available knowledge about illness and disease at a given point in time.

9.3.1 *Western Concepts*

Clarifying the integrated clinical presentation in a Western/European context over time, of the overlapping of mind-body concepts and symptoms, Alter and Epstein (2009) provided a succinct overview of the history and trends, as well as of the clinical practice of Psychosomatic Medicine. They referred back to Hippocrates (460–370 BC), who selected from Egyptian and Greek traditions and conceptualised the origin of disease within the body at the time to be due to an imbalance in fluid matter (Alter and Epstein 2009). They also referred to Edward Shorter's summary of the historic development of mind-body concepts, developing from pre-1800 where (European) physicians did not distinguish somatic from psychogenic illness, using diagnoses such as “hysteria” and “hypochondriasis” in the presence of actual medical illness (Alter and Epstein 2009). Moving on to the mid nineteenth century”, concepts and code words used for the “cultural shaping” of patients' symptoms, included “spinal irritation”, “reflex neurosis” and the association, for instance by Romberg, in particular with the uterus and ovaries, to when “irritated”, cause “globus hystericus”, “hysterical seizures” and other psychogenic disorders (Alter and Epstein 2009). “Hysteromania” in Germany (Rheinstadter), types of “motor hysterias” including catalepsy and uncontrolled motor activity such as “thrashing about”, or “hysterical conversion disorders” in France (Briquet's syndrome), “hysterical paralysis” in Belgium (Verhaeghe), “astasia-abasia” or “hysterical motor ataxia” in the United States (Mitchell), and back to Europe with Charcot's influential theory of hysteria as a chronic inherited “functional” disease of the nervous system (Alter and Epstein 2009). They alluded to Freud being credited as “the principal theorist to bring psyche and soma together” during the first part of the twentieth century, by demonstrating the importance of emotions in producing mental disturbance and somatic disorders, while in the latter part of the twentieth century, somatization symptoms changed from pre-dominantly neurologic to other symptoms, such as fatigue and chronic pain (Alter and Epstein 2009). Understandably, notions about the causes of illness kept changing with improvements in medicals diagnostic techniques, where e.g. currently, central nervous system explanations of fatigue and chronic pain gained prominence, demonstrating brain dysfunction among individuals with fibromialgia and chronic fatigue syndrome (Alter and Epstein 2009).

9.3.2 *African Concepts*

In terms of the “cultural shaping” of symptoms of patients in SSA populations, relevant influences in this regard may include concepts and terms from African religions and traditional medicine, such as the realm of spirits (ancestral, nature, or deities), adherence to required ceremonies, observances and rituals/symbolism, concepts of divinity and intermediaries (e.g. diviners, healers and ancestors), as well as social and community concepts, which include a people centered ethics (Krüger et al. 2009). They noted that African Religion is diverse and belongs to a category of religious approaches worldwide where the traditional religion of a particular society is still intact (Krüger et al. 2009). These include sacred stories, wisdom and law through the immediate medium of oral tradition. It is diverse in that the polytheism of the Yoruba of Nigeria is, for instance, not shared in other parts, while in the religious orientation of the Koi-San in Southern Africa, the ancestors play a less significant role. Commonalities include belief in a Supreme Being, in a realm of spirits and the sanctity of a unified society (Krüger et al. 2009). Similarly, the adherence literature also highlights the importance of models of explanation of disease/illness and of service users’ belief systems in their agreement to accept and cooperate with physicians explanations of clinical problems and resulting management strategies (Leo et al. 2005). According to Leo et al. (2005), in addition to mediation and illness factors, reasons for non-adherence with (psychiatric) treatments include “patient factors”, such as denial, beliefs, attitudes and stigma. Patient attitudes and beliefs were also addressed by others authors (Richardson et al. 2013; Chakraborty et al. 2009; Lan et al. 2003; Kelly et al. 1987), including factors such as self-stigma and community attitude (towards mental health) and community beliefs (Fung et al. 2007; Fung et al. 2010; Botha et al. 2006; Hugo et al. 2003).

Contextualising psychiatry and African Religion, Njenga et al. (2010) – referring to the influence of different historical periods (pre-colonial – pre 1850, colonial – 1860–1960, post-colonial – since 1960), concurred that a number of common themes emerge which are relevant to Psychiatry and mental health. These include: the high number of Africans believing in the existence of a supernatural being; the powers of spirits to positively and negatively influence and interfere in their lives; the need and importance of rituals to please spirits and maintain a link with them and ancestors; the link between past, present and future generations in a common bond and in harmony with nature; the existence of malevolent and benevolent spirits; and the link between spirits and mental health and the need to appease these spirits for the achievement of good health (Njenga et al. 2010).

Conceptualisations of health and illness, as well as the remedial or interventive actions to take, are therefore closely related to these aspects of African religious models of explanation. The concept of health in the African tradition, based on the African unitary view of reality, is embracing and inclusive (Omonzejele 2008). It is not only the proper functioning of bodily organs, but good health is constituted by stability in the mental, physical and emotional spheres for oneself and that of the community. This also extends to the delicate relationship with the ancestors (who

also have to remain healthy in order to protect the living), hence disease causality would go beyond organicity or physically/bodily pathology.

Ventevogel et al. (2013) explored concepts of “what constitutes mental illness”, as well as the presumed aetiology and preferred treatment in groups of participants in Burundi, South Sudan and the Democratic Republic of the Congo, by inviting them to describe problems they knew of, that related to “thinking, feeling and behaviour”. They described localized syndromes characterized by severe behavioural and cognitive disturbances with considerable resemblance to psychotic disorders (seen as an abnormality in need of treatment), as well as local syndromes that included sadness and social withdrawal as core features (having similarities with nonpsychotic mental disorders, such as major depression or anxiety disorders) (Ventevogel et al. 2013). The latter were however not regarded as “medical” disorders and were considered to rather require social and emotional support from relatives, traditional healers and community members. Aetiological concepts varied a great deal within each setting, and attributed causes ranged from the supernatural to psychosocial and natural causes (Ventevogel et al. 2013).

Conceptualization of illness/health, help-seeking behaviour and response to treatment was also reported on by Aghukwa (2012) in Nigeria and Sorsdahl et al. (2010) in South Africa. The different views on the validity and reliability of Euro-American diagnostic systems to identify common mental disorders in Sub-Saharan Africa have also earlier been explored by Patel (1998), Ventevogel et al. (2013) noted that in their study it was not uncommon to find other aetiological factors reported with similarities to those in Western medicine. They e.g. highlighted the striking similarity of symptoms described for conditions known as (DSM-IV) “culture bound syndromes” (Ventevogel et al. 2013). Jegede (2005) explored the concept of mental illness of a Yoruba community in Nigeria. Their concept of “Were” refers to a derogatory concept of abuse and defines mental illness from a terminal point of view, which has implications for both help seeking behaviour and social interaction. The term therefore incorporates a stigmatised view, as the onset of mental illness is usually observed in the disruptive (“wild”) behaviour of patients, while help seeking mostly commences (only) at this crisis stage. Gureje et al. (2006) and Gureje (2007) also explored the knowledge of and attitudes to mental illness in Nigeria and the relationships between views about causation and attitudes, in a stratified multistage clustered probability sample of household residents aged 18 years or older, in three Yoruba-speaking states in south-western Nigeria. With regards to socio-demographic attributes, they found that participants who held exclusively biopsychosocial views of causation were not different from those holding exclusively religious-magical views, while the two groups were not very dissimilar when general knowledge of the nature of mental illness was compared. They noted though that religious-magical views of causation were more associated with negative and stigmatizing attitudes to the mentally ill (Gureje et al. 2006).

While religious-spiritual factors are often highlighted as a prominent aetiological factor to consider in an African traditional medicine context, divination will remain an integral part of this approach to uncover causality of ill-health and to facilitate recovery to good health (Omonzejele 2008). In a South African context it can be

noted that traditional African health practice has in recent years been mainstreamed in South Africa by the promulgation of the Traditional Health Practitioners Act, No. 35 of 2004 (South African Government 2004). In a literature review of pertaining documentation, the extent of integration of mental health in these legal definitions of traditional health practice, was described as the introduction of a “changed climate” for health and mental health care delivery in particular (Janse van Rensburg 2009). For example, this legislation defines traditional philosophy as “*indigenous African techniques, principles, theories, ideologies, beliefs, opinions and customs, and uses of traditional medicines communicated from ancestors to descendants or from generations to generations, with or without written documentation, whether supported by science or not, and which are generally used in traditional health practice*”. Traditional Medicine means: “*an object or substance used in traditional health practice for: (a) the diagnosis, treatment or prevention of a physical or mental illness; or (b) any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-being in human beings, but does not include a dependence-producing or dangerous substance or drug.*” The scope of traditional health practice is defined as: “*the performance of a function, activity, process or service based on a traditional philosophy that includes the utilisation of traditional medicine or traditional practice and which has as its object: (a) the maintenance or restoration of physical or mental health or function; or (b) the diagnosis, treatment or prevention of a physical or mental illness; or (c) the rehabilitation of a person to enable that person to resume normal functioning within the family or community; or (d) the physical or mental preparation of an individual for puberty, adulthood, pregnancy, childbirth and death*”.

9.3.3 Physical Symptoms and Stress

Another prominent area to consider in the conceptualization of mind-body symptom presentation, is the extent to which many confirmed psychiatric disorders, according to current diagnostic criteria, as well as different forms of epilepsy – in particular temporal lobe epilepsy, present with (episodic) somatic, or physical symptoms. Such physical symptoms are well described as seizures of different types, as well as partial or full panic attacks, with a range of physical symptoms, including respiratory (hyperventilation), cardiovascular (tachycardia, palpitations, dysrhythmias), gastro-intestinal (nausea, vomiting), and neurological symptoms (dizziness, dissociation, sensory changes). In terms of current diagnostic criteria, defined psychiatric disorders in this regard would include the whole spectrum of anxiety disorders, trauma and stress related disorders, as well as the different mood and neurocognitive disorders (American Psychiatric Association 2013).

In terms of the physical or motor symptoms e.g. associated with “stress reactions”, Dimsdale et al. discussed the relation between stress and psychiatric symptoms in a detailed overview, alluding to vulnerability and resilience and to selected physiological responses to stressors (neurotransmitters, endocrine, and

psychoneuroimmunological) (Dimsdale et al. 2009). Considering in this regard also the phenomenology of different “culture-bound” syndromes, as described by Lewis-Fernandez et al. (2009), what most of the presentations of these respective syndromes seem to have in common, is the exposure to a stressful stimulus, and/or a certain subacute conflict or more longer term frustration.

9.3.4 Types of Clinical Problems and Interventions

Alter and Epstein (2009) include a very useful table in their chapter on Psychosomatic Medicine, classifying the types of presenting clinical problems, namely: psychiatric symptoms secondary to a medical condition (delirium, dementia); psychiatric symptoms as a reaction to medical condition or treatments (anxiety related to chemotherapy); psychiatric complications of medical conditions and treatments (depression secondary to limb amputation); psychological factors precipitating medical symptoms (somatoform disorders); medical complications of psychiatric conditions or treatment (substance withdrawal, neuroleptic malignant syndrome); and co-occurring medical or psychiatric conditions.

They also listed the clinical experiences in Psychosomatic Medicine in terms of the scope of assessment and intervention required (Alter and Epstein 2009): psychiatric complications of medical illnesses); psychiatric complications of medical treatments; typical and atypical presentations of psychiatric disorders due to medical/neurological/surgical illnesses; evaluation and management of delirium, dementia and secondary psychiatric disorders; evaluation and management of somatoform disorders and chronic pain; assessment of capacity to give informed consent (cognitive impairments); providing nonpharmacological interventions (cognitive-behavioural and other psychotherapy); indications for and use of psychotropics in specific medical, neurological, obstetric and surgical conditions; interactions of psychotropics and other medication; collaboration with other physicians and the multi-disciplinary team; teaching of such colleagues regarding psychiatric disorders; and leading and integrated psycho-social health care team in a medical setting (Alter and Epstein 2009).

9.3.5 Bio-psycho-social-spiritual Dimensions

While psychosomatics still has a prominent place in the psycho-analytical discourse, its additional position is evident in relation to the biology and neurophysiology of medical and psychiatric disorders, in the presentation of these clinical problems, as well as the particular psycho-social context in which it present (Chapman 1999). Progressive thinking during the past decades allowed more holistic approaches like George Engel’s bio-psycho-social model and Herbert Weiner’s proposition of multifactoriality (Iacovides 2010). Since the 1980s, Psychiatry has thus in many counties been taught to undergraduate medical students and

postgraduate registrars, in particular from the perspective of Engel's 'biopsychosocial' model of assessment and care (Engel 1977; Engel 1980). Psychiatry has therefore, over these past decades also been practised within a multidisciplinary environment, with intervention teams involving nursing professionals, psychologists, occupational therapists and social workers (Janse van Rensburg et al. 2014). The "social" component of the "bio-psycho-social" approach incidentally underwent a further development and clarification in recent years, following Sulmasy and others' motivation for the addition of a spiritual component in the approach to the assessment and management of medical and psychiatric conditions (Sulmasy 2002).

This development also necessitated the clarification of a definition of "religion", which usually alludes to 'the outward expression of spiritual beliefs' that have been organised into integrated systems of doctrine and institutionalised structures (Pembroke 2008). For the purposes of this chapter, it suffices to say that a definition of "spirituality" should at least include the notions of a 'quality', a 'journey', a 'relationship' and a 'capacity' (De Quincey 2009; Josephson and Dell 2004). In the context of its role in specialist psychiatric training and practice, Janse van Rensburg et al. (2015), defined spirituality, as opposed to religion, as the progressive individual or collective inner capacity, consciousness or awareness of transcendence. It also consists of relational aspects or connectedness and essentially exists as a process, representing growth, or a journey (Janse van Rensburg et al. 2015). This capacity, consciousness and connectedness provide the motivating drive for living and constitute the source from which meaning and purpose is derived Janse van Rensburg et al. (2015).

9.4 Concept of Psychosomatic Medicine

Lipsitt (2006), describing the concept of psychosomatic medicine, in the context of the development of it as a new area of specialty, noted that the recognition of the mind-body link dates back many centuries, bringing to light the informal origins of psychosomatic medicine.

9.4.1 *Theoretical Framework Behind Psychosomatic Medicine and Consultation-Liaison Psychiatry*

Since the early twentieth century, the psychoanalytic influence propagated by Freud and his followers, had a strong influence in the practice of medicine (Dodds undated). Dodds (undated) highlighted that Freud already appreciated that a combination of factors – genetic, environmental, psychosomatic, are involved, in which the physical and mental states interacted via the emotions, to effect vulnerability or resilience to diseases. Dodds noted that Freud emphasized how the human body functions as a unit, by describing how the organic processes are affected by the

psychic ones, which was largely evident in Freud's works on hysteria, conversion and somatization (Dodds [undated](#)).

The earlier narrower definition of psychogenesis as the operational framework, as conceptualized in the early twentieth century has, however, been replaced over time in recognition of the (multi-causality) multifactorial origins of disease processes as promoted by Engel ([1980](#)), Lipsitt ([2006](#)) and Iacovides ([2010](#)). This newer framework has thus allowed more interdisciplinary interventions to diseases, to replace the reductionist model that sought to undermine therapeutic outcomes that depended on several inputs (Fava and Sonino [2010](#)). It is against the background of these developments that Consultation-Liaison Psychiatry (CLP) was born (Lipsitt [2006](#)). It is understood from the medical historians that CLP and psychosomatic medicine are not the same, in fact, as Lipsitt put it, "*(psychosomatic medicine) ... provided the scaffold for Consultation-Liaison-Psychiatry ...*" (Lipsitt [2006](#)).

Although the two concepts have been used as synonymous to one another, historical observations demonstrated that CLP was pre-dated by psychosomatic medicine by about a century (Lipsitt [2006](#)). CLP was seen as the clinical practice, whereas psychosomatic medicine was regarded as a research discipline. This development has brought with it an explosion of specialization and collaboration of psychiatrists with other medical specialties in CLP such as Psycho-oncology, Psycho-dermatology, Psycho-radiology, Psycho-gastroenterology, Psychosomatic Gynaecology, Psycho-nephrology, etc. (Fava and Sonino [2010](#)). The sub-specialty of psychosomatic medicine has flourished in developed countries but it has not been particularly popularized in the sub-Saharan region. CLP, and a few other subspecialties like Child and Adolescent Psychiatry, Neuropsychiatry, Geriatric Psychiatry and Forensic Psychiatry are however, are now gaining momentum on the continent (Lyketsos et al. [2006](#); Szabo [2013](#)).

9.4.2 CLP Services

There is very little description in the literature on how the CLP services are undertaken in SSA region. It would seem however that psychiatric units situated within general hospitals are charged with providing these services (Abiodun and Ogunremi [1990](#); Tema and Janse van Rensburg [2016](#)). The responsibilities of CLP service providers are more than just providing consultation, as alluded to by Lipowski ([1977](#)). He emphasized, for example, the need for CLP teams to be integrated with medical teams. The SSA setting is generally far removed from the ideal recommendations described by Lipowski ([1977](#)). The design, or lack of it, of CLP services in the SSA region is seemingly largely being dictated by the shortages of skilled personnel, in particular of specialist psychiatrists. The staff composition for the available CLP teams is also quite varied from one country to another, even within specific countries (Lipowski [1977](#)).

It is also likely that the absence of standardized practice guidelines contributes to a large degree to these variations in the CLP services, where services are largely

offered by general psychiatry specialists and rotating registrars (residents) in the general units (Lipowski 1977). It is however evident from some reports that countries in which CLP services were established (Abiodun and Ogunremi 1990; Szabo 2013; Ramchandani and Wise 2004), have indeed pursued the goals as of CLP, as defined by Bibring (1956). As Bibring put it, “*the three goals for CLP services are ... 1) differentiating organic disorders from psychogenic conditions, 2) offering treatments for patients in medical settings with comorbid psychiatric conditions, and, finally, 3) encouraging self-awareness in physicians*” (Bibring 1956).

9.4.3 CLP Training

As noted, a significant gap in the literature relates to the description of training offered for CLP both on undergraduate and postgraduate levels. This further highlights the unstructured nature of services, as well as the lack of specific training, in particular sub-specialty training in CLP, in most countries in the SSA region. It could be argued that the particular experience with the referral to CLP services in respective countries in the SSA region, should guide the construction of training programs and curriculum content that would be appropriate to their particular context. Such information could have been used to also complement and adjust the available curricula for subspecialist CLP psychiatrists in developed countries, which seems to be well established. The scope of this training framework is quite wide, but speaks to the complexity of the sub-discipline and its wide overlap in general clinical practice (Leentjens et al. 2011).

There is currently no structured curriculum developed for CLP subspecialist training for most SSA countries, although there are some reports alluding to a number of countries that have been offering training in CLP as a rotation for post graduate psychiatry (resident) training, as e.g. suggested by Stein et al. (2010). The local College of Psychiatrists in South Africa, has started the process of formalizing CLP as a sub-specialty area, while commencing with the blue printing of the curriculum (South African College of Psychiatrists 2016). The proposed content of such a blue print could include many of the fundamental components for such curricular requirements, as suggested by Leentjens et al. (2011), Lipowski (1977), and others. Some departments of Psychiatry in South Africa, such as the University of Cape Town’s Department of Psychiatry and Mental Health, has already begun training in CLP through their MPhil programs (University of Cape Town 2016).

The limitation for registration of formal subspecialties has largely been restricted by limited skilled human resource capacity (Leentjens et al. 2011), did however argue for the advantages of having different subspecialties in Psychiatry and suggested that trainees could spent a portion of their training in a particular area which would be recognized as a specific skill in that sub-discipline, in places where it may not be possible to have sub-specialties. Vythilingum and Chiliza (2011) also supported the approach to develop subspecialty CLP service even in low resourced areas.

9.4.4 CLP Research

The three goals of CLP, as described by Bibring (1956), lend themselves to broad areas in which research should be undertaken. It is further proposed by Hengeveld et al. (1988), that CLP data should be standardized. Their argument was that this standardization would facilitate generalizability and comparability of findings in the different CLP settings. The little content on the topic that is available in the literature, emphasizes the need for these services and highlights very import issues.

Literature in the SSA region on CLP has been dominated by only a few countries, namely, Nigeria, Uganda, Kenya, South Africa. This has most probably been because several sub-specialties areas in Psychiatry had not yet been established in many of these countries, while training sites and curricula have generally not been formalized. The trend in most reports available has been to describe patterns of referral to (general) psychiatric services, while also including epidemiologic information on demographic and clinical variables (Abiodun and Ogunremi 1990; Tema and Janse van Rensburg 2016). The referral rate to CLP services and the reasons for referral in the documented SSA countries, however, seem to be in keeping with findings from developed countries (Tema and Janse van Rensburg 2016; Lipowski 1977; Hengeveld et al. 1988).

Literature from the SSA region has not paid particular attention to the framework in which CLP services have been conducted in different countries. This makes comparability within the sub-continent and with other developed countries difficult. Hengeveld et al. (1988), also described fundamental characteristics of the CLP services that should be highlighted in the studies describing the framework of the services and facilities.

9.5 Generalist Versus Sub-specialist Approach

Generalist psychiatry components of CLP may include modules in: emergency psychiatry, psychopharmacology, ethics, management and leadership, culture and spirituality and even public mental health and community psychiatry principles (South African College of Psychiatrists 2016). In addition, sub-specialist CLP generally include the following field in much more detail and focus: clinical consultation-liaison psychiatry; clinical sub-specialty care; clinical syndromes and emergency presentations; stress-related symptomatology and somatic presentations; behavioural disorders; applied subspecialty psychiatry; psycho-pharmacology; consultation-liaison skills in interpersonal, multidisciplinary team, facility and regional contexts; relevant ethical and legal aspects; pertaining cultural competency aspects (American Psychiatric Association 2013; Sadock et al. 2009) (Table 9.4).

Table 9.4 Common sub-specialist CLP psychiatric disorders and problems

Clinical consultation-liaison psychiatry	Neurological, cardio-vascular, respiratory, gastro-intestinal, renal, endocrine, hormonal, immunological, rheumatological, dermatological conditions and reproduction
Clinical sub-specialty care	Intensive care, pain management oncology, palliative and end-of-life care
Clinical syndromes and emergency presentations	Delirium, catatonia, acute restless/aggressive behaviour, suicide risk assessment and management of suicidal ideation, substance withdrawal (alcohol, cannabis, hallucinogens, inhalants, opioids, sedatives/hypnotics/anxiolytics, stimulants)
Stress-related symptomatology and somatic presentations	Identified psychiatric syndromes such as trauma and stressor-related disorders, dissociative disorders, somatic symptom and stressor-related disorders, feeding and eating disorders, elimination disorders, sexual dysfunctions, and sleep-wake disorders, medication-induced movement disorders
Behavioural disorders	Personality disorders, paraphilic, disruptive, impulse-control and conduct disorders, and other conditions that may be the focus of clinical attention (relational problems, abuse and neglect, educational and occupational problems, other circumstances of personal history)
Applied subspecialty psychiatry	Addiction, geriatric, neuro, forensic and child-and-adolescent psychiatry, as well as public mental health and service delivery principles
Psycho-pharmacology	Polypharmacy, drug interaction and medication of co-occurring conditions/co-morbidity
Consultation-liaison skills	In an interpersonal, multidisciplinary team, facility and regional context, including communication, advocacy, collaboration, management and leadership
Ethical and legal aspects,	Including mental capacity assessment
Cultural competency aspects	Language, cultural/spiritual background, culture-bound stress syndromes and general perceptions on mental health held in different faith traditions

9.5.1 *Generalist CLP Services and Training*

In countries with fewer numbers of psychiatrists it remains the practice that the different CLP disorders and problems are being managed by generalist psychiatrists. Even in South Africa, not all are in support of the notion of subspecialty, as it will remain a reality that in areas outside of the better resourced urban areas, psychosomatic problems are being managed by general specialists, or by general practitioners providing primary care.

9.5.2 *Sub-specialty CLP Services and Training*

However, CLP has recently been approved in South Africa as an additional sub-specialty in Psychiatry, and the South African College of Psychiatrists is currently in the process of confirming the regulations for the curriculum and blueprinting of the *Sub-Specialty Certificate in Consultation-Liaison Psychiatry (Cert Consultation-Liaison Psychiatry, SA)*, (South African College of Psychiatrists 2016). The aim with this qualification will be that it forms part of a process to accredit well-trained, competent consultation-liaison psychiatrists to attend to the requirements of providing sub-specialist services to individuals who require psychiatric assessment and treatment in different consultation-liaising contexts. These contexts include consultation-liaison with:

- different other medical and surgical specialties and sub-specialties, including Emergency Medicine, Internal Medicine, Neurology, General Surgery, Orthopaedic Surgery, Obstetrics and Gynaecology, Anaesthesia, Paediatrics, etc.
- other psychiatric subspecialists (neuropsychiatry, addiction psychiatry, geriatric psychiatry, child-and-adolescent psychiatry and forensic psychiatry) and general psychiatrists, as well as in terms of
- public mental health outreach, training, supervision and service delivery on different levels of service specialization (e.g. primary, secondary, tertiary and specialized services).

An overall training objective of the *Cert Consultation-Liaison Psychiatry (SA)* may be to develop a sound knowledge base of the principles underlying consultation-liaison psychiatric practice, in relation to underlying neuroscientific and psychotherapeutic principles, as well as the social context and cultural/religious and spiritual environment in which clinical symptoms and problems present (South African College of Psychiatrists 2016). Also, to develop refined skills in terms of the core competencies required from specialists and subspecialists, including: Medical Expert/Clinical Decision-Maker, Communicator, Collaborator, Manager, Health advocate, Scholar, Professional and to contribute to the development of this multi-dimensional profile of professional clinical practice.

9.6 Conclusion

In this chapter, a brief overview was given of the SSA area, in terms of countries in the different World Bank regions with organized associations of psychiatrists and medical schools training Psychiatry to undergraduate and postgraduate students and those without, but possibly with some facilities to train mental health care staff. While different historic and cultural factors may have impacted on the development of mind-body concepts in Western countries, as opposed to in African SSA countries, there seems to be some shared common factors. This is namely, that

stress-related symptoms, including the spectrum of formal anxiety, mood and neurocognitive disorders, present with similar physical symptoms (e.g. panic attacks) as well as most of the “culture bound” syndromes, which have the exposure to a stressful stimulus in common. Alter and Epstein provided an approach to the classification of typical clinical problems presenting in CLP, while a more recent development in terms of Engel’s bio-psycho-social model, includes the addition of a spiritual dimension in the approach to clinical training and practice. While the sub-specialization of CLP has commenced in certain SSA countries, the possibilities and options are usually restricted by the lack of resources, such as sub-specialty training sites or enough general specialists in psychiatry. In some countries, most psychosomatic problems are still managed by general practitioners and other primary (mental) health care staff.

9.7 Summary

Distribution of psychiatrists in Sub-Saharan Africa (WHO Atlas 2014)

	Population	Psychiatrists per 100,000 population	Number of medical schools
Central Africa (Middle Africa)			
Burundi	10,484,752	0.01	1
Central African Republic	4,709,205	Not reported	1
Democratic Republic of the Congo	69,360,118	0.10	19
Congo	4,558,592	Not reported	1
Rwanda	12,100,505	Not reported	1
São Tomé and Príncipe	197,884	0.51	
South Sudan	11,738,720	0.00	29 (Sudan)
West Africa			
Benin	10,599,511	0.11	2
Burkina Faso	17,419,617	0.05	2
Gambia	1,908,935	0.10	1
Ghana	26,442,176	0.06	4
Guinea	12,043,899	Not reported	3
Ivory Coast	20,804,775	0.10	2
Liberia	4,396,871	0.02	1
Mali	15,768,229	0.04	2
Nigeria	178,516,906	0.10	25
Senegal	14,548,171	0.14	4
Sierra Leone	6,205,384	0.03	1
Togo	6,993,243	0.04	1

	Population	Psychiatrists per 100,000 population	Number of medical schools
East Africa (Horn of Africa)			
Djibouti	886,313	Not reported	1
Ethiopia	96,506,028	Not reported	12
Somalia	10,805,650	Not reported ^a	2
Southeast Africa			
Kenya	45,545,979	Not reported ^a	3
Uganda	38,844,626	Not reported ^a	4
Southern Africa			
Botswana	2,038,585	0.29	1
Lesotho	2,097,513	0.10	
Madagascar	23,571,962	0.06	2
Malawi	16,829,146	0.01	1
Mauritius	1,249,150	Not reported ^a	1
Mozambique	26,472,9787	Not reported ^a	4
Namibia	2,347,984	0.34	
South Africa	53,139,528	Not reported ^a	8
Swaziland	1,267,703	0.00	
Zambia	15,021,004	0.05	1
Zimbabwe	14,599,325	0.08	

^aWHO AIMS Version 2.1 Geneva: WHO 2005:

Ethiopia: 0.02; Kenya: 0.2; Uganda: 0.08; Mauritius: 1.0; Mozambique 0.04; South Africa: 0.28

Questionnaire Response

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry

Please return this as an attachment to your email

Country on which you are reporting:

Your Name: **Bernard Janse van Rensburg**

Institution: **University of the Witwatersrand**

City & Country (e.g. London, UK): **Johannesburg, South Africa**

Name(s) and Country of Others who provided information:

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?

Yes () No () In some sense (X)

- a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes (X) No ()
- b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes (X) No ()

2. Is there a Department (or equivalent) of Psychosomatic Medicine in institutions in the country?

Yes (X) No ()

Is teaching of psychosomatic medicine in medical schools required by law or health care system in the country? YES () No (X) **Not by law, but is incorporated in undergraduate medical and postgraduate specialist training**

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in the institution or other institutions in the country?

Yes (X) No () **UCT Department of Psychiatry has a Division within its department for Liaison Psychiatry <http://www.psychiatry.uct.ac.za/psych/liaison-psyhciatry>**

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in the country? Yes (X in the process of . . .) No () **The SA College of Psychiatrists have applied for the registration of a subspecialty in Consultation-Liaison Psychiatry**

- a. If YES, which?

Psychosomatic Medicine () Consultation-Liaison Psychiatry (X)

- b. If YES, the status of such certification is:

i. Independent Medical Specialty ()

ii. Subspecialty of Internal Medicine ()

iii. Subspecialty of Psychiatry (X proposed to be)

iv. An independent non-medical discipline, as Psychology, Social Work ()

v. Other (Specify):[]

5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in the country? Yes () No (X)

If YES, please list names of the organizations and the websites if available:

6. Please list the names of professional journals published, if any, in the country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry: **South African Journal of Psychiatry**

7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in the country? Yes () No ()
- a. If YES, where does it occur? Check all that apply: **Eight medical schools in SA, included in undergraduate medical curriculum**
- b. Medical School () Residency () Fellowship () **included in the current curriculum blue print and regulations for the FCPsych(SA) qualification of the SA College of Psychiatrists**
https://www.cmsa.co.za/view_exam.aspx?QualificationID=30
8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in the country? Yes () No () **Regulated by the Allied Health Professions Council**
<http://ahpcsa.co.za/professional-boards/>
9. Concerning traditional/folk/indigenous practice of healing in the country (please check all that apply) **Refer to the Traditional Health Practitioners Act No. 22 of 2007, which established a Council to register African traditional healers**
<http://pmg-assets.s3-website-eu-west-1.amazonaws.com/act22-2007.pdf>
Several associated societies/ associations have been formed
- There is also active faith-based self-help and therapy orientated groups and traditions, including pastoral counsellors** <http://www.saap.za.net/> and services
<http://www.hospivision.org/>
- a. It is insignificant ()
- b. Some subgroups (e.g. ethnic, religious) practice it ()
- c. A significant part of the general population practice it ()
- d. Is the most prevalent healing method used ()
- e. It is often used in combination with Western medicine ()
- f. More widely used methods are as follows (Please list,e.g., spiritual healing, meditation, herbal, etc):

10. Please add any comments to your response here:

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Part II
Contemporary Psychosomatic Medicine
and Consultation-Liaison Psychiatry in
Europe: Development, Research,
Education, and Practice

Chapter 10

Psychosomatic Medicine: The British Experience



Peter Aitken and Geoffrey Lloyd

The story of psychosomatic medicine in the United Kingdom is essentially the story of liaison psychiatry. The psychosomatic movement which flourished in the United States during the 1930s never gained much of a foothold in British medicine. British scepticism took a dim view of the psychogenesis of physical illness upon which much of the psychosomatic movement was based. Franz Alexander, who along with Flanders Dunbar pioneered the psychogenic theory, was a traditionally trained psychoanalyst and based his theories on his observations of patients with physical illnesses undergoing psychoanalysis. He had no doubt that there were specific psychological profiles for a number of physical illnesses:

“The results of the current investigations are all in favour of the theory of specificity. Gastric neurotic symptoms have a different psychology from those of emotional diarrhoea or constipation; cardiac cases differ in their emotional background from asthmatics.” (Alexander 1943)

Alexander subsequently appears to have modified his views on psychogenesis and the following statement is more in accord with how the term psychosomatic was used in the United Kingdom:

‘The attempt to single out certain diseases as psychosomatic is erroneous and futile. Every disease is psychosomatic because both psychological and somatic factors have a part in its cause and influence its course..... We use the expression “psychosomatic” exclusively as a methodological concept; it is a type of approach in medicine, a simultaneous study and treatment of psychological and somatic factors in their mutual interrelation.’ (Alexander 1948)

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Although Sigmund Freud had settled in London after leaving Vienna in the face of Nazi persecution psychoanalysis had little impact on mainstream psychiatry in Britain. Most psychiatric practice was in large asylums away from centres of medical excellence and had little contact with University medical schools. Psychiatry and psychosomatic theories made little impact on the care of medically ill patients.

10.1 Historical Roots

Psychiatry's place within British medicine can best be understood from a historical perspective by tracing the growth of hospitals for the medically ill and the insane. Little is known about care for the sick before these hospitals were established. The earliest hospitals were religious foundations. St Bartholomew's in London was founded in 1123 and St Thomas's in 1215. The Priory of St Mary of Bethlehem, later to become Bethlem Royal Hospital, was established in 1247 and began to specialise in the care of the mentally ill. All these institutions survived the reformation but there was little further hospital development until the eighteenth century. Most sick people sought help from their families, from folk remedies or from faith healers. Those who could afford it consulted a surgeon-apothecary to deal with conditions such as bladder stones, fractures, wounds and abscesses. In London, five more general hospitals were then founded, Westminster in 1720, Guy's in 1724, St George's in 1733, the London in 1740 and the Middlesex in 1745. These foundations relied heavily on enlightened philanthropy (Porter 1997). The Edinburgh Royal Infirmary was founded in 1726 and was crucial to Edinburgh's development as the leading medical centre in Europe during the eighteenth century. Several provincial English cities followed this example, notably York, Norwich, Bristol, Bath and Winchester. Some hospitals provided accommodation for the mentally ill (Mayou 1989). Guy's Hospital was probably the first to do so. Indeed the hospital was founded specifically to provide care for patients deemed incurable, including lunatics. The hospital opened a separate lunatic house in 1728.

Of the 35 patients admitted to the Royal Infirmary of Edinburgh during its first year two were diagnosed with 'hysterick disorders' (one of whom was discharged as cured) and one with melancholy (also discharged as cured). It later established a specially designated ward for the mentally ill. Other hospitals built accommodation for lunatics as annexes to the main hospital (Porter 1997). Only a small proportion of the mentally ill could be cared for in these hospitals. Many were looked after by their families or were ostracised by their community and neglected if they lacked family support. Others were sent to prison if they had committed an offence. Some were also looked after in private madhouses, with very little medical input.

All this was to change during the nineteenth century after a parliamentary enquiry published in a highly critical Report in 1815 on the conditions in Bethlem Hospital, documenting many examples of severe patient neglect and abuse.

At this time, the Quaker run York Retreat founded by William Tuke served as an exemplar of the "moral treatment" of Pinel and Poussin, an antithesis of the practices of Bethlem. The report led to demands for reform and to the development of

what came to be known as the asylum movement, which in turn influenced the emergence of a similar movement in America by Dorothea Dix, who had become familiar with the work of Pinel and Tuke while staying in Liverpool for 18 months. Several large asylums were built and in 1845 the British Parliament passed the Asylum Act compelling each county in England and Wales to build an asylum for the pauper insane. Thereafter the practice of British psychiatry was closely identified with these institutions which were nearly always built in rural locations at a considerable distance from the largely urban populations which they served.

Physicians who chose to work in these hospitals were regarded as alienists. Their professional status was low but they began to organise themselves as a specialty and in 1841 founded the Association of Medical Officers of Asylums and Hospitals for the Insane (Bewley 2008). This evolved into the Medico-Psychological Association, later the Royal Medico-Psychological Association but it remained very much an organisation for doctors who worked on the fringes of mainstream medicine. The Association published the *Asylum Journal*, later named the *Journal of Mental Science* which was the forerunner of the *British Journal of Psychiatry*.

The majority of patients admitted to the asylums had developed what would now be regarded as psychotic illnesses or dementia. Conditions such as hysteria, hypochondriasis, neurasthenia and other functional syndromes were regarded as the province of neurologists.

Experience acquired during the First World War resulted in the medical profession developing a broader view of the extent of psychiatric disorders, including recognition of shellshock and the various problems following head injury. Patients were encouraged to seek treatment voluntarily and the British government recommended the establishment of outpatient facilities in general hospitals which were recognised as having great potential for teaching medical students.

10.2 The National Health Service

Even prior to the Great War (1914–19) a series of reforming governments had sought ways to bring comprehensive health care to the whole population of Great Britain and Ireland. The, at the time controversial, National Insurance Act of 1911 paved the way for what was to become the National Health Service (NHS). Prior to the NHS Act of 1946 hospitals in the United Kingdom were variously owned and run by charities, benevolent societies and local authorities. In 1948 many of these infirmaries and hospitals were brought under the new National Health Service funded from central government. This included the mental hospitals.

The Madhouses Act of 1774 required for the first time that all private madhouses and asylums for the insane were licensed by the Royal College of Physicians. Their journey separated from health with the Lunacy Act of 1845 that passed to the Home Office. The Lunacy Commission, then established, ran the asylums until succeeded by the Board of Control for Lunacy and Mental Deficiency following the Mental Deficiency Act of 1913. This board was transferred from the Home Office to the Ministry of Health in 1919 and became part of the NHS in 1946.

10.3 General Hospital Units

A major development in the organisation of mental health services occurred in 1961 when the then Minister of Health, Enoch Powell, announced the government's Hospital Plan whose intention it was to run down and close the large asylums which by then had become the focus of much criticism from within and outside the medical profession. In addition to allegations of neglect and abuse the asylum hospitals were considered to be too large and too far from the centres of population which they served. The Plan proposed that smaller mental health units should be established within district general hospitals. This development brought psychiatry into closer contact with general medicine and facilitated collaboration between psychiatrists and other medical specialists. At about this time there was a great increase in the number of patients admitted to general hospitals following episodes of self-harm, usually with drug overdoses; this was sometimes referred to as an epidemic of attempted suicide. The need for a psychiatric assessment following self-harm underlined the importance of the psychiatrist's presence within general medicine.

Collaborative research studies demonstrated the high prevalence and nature of psychiatric illness in medically ill patients (Mayou and Hawton 1986). Examples of effective working relationships between physicians and psychiatrists began to be reported (Crisp 1968; Macleod and Walton 1969). In retrospect these can be seen as pioneering initiatives. The Society of Psychosomatic Research was established and during the 1970s and 1980s organised a series of successful annual conferences which attracted contributions from several disciplines, notably psychologists physicians and general practitioners. Unfortunately the conferences ceased in the 1990s and their society became defunct. Many of its functions were taken over by the Royal College of Psychiatrists' liaison psychiatry group.

The Journal of Psychosomatic Research had been established in United Kingdom by Pergamon Press. This was edited by a series of British psychiatrists and attracted research papers from all over the world. It continues to publish original research papers and now has joint British and North American editorship.

10.4 Royal College of Psychiatrists

The Royal College of Psychiatrists was founded in 1971. This was the official successor to the Royal Medico-psychological Association and for the first time psychiatry had its own institution to match those of the longer established specialties, notably medicine, surgery and obstetrics and gynaecology. The fledgling Royal College set about raising standards of practice and patient care. It conducted a systematic approval exercise, inspecting training programmes for junior psychiatrists throughout the country. Those that were deemed inadequate were given qualified approval and advice about how the training programme might be improved before the next inspection. The College also held a rigorous membership examination

which trainees had to pass before proceeding to higher training. However the College did little at first to enhance training in liaison psychiatry, as it had come to be known in the United Kingdom. Child psychiatry, psychotherapy, old age psychiatry and forensic psychiatry were given specialty status but liaison psychiatry was ignored and lacked official recognition.

A small number of psychiatrists had started to specialise in liaison psychiatry and the need for effective collaboration between psychiatrists and other medical specialists was clearly apparent (Lloyd 1980). Informal discussions resulted in an agreement to seek support for the establishment of a special interest group within the College. A letter to the *Psychiatric Bulletin*, an official College publication, suggesting a forum for discussion of clinical, research and teaching interests, elicited an enthusiastic response (Mayou et al. 1983). The support of the president of the College of the time, Sir Desmond Pond, was crucial. An informal planning session was held during the College quarterly meeting in Oxford in 1983, followed by a more formal session during the annual general meeting in Edinburgh in 1984 (Lloyd 2001). Sufficient momentum had been generated to make an application to establish what was then referred to as a special interest group and this received official approval, although not without opposition from some senior psychiatrists who did not consider liaison psychiatry to require any special expertise (Aitken et al. 2016).

The name of the new group provoked some controversy. Psychosomatic medicine was considered inappropriate, given its historical association with discredited aetiological theories. Psychological medicine was the term preferred by several members but it had recently been used as the title for a British journal in general psychiatry. The American term, consultation liaison psychiatry, was considered too cumbersome and eventually it was decided to stick with liaison psychiatry, which by then had the advantage of familiarity in Britain.

A survey of College members in 1985 showed that there was far more clinical and research interest in liaison psychiatry than had been appreciated (Mayou and Lloyd 1985). However at that stage there were few specially designated consultant posts. In the United Kingdom, Republic of Ireland, and parts of the British Commonwealth, “consultant” is the title of a senior hospital-based physician or surgeon who has completed all of his or her specialist training and been placed on the specialist register in their chosen specialty. Services had grown haphazardly, usually influenced by the energy of enthusiasts who had persuaded their health district to develop a service, albeit at a rudimentary level. The special interest group organised sessions at College meetings and then the first of its annual conferences at Oxford in 1987. The success of that conference in terms of attendance and academic standard was crucial in consolidating liaison psychiatry as an important specialty and the future success of the group.

If liaison psychiatry was to grow throughout the country it was important to establish training posts so that more junior doctors could acquire relevant experience and proceed to take up consultant appointments as and when they became available. The special interest group drew up proposals for training and after battling against a significant opposition persuaded the College Council to accept them. Training requirements were published and later incorporated into a College publica-

tion (House and Creed 1993; Benjamin et al. 1994). Important contributions were made by child psychiatrists and old-age psychiatrists, groups which had already established close working relationships with other medical specialties. It was recommended that each approved training scheme should contain at least one post in liaison psychiatry at senior house officer or registrar level. This would enable junior trainees to obtain liaison psychiatry experience before sitting the College membership examination. There were also to be training opportunities for higher trainees (senior registrars). Their experience was to include supervised research, audit and teaching medical students and junior hospital doctors. A highly successful residential programme for higher trainees was organised in Manchester by Francis Creed and Elspeth Guthrie from 1992. This programme, which continues to flourish, now in Exeter, attracts trainees from United Kingdom and abroad and has been influential in career development for many current consultants.

10.5 Research

Several of the early members of the group held academic appointments and were keen to establish an evidence base for the specialty. The high prevalence of psychiatric disorders in various groups of medical patients was confirmed by many studies. There was also confirmation of the clinical problems associated with the presentation of psychiatric disorders with physical symptoms, a phenomenon familiar to physicians and general practitioners but which had hitherto been neglected in research and in medical student teaching (Bass 1990). Having established the need for intervention research then moved on to evaluate various methods of treatment. There is now a body of high quality evidence which supports the effectiveness of pharmacological and psychological treatments (Cassidy et al. 2012; Schröder et al. 2012). Counselling has been shown to be effective in reducing alcohol consumption in medical patients with alcohol-related pathology and cognitive behaviour therapy has been successfully evaluated in patients with a range of functional somatic symptoms (Chick et al. 1985; Guthrie 2006).

Most recently the National Institute for Health Research in England has turned its attention to health services research and models of care. The LP-MAESTRO study (2015–2017) is examining models of liaison psychiatry services in England and their effectiveness (House 2015).

10.6 Collaboration

Liaison psychiatry, as the terms implies, involves working with other healthcare professionals and from the outset the group was keen to collaborate with other professional bodies to improve patient care. Links with the Royal College of Physicians of London were thought to be crucially important and these were fostered by two

joint conferences on medically unexplained symptoms and the psychiatric aspects of physical disease. The success of these meetings led to the establishment of a joint working party on the psychological care of medical patients. The report prepared by the working party made recommendations on the provision of a liaison service in each general hospital as well as on the training of medical and other staff in managing psychological problems in medical patients (RCP and RCPsych 1995). A second report with the Royal College of Physicians was published in 2003 and launched at another successful conference on the psychological care of medical patients. Similar reports were published jointly with the Royal College of Surgeons the British Association for Accident and Emergency Medicine and the Royal College of General Practitioners (RCPsych and BEAM 2004; RCPsych and RCGP 2008; RCSENG and RCPsych 1997).

10.7 The Faculty of Liaison Psychiatry and Its Influence

British liaison psychiatry's profile has grown since the special interest group was founded. The College accorded it "Section" status in 1997 and "Faculty" status in 2004, making it similar to the longer established subspecialties. Membership of the faculty now exceeds 4000. This growth has been accompanied by an increasing attendance at the faculty's annual residential conference. There has been a great increase in the number of consultant posts and training opportunities. Butler and Temple (2012) have written instructive accounts of how they developed their own services, describing the obstacles they had to overcome in doing so. Their accounts demonstrate the importance of initiative and energy at a local level.

A continuing obstacle to the development of services is the almost complete separation between the delivery of physical and mental healthcare. Although the patients treated by liaison psychiatrists are the responsibility of acute hospital trusts the liaison psychiatry service is usually managed and staffed by mental health trusts whose major concerns lie elsewhere in the care of patients with psychotic disorders and dementia and whose managerial staff have little experience of working in the general hospital. Several reports have advocated bringing liaison services within the management structure of acute hospital trusts but so far this logical step has been resisted. Liaison psychiatry should be part of the commissioning process which acute trusts have with whatever bodies are purchasing their services.

10.8 The Rise of Evidence Based Medicine

The formation of the National Institute for Clinical Excellence on April 1st 1999 (now the National Institute for Health and Care Excellence) set the way for the creation of a number of clinical guidelines. Whilst a number of guidelines are specific to mental health conditions in general health and primary care settings, most clinical

guidelines across all disease groups carry some reference to the place of psychological care in contributing to effective recovery. This has produced pressure on commissioners charged with commissioning for quality to require services to have access to psychological medicine input. (NICE 2004, 2005, 2006a, b, 2007, 2009a, b, 2010). However, despite the rise of evidence based medicine, there is still a demand in Britain for complementary medicine, including homeopathy, much of which is met in the private sector. Some older immigrants from China and India prefer to consult practitioners who use methods of treatment traditional in their cultures including acupuncture, moxibustion and Ayurvedic techniques. Second and third generations of immigrant families usually prefer Western medicine.

10.9 Recent Policy and Progress

UK Government policy since before the time of the Blair ‘New Labour’ administration (1997) has sought to re-organise mental health services to reflect the move away from hospital-based care in favour of a community-based model (Department of Health 1999). Limits on public spending and historical underinvestment in prevention and primary care mental health meant a decade pre-occupied with providing evidence based community interventions for people with severe and enduring mental illness – the National Service Framework for mental health (1999) (2000–2010). The psychological care of medical patients and specifically the mental health care of people in general hospitals was overlooked and excluded from this framework. The impact was dramatic. The existing liaison psychiatry services and departments of psychological medicine built over years came under extreme pressure; some were reduced to little more than crisis services, others were abolished altogether.

Part of the salvation came from clinical psychology. Leaders in psychology and economics independently persuaded government directly to confront the failure of the National Service Framework to adequately address the disability resulting from untreated depression and anxiety so prevalent in the community. The resulting policy shift in favour of Improving Access to Psychological Medicine (IAPT) brought new resource and focus to the historical unmet need in primary care. New models of psychological therapy service with evidence based interventions, clinical outcome measures and underpinning information systems have transformed the care of people with anxiety and depression in primary care in England, provided people presented with psychological symptoms like worry and misery. Unfortunately these services did not initially provide to people presenting with physical symptoms like ache, fatigue or pain even when the association with depression and anxiety seemed obvious. Responding to this further pilot work was carried out and good data obtained showing that people with physical conditions and associated depression and anxiety benefited and so too people presenting with physical symptoms where the underlying cause is depression or anxiety (Department of Health 2008, 2014).

Nevertheless, despite these innovations and advances in the community, there remained a case to be made for liaison psychiatry or psychological medicine ser-

vices to meet the needs of people in general hospitals, and reciprocally better physical health care for people in psychiatric hospital beds, in particular secure services.

The Royal College of Psychiatrists began to lobby Government strongly for 'parity of esteem' for people with mental illness and learning disability, arguing that people with mental illness and learning disability should not be disadvantaged or denied access to mainstream services in health, education and employment. The College had found an issue, 'No Health Without Mental Health', on which to campaign that enjoyed almost universal support from charities, third sector organisations, patients and carers. This has had the effect of shining a light on the poor experience of people with mental illness and learning disability attending accident and emergency departments, the problem of 'diagnostic overshadowing' and lack of access to mental health practitioners.

This has coincided with a political pressure on the health service to see, treat or admit people attending accident and emergency departments within 4 hours, many of whom have mental health problems, addiction or behavioural and social problems for which no adequate facility, clinical skill or onward pathway existed.

The Rapid Assessment Interface and Discharge Service (RAID) at the City Hospital in Birmingham has been highly influential in changing political and health professional attitudes to the importance of getting mental health care right in general health pathways. This innovation, well supported by commissioners and policy makers and well-resourced and evaluated, helped show that not only did the quality of care improve for people with mental illness and learning disability but so too for those with dementia and related conditions of later life. In fact the greatest economic benefit came from the improved quality of care to the later life group. In addition, policy makers, commissioners and other professional groups were made aware of people who were attending accident and emergency and other general health services more frequently than expected, many of whom had complex health and social care problems with associated anxiety and depression (Parsonage and Fossey 2011).

In 2012 the Faculty of Liaison Psychiatry met in Exeter for its annual residential meeting and took as its focus the need to explain the value proposition of liaison psychiatry and psychological medicine services simply and succinctly for the benefit of policy makers and commissioners.

From a series of workshops simple key messages were produced explaining in lay and professional terms how liaison psychiatry services could benefit people needing urgent and emergency care, and how in addition they might benefit people with long-term conditions and symptoms otherwise unexplained by medical investigation. These messages have been used in short animated films, lay press and policy documents to explain consistently what liaison psychiatry is and what it does.

The Collaborating Centre for Mental Health then published guidance for commissioners of liaison psychiatry services (Joint Commissioning Panel for Mental Health 2013). Later that year a group led by Aitken in the Southwest of England wrote down outline service descriptors in the form of guidance to commissioners setting out the minimum requirements for a core service and a comprehensive ser-

vice drawing heavily on existing model services across the UK (Aitken et al. 2014a, b, c, d).

In 2013 a compelling briefing paper ‘Bridging the Gap’ by the Royal College of Psychiatrists and the Centre for Mental Health in the UK set out the economic case for closer integration between physical and mental health care system (Academy of Medical Royal Colleges 2008; Bailey et al. 2013; Department of Health 2011; Foley 2013). Some £3.5 billion were estimated to be being spent on the wrong care for people with symptoms unexplained by medical conditions and as much as £14 billion the additional costs of failing to address the anxiety and depression complicating long term health conditions.

Supported by the National Clinical Director for Mental Health in England a survey followed of all hospitals in England with an accident and emergency department looking at what existed against the test of ‘adequacy’ based on the description of a core service.

In parallel, driven by the work on parity of esteem, Department of Health policy now included liaison psychiatry and required ‘adequate services’ in all English hospitals, a commitment passed onto NHS England for delivery through the ‘NHS mandate’ (2015). Within a year the Care Quality Commission had developed standards for inspecting the provision of liaison psychiatry services in the emergency and urgent care pathway. Liaison psychiatry services appeared alongside Crisis and Home Treatment as essential services in a new Crisis Care Concordat aimed at improving mental health service support to front line first responder agencies in Police, Ambulance, Fire and Rescue.

The effect on commissioning has been considerable. Around the United Kingdom there is evidence of wholesale change and investment in liaison psychiatry services to support the urgent and emergency care pathways. Some centres, like Oxford University Hospitals, anticipating the economic and quality benefit in planned and elective care, have gone further, directly employing consultant liaison psychiatrists into their general hospitals. The IAPT programme is being rapidly expanded to provide evidence based psychological interventions to people presenting with physical symptoms and depression and anxiety in general health pathways. The second and third annual surveys of liaison psychiatry services to English Hospitals have approached census level and show the growth of liaison psychiatry services in England. Wales, Scotland and Northern Ireland are making similar investments (Barrett et al. 2015) (Fig. 10.1).

The main challenge now in the United Kingdom is to develop and sustain a high quality psychological medicine workforce. Consultant psychiatrists are being offered new training routes into the specialty with the support of a ‘credentialing scheme’ and the current endorsement previously only open to liaison psychiatrists training as general adult psychiatrists is available now to people training in old age psychiatry. Nursing numbers need to double to manage the growth in core services and many more psychologists, occupational therapists and social workers will be needed if these teams are to be genuinely multidisciplinary.

In Oxford University Hospitals, the addition of consultant liaison psychiatrists into general hospital teams is being used to add mental health expertise, coaching

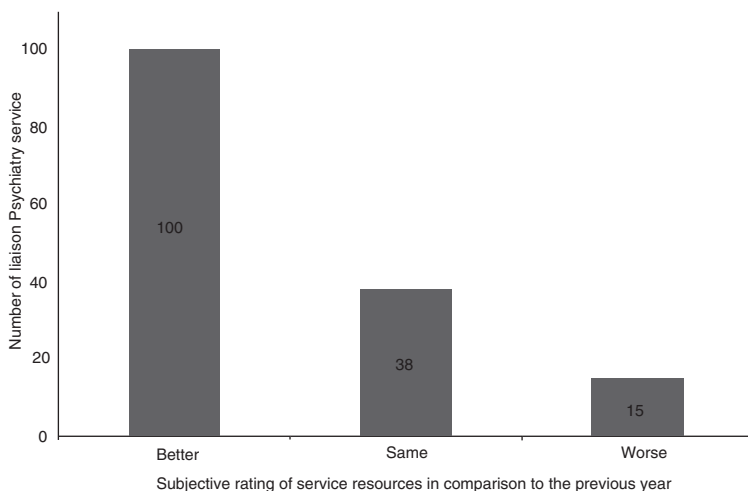


Fig. 10.1 Number of Liaison Psychiatry services which report a better, same or worse resourced service than the service recalled from a year previously. Most (100/153 of services who answered), said their service was better resourced than a year previously, while 15 reported their service was worse resourced and the remaining 38 reported no change. (From *Survey of English Hospitals*)

and support to their multidisciplinary workforce. This seems to offer a future of truly integrated health care with physical and mental health expertise held in all the practitioners across the multidisciplinary team (Butler and Hicks 2013; Sharpe 2014). In policy terms there are about 10 years to go to realise the ambition, but there is now very welcome light at the end of the tunnel (NHS England 2016).

Year	Post-graduate medical training in UK	
1	Foundation doctor (FY1 and FY2), 2 years	
2		
3	Specialty registrar, general practice (GPST), 3 years	Specialty registrar, hospital speciality (SpR), minimum 6 years
4		
5		
6–8	General practitioner, 5 years total time in training	Consultant, minimum 8 years total time in training
9		
Optional	Training is competency based, times shown are a minimum. Training may be extended by obtaining an Academic Clinical Fellowship for research or by dual certification in another speciality.	

Questionnaire Response

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry in your (or your chapter's) Country.

Please return this as an attachment to your email

Country on which you are reporting:

Your Name: Peter Aitken

Institution: Royal College of Psychiatrists

City & Country: London, UK

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?

Yes () No () In some sense (x)

- a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes (x) No ()
- b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes () No (x)

2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?

Yes () No (x)

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?

Yes (x) No ()

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes (x) No ()

- a. If YES, which?

Psychosomatic Medicine () Consultation-Liaison Psychiatry (x)

- b. If YES, the status of such certification is:

i. Independent Medical Specialty ()

ii. Subspecialty of Internal Medicine ()

iii. Subspecialty of Psychiatry (x)

iv. An independent non-medical discipline, as Psychology, Social Work ()

v. Other (Specify):[]

5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes (x) No ()

If YES, please list names of the organizations and the websites if available:

Faculty of Liaison Psychiatry, Royal College of Psychiatrists

<http://www.rcpsych.ac.uk/workinpsychiatry/faculties/liaison.aspx>

6. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:

7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in your country? Yes () No ()
 - a. If YES, where does it occur? Check all that apply:.

 Medical School () Residency () Fellowship ()
8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes () No ()
9. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)
 - a. It is insignificant ()
 - b. Some subgroups (e.g. ethnic, religious) practice it ()
 - c. A significant part of the general population practice it ()
 - d. Is the most prevalent healing method used ()
 - e. It is often used in combination with Western medicine ()
 - f. More widely used methods are as follows (Please list,e.g., spiritual healing, meditation, herbal, etc):
10. Please add any comments to your response here:

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Chapter 11

Psychosomatic Medicine in Germany



**Wolfram Dieter Schüffel, Markus Herrmann, Volker Köllner,
Wolfgang Merkle, Martin Teufel, and Iris Veit**

*The Honorable
Honor always the whole; I can respect only individuals: In the
individual alone do I always behold the whole.*

Friedrich Schiller

11.1 Introduction

During the first meeting of the Work Group on Psychosomatic Research and Practice in Lisbon 09/2016 (www.wprp-program) chaired by A. Barbosa, G. A. Fava and F. Sosci. I was asked about psychosomatic medicine's standing in the Federal

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Republic of Germany. For lack of time I had to keep my answer short. I thought a moment and said: “Psychosomatics has arrived in Germany.”

With this I mean that psychosomatic medicine has established itself as a concept in the general public’s minds as well as in the conscious minds of physicians and their assistants. It has its solid institutions in out-patient and in-patient care, in rehabilitative medicine, and in institutions of vocational/professional, continued, and postgraduate training. In universities it has developed to an independent discipline in education, in-depth training and research.

In other words, psychosomatic medicine extends far beyond what is primarily understood in the Anglo-American literature as largely identical with the term consultation-liaison-service. In the German speaking countries, i.e. in Germany, Austria and Switzerland, psychosomatics is viewed as a holistic approach to human beings. As I describe in the chapter “The History of Psychosomatic Medicine in Europe” the field has developed through the efforts of internists, neurologists and members of other medical fields such as gynecology, dermatology, etc., who in a similar manner as Eric Wittkower (formerly of the Charité Berlin, later University of Montreal) each work as representatives within their disciplines toward a psychosomatic approach beyond psychiatry.

I describe in the historic background chapter of this book in more detail how Wittkower first conveyed his ideas about this approach in London at the Tavistock Institute (Wittkower 1937, 1977; Wittkower and Warnes 1974). There he was – as he tells us – already conducting a group work that was later pursued by E. and M. Balint (Balint et al. 1993; Balint 1957; Balint and Norell 1973). – Wittkower, who was both an internist and a psychoanalytically trained psychotherapist had been forced to flee the Nazis, his name was put on a black list so that he could be arrested immediately should Great Britain become occupied. He spread his views on an integrated medicine, as we would call it today, and these were taken up especially in Canada and transformed to a consultation-liaison-service within psychiatry by, among others such as Zbigniew (Bish) Lipowski, whose advisor he was (Lipowski 1969, 1977a, b). Independent of Wittkower but with a comparable approach, George Engel and his team worked in the USA on the concept of biopsychosocial medicine (Engel 1961, 1962, 1968) which is the North American counterpart to integrated medicine in German-language literature. George Engel, too, had a double identity as well, that is, he was both internist and a psychotherapy minded psychiatrist. Thus, we owe it to North American psychiatry that psychosomatic medicine, after having been banished from Europe, could enjoy further development as I was taught by John Nemiah among others, (Nemiah 1970; Nemiah and Sifneos 1970).

As a writers’ collective the co-authors of this chapter have set ourselves the task of presenting the status and development of psychosomatics in Germany at the beginning of the twenty-first century and more than two generations after World War II and the Holocaust. The overall theme will be broken down into the following topics:

1. Overview and introduction: Wolfram Schüffel
2. Psychosomatics in primary care: Markus Herrmann, Iris Veit

3. Psychosomatic medicine in regional health care: Wolfgang Merkle
4. Transregional rehabilitation and psychosomatics: Volker Köllner
5. Vocational/professional, continued, and postgraduate training: Wolfram Schüffel
6. Psychosomatic medicine at the universities: Martin Teufel

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The authors proceed from the fundamental consensus that health care adhere to both the bio-psychosocial concept and the concept of integrated care. This is officially implemented in the advanced education policy of psychosomatic primary care BÄK(Bundesärztekammer); German Medical Association, Köln 2001; <http://www.Bundesaerztekammer>). The German general practitioners and the German gynecologists and obstetricians have legally bound themselves to consider psychosomatic primary care a fixed component of their advanced education and training. Furthermore, there is increasing consensus that the subject matter of psychosomatic primary care be considered mandatory in medical practice altogether. Training in psychosomatic primary care comprises 80 hours of advanced education in three major areas: 30 hours of group work according to the Balint method or the interactional approach; 30 hours of verbal interaction; 20 hours on the theory of psychosomatic medicine.

Originally, the contents were compiled in the German College of Psychosomatic Medicine (DKPM; Chair: von Uexküll; Meyer) in agreement with the German Balint Society (Balintgesellschaft), and was accepted by the German Medical Association (Bundesärztekammer) in cooperation with the [Kassenärztliche Bundesvereinigung](#) (KBV) (National Association of Statutory Health Insurance Physicians; NASHIP) (Chair: Siegfried Häussler); The results were published in a book at the end of the eighties (Bergmann 1989) and revisited in the context of DKPM/DGPM and in the context of DEGAM (Mader 2016).

11.1.1 The Common Thread of Biography: Four Phenomena, Four Times, Four Manners of Approach, and Seven Realities

In the section History of “Psychosomatic Medicine in Europe”, I describe in detail how we exist within the stream of historical development that moves us to perceive particular selected phenomena; this occurs in relation to the various time frames, to how we approach our environment then retreat within ourselves and vice versa, and to how diverse realities arise as a result. After 80 years, 50 of which as a physician, I believe to have found the following pattern I refer to as motivating phenomena, time periods, approaches, and realities.

Four motivating phenomena I have found in my practice as a psychosomatic physician are (1) primordial experience, (2) experience of self at any given moment, (3) leitmotiv for perception and behavior/action, (4) manifestation of experience; short: “dwelling”. Elsewhere I have referred to these as: primordial experience, at any time, leitmotif, dwelling. These four phenomena and the subsequent contemplations on time within a phenomenological perspective will be the “markers” of this contribution. – The five decades of medical practice have led me to discover that I consistently refer to ...

Four times: The NOW (here); the past, the present, the future. – The NOW is not identical with the present. The NOW takes place in the HERE, the immediate environment in which the other three times flow together and are always decisively determined by my earliest biographical experiences going back to the earliest intra-uterine impressions (Janus 2011, 2012). Those are times in which I was moving but not yet breathing. Most certainly did I as an intrauterine being hear my mother’s voice. Even earlier I took part in her affective experiences, – joy, sadness, worry, expectation, in that her blood flowed through me.

Oxygen was provided by the maternal organism. I began to breath perinatally. At that time my lungs expanded, there was a differentiation between the large and the small circulation (Schüffel 2013). It was and is the most decisive psychosomatic experience of my life. It is THE primordial psychosomatic experience of each and every human. Woven within this experience are past, present and future. Even the time frame of a future II (Blankenburg 2007) belongs to this. With the delivery, the separation from the maternal organism, I grow into a world that increasingly demands independence i.e. autonomy. In comparison to other mammals, humans succeed in this only after some delay (Portmann 1969). In addition, the first year of life is marked by the ability to breathe and drink simultaneously. Should I attempt the same later, I would suffer aspiration pneumonia or even suffocation.

Psychosomatics as a science is based equally on the knowledge of prenatal and postnatal developments, equally on developmental-psychological insights and the knowledge of biologically described epigenetics (McEwen 2017). More and more differentiated powers of influence come with age. To perceive them we require

high communicative-interactive skills. They force us to take responsibility for our feelings (deMause 1974). I will return to this in the following section.

Four manners of approach: In analogy to the four motivating phenomena and the four times I see here an occurrence I can describe in four ways:

- I develop from the dyad into a group/team/collective/equip (as the French say).
- In order to pursue this development, I formulate a question as a double-how: How do I gain entry into the group's interior, that is, develop myself outwardly; how do I develop my own self, that is, inwardly?
- There is neither an "embodiment" nor a "mental representation" nor "mentalizing"; instead there is "the whole" that corresponds to the introductory quote from Schiller. For this we have the expressions in the German language, namely, Leib, Leibgeschehen (body/nature and bodily experience/nurture).
- Whenever I lead the conversation, I try not to ask "why?" Instead, I ask "how" I come within the NOW (here) to the next step.

In the sense of the double "how" and across time, the four motivational phenomena take effect under the influence of the four times and the four manners of approach. They produce ...

Seven "Realities"/"Horizons" These are described in more detail in the chapter "History of Psychosomatic Medicine in Europe" as well as under the section of "Socialization" of this book.

Here I shall briefly cite them: Proscenium (the emerging reality), stage, context, background, rhythm, democracy, culture. These seven realities took form in retrospect over 20 years of daily occupation with psychosomatics. With the clinical sketch of a Balint group session I would like to illustrate next how we come to new realities.

Wagners "Rheingold" is like Tolkiens "Lord of the Rings"

At the core of primary psychosomatic care is an interactive group session (M. Balint, 57, 73; E. Balint, 93). The feedback to psychosomatic primary care since its nationwide introduction in Germany in 1988 shows that the Balint group has been perceived as a call to regularly advance one's knowledge and training in the affective area. In all regions of Germany, as well as in Austria and Switzerland (Luban-Plozza et al. 1996; Petzold 2008a, b), it is possible to participate in Balint groups that generally meet every 4 weeks. Participation might extend over years. In the four groups I have led in Marburg and Kassel, the average length of participation is about 10 years, in the particular case presented here it was even over a period 28 and 29 years. Such groups likewise become venues of yearlong voluntary, self-steered quality control in what is distinctly referred to in German as "Beziehungsmedizin" (relationship-based medicine). – A clinical (in a broad sense) example that could apply to practically all regions of Germany I will describe from my own work experience.

In 1977 i.e. four decades ago ten colleagues met with me in Kassel to initiate a Balint group. Not quite 10 years later two general practitioners from Kassel, each

of whom had recently opened a private practice, joined and as of autumn 2016 left the still existing Balint group. Out of the original group a so-called “slow-open-group” had grown that in the meantime carried on a 40-year tradition. The first members had withdrawn but had developed a group culture with their successors.

Two months after the two retired colleagues had left, that is, in November 2016 and one day before All Souls Sunday (!), we were sitting again in our newly reduced circle. We were talking about changes, loss of continuity, loss of coherence, but also about the principle of salutogenesis. Sad yet angered, a young colleague, who just 3 months before had completed her exams as a specialist in general practice, said in the direction of the two empty seats once occupied by these two retired family doctors: “They could just as well have stayed on. Instead, they drop out from one moment to the next.” I pointed out: “After all, for 29 years they sought out our group every four weeks. We could instead try to imagine what you miss in the face of those empty chairs.” – The ENT physician who belonged to the group mentioned how she could empathize with the general practitioner. As an ENT physician she had suddenly found herself alone without any guidance in her empty ENT practice. No one was there to work her in. The anesthetist sitting next to her was approaching retirement age and remained “cool”. The stream of life flows along. He visited his 6-month-old granddaughter each week. He had simply phased down his working time to another 12 hours per week (early retirement). – Another member of the group, a neurologist, associated visits with her grandchildren with “vacation time”: She had missed the last meeting and had driven to Dresden the capital of Saxony with her husband to visit their adult son. He was studying medicine there. They had invited him to see Richard Wagner’s “Rheingold” in the Semper Opera house. They themselves, the parents, had always been skeptical of Wagner operas. It would be a gamble to see how their son would react to the Rheingold opera. As they were leaving the opera house after the performance they dared to ask, “How did you like Wagner’s ‘Rheingold’” – To their surprise he answered: “Not bad. Like Tolkien’s ‘Lord of the Rings’.”

Everyone in the group laughed. It was a deep sigh of relief. There it was suddenly, the continuity, the coherence. THAT is the goal of this year-long, continuous self-experience that sees the medical profession as a fixed component of individual life. The young man, a medical student and future colleague, addressed us. The anesthetist said he was entering early retirement simply in order to gradually grow into the grandparent phase. The ENT physician told us how her receptionist had helped her so well to find her place in the empty, cold-looking practice. The general practitioner, who was so sad and angry at the same time, came up with her own special case. She had joined a group practice of two experienced doctors in their late fifties. One of them felt hindered; the weekly conference was cancelled. She sorely missed this conference. Now she was able to talk about it.

This meeting is a fitting occasion for me to elaborate on how productively the movement initiated by Balint has expanded across Europe, even worldwide. In this context I shall convey a few thoughts that have been collected and compiled into systematic form (Bergmann 1989, 2010).

1. The group is a place where the individual can move and breath in a liberated manner. Liberated means finding oneself within a group and playing out one's creative potential i.e. "leiblich", in a "leib" way.
2. The group is a place of trust: The physician and subsequently the patient learn to perceive their sphere as a group. The physician learns, senses, feels how the own sphere arises in the group. The patient picks up this experience to a great extent nonverbally, which the physician conveys verbally (Critical Incidence Report System; CIRS): the contingency ("relativity") of a healthy state.
3. The group is a place of autonomy ("island of sensibility"). A place to grow in independence (Continuous Improvement Process; CIP) – to gain autonomy between "flu-like" infections and a "final breath".
4. The group is a place of sensing manifestation (dwelling), a quest for meaning in a bio-psycho-social sense, but also in the sense of an integrated medicine.

In the last five decades in Germany, psychosomatic medicine has played a significant role in increasing awareness for the psychosocial factors of health and especially of health care for the general population. This has happened essentially where the roots are: In the individual person's growing awareness, that is, in the education sector, hand in hand with a continuous development of advanced and in-depth education and training. Corresponding institutions have been founded to foster holistic care: German College of Psychosomatic Medicine (Deutsches Kollegium für Psychosomatische Medizin; DKPM); German Society of Psychosomatic Medicine and Medical Psychotherapy (Deutsche Gesellschaft für Psychosomatische Medizin und Ärztliche Psychotherapie DGPM); German Balint Society (Deutsche Balint-Gesellschaft); German Society of General Medicine (Deutsche Gesellschaft für Allgemeinmedizin DEGAM), German Society of Psychosomatic Gynecology and Obstetrics (Deutsche Gesellschaft für Psychosomatische Gynäkologie und Geburtshilfe), among others. There is a growing trend toward the personal project "health and well-being", the individual's striving to view health and well-being as a basic right, above and beyond any occupational boundaries (Schüffel 2012; Fava 2016).

For their part, the present six authors consider themselves a self-experience group that is tracing a common conjoined (shared) case history, the development of psychosomatic medicine in Germany. Each author is contributing personal horizons to define holistic medicine. This applies to rehabilitative medicine, which focuses on functional capacity. This applies to university medicine, where the causal orientation predominates. It can be seen in its emphasis on the International Classification of Functioning (ICF) in rehabilitative practice and its emphasis on the International Classification of Diseases (ICD) in the work within medical faculties. – In contrast to this, general medicine stresses conjoined (shared) anamnesis and regional health care stresses the local provision of health care, within the patient's environment. This manner of practice is guided by the question of how the physician and the patient will succeed together not only in comprehending illness as a biographic event, but also in creating spaces in which the individual can convalesce.

11.2 Psychosomatics in Primary Care in Germany

Markus Herrmann and Iris Veit

11.2.1 *A Short Historical Account*

In order to handle the increasing psychosomatic demands on primary care, psychosomatic primary care was introduced into the health care system in West Germany in 1988. The psychosomatic primary care became an article in the billing system in private practices, the Association of Statutory Health Insurance Physicians, and the statutory health insurances. Introducing this term was meant not only to clarify the formal aspects of billing, but also to elicit a discussion about the content of psychosomatic primary care and what it can be (Bergmann 1989). It was expressly committed to a bio-psycho-social understanding of illness and up to today the specialized education covers 50 hours of theory and training in verbal intervention techniques and 30 hours of Balint group work.

At first the stated goal of psychosomatic primary care was to compile as soon as possible a differential diagnosis of complex disorders in their concurring somatic, psychological (affective-cognitive) and psychosocial aspects. However, an active, consistent and trust-building frame for the doctor-patient relationship was considered a vital basis to this (Tress et al. 1996) and the participation in a Balint group became a component of the postgraduate education. The transition from a paternalistic, prescriptive, authoritarian style in medical treatment to a counseling, advisory and accompanying interaction was initiated to strengthen the patient's self-responsibility and self-healing potential. Even at that time, the maladaptive structure of the doctor-patient relationship was analyzed as a diagnostic and therapeutic interference, i.e. a most helpful (!) tool.

In 1994 the prerequisites for billing the numbered psychosomatic primary care items were defined. Besides a minimum 3 years of independent medical practice, a course in psychosomatic primary care was required that covers the following blocks within a total of 80 hours:

1. Seminars on theories of the doctor-patient relationship, on psychosomatic pathology in disorder and family dynamics, on the interaction in groups, on coping with disease and differential indication of psychotherapeutic methods (20 hours).
2. Reflection on the doctor-patient-relationship in a continuous Balint-Group or interactional method (30 hours).
3. Instruction and practice in verbal intervention techniques (30 hours).

The German Medical Assembly passed a resolution in 1995 to integrate psychosomatic primary care in the postgraduate training and to amend the postgraduate training ordinance accordingly.

In 1997 the German Medical Association presented a first position paper and model curriculum to improve structural quality (German Medical Association [BÄK/Bundesärztekammer], <http://www.bundesarztekammer.de>).

The 80-hour course in psychosomatic primary care is a fixed component in post-graduate training for general practice and for gynecology and obstetrics. Currently, the German Medical Association specifies the psychosomatic primary care and specialty-related psychotherapy offered by primarily somatic physicians and the evidence-based psychotherapy conducted by psychosomatic and psychiatric specialists as integral parts of health care.

So far, only a few evaluative studies exist, and their significance is very limited due to methodological weaknesses such as one-occasion assessments with no follow-up or lack of access to administrative data because of data protection regulations. A positive effect of primary care on how symptoms develop can be found, however, in several studies. Even relatively simple measures like regular check-ups and examination of somatoform physical complaints showed statistically significant effects. It was also possible to reduce costs by approximately one third. Furthermore, results have been presented that show improvements in understanding illness and in satisfaction with treatment (Bundesärztekammer/BÄK [German Medical Association]).

11.2.2 Phenomenological and Hermeneutic comprehension of General Practice Cases

During the past two decades psychosocial medicine has become more differentiated and specialized, which has led to tailored health care offers for a series of disorders. According to more recent guidelines, some of the tasks in primary care that were once fulfilled exclusively by general practitioners should be performed more often according to more recent guidelines in interdisciplinary and multimodal settings, although specialists are not distributed evenly over wide areas (Herrmann 2016; Herrmann and Veit 2016).

Even if the primary care model has not yet been established nationwide, patients doctor function, health information, integrating and coordinating functions they are responsible for the broad provision of primary care.

For a single case, the general practitioner must weigh various treatment options against each other without knowing all of their side-effects and consequences. To a physician, professional care also means administering treatment with some uncertainty, for theoretical knowledge of nosology can never be applied one-to-one to the individual case. This is especially true for the general still bring their health problems and needs first to their general practitioners. In their filter and referral function (as gate-keeper), family-practitioner (Donner-Banzhoff 2008). The differentiation between special medical fields has generated specificities that cannot be imitated in the general practice (Barth et al. 2014). On the one hand, general practitioners approach a case hermeneutically and place the illness's significance somewhere within a bio-psycho-social context; on the other hand, the general practitioner stands at the beginning of a medical treatment chain and therefore has a much broader choice of options than the preselected specialist.

Psychosomatics may perhaps be understood as the attempt to overcome the deeply rooted occidental notion of separating body and mind. Yet psychosomatics implies perpetuating the dualistic way of thinking whenever it is guided by nosology and specific disorders. Exactly this comprehension – grasping the relationship between different phenomena in the patient – uncovers the mood, situation, attitude, sequence of movements, and contacts with other people in which the suffering patient decides to seek the general practitioner just at this time and just in this way. This will be illustrated below with a case study.

Beyond the body-mind duality and in the sense of New Phenomenology from the philosopher Herman Schmitz, (we can assume there are involuntary life experiences, or unschooled perceptions each human being feels in his/her own body). Medicine is concerned with the physical body, whereas a holistic medicine must address the psychophysical body in order to grasp the significance of situations (Kamps 2016). These ideas are compatible with those of Donn Welton, who in turn refers to Husserl to describe environment as an interaction between context and a universal background of the human potential for bodily experience, each being intrinsic to interpreting the world (Welton 2003).

More recent discoveries in neurobiology, infant observations and research on bonding behavior have shifted human relationships to the center of human development. Neuronal plasticity explains how the brain guides the course of interactions with others and is modified in the process. Infant research has shown that body and mind develop from the very start in communicative exchange with parents (Stern 1985). The attachment research has shown that by the end of the first year of life a pattern of attachment has already developed that determines how future relationships to other people are formed (Grossmann and Grossmann 2009). These more recent insights allow us to abandon the dualistic disposition that sees a division between body and mind and between a subject and its environment.

It is precisely this increase in differentiation and specialization within somatic and even psychosomatic-psychiatric medicine, guided by categories of disorders and nosology, that demands coordination and integration of various forms of treatment. Not only this, it also underlines the need for general practitioners to focus on case-related personal relationships, phenomenology and hermeneutics (Veit 2010, 2014).

11.2.3 Position Paper from the German College of General Practitioners and Family Medicine (DEGAM) ***(<http://www.degam.de/files/Inhalte/Degam>)***

The position paper on the topic “Psychosomatic Primary Care in general practice – Goals, Responsibilities, Methods” describes a general practitioner’s core domain of competency and includes psychosomatic and psychosocial primary care in this special field.

The following 14 fundamental positions were defined:

1. Psychosomatic primary care in the general practice offers patients a safe space to pause in situations of stress or insecurity due to illness or other exceptional life events. It is more than psychosomatic or psychiatric pathology; it is an approach to general practice that is not supplementary, but should be a component of general practice care. It is a part of the general practitioner's identity.
2. It is based on the trusting, long-term relationship between doctor and patient for diagnosis and therapy of all the patient's complaints, and is guided by the system of family, neighborhood, community and culture.
3. It evaluates a patients' complaints in the context of their biography and current relationships in the family and the extended social and cultural environment, and offer patients support in a holistic perception of their complaints, themselves and their relationships (Bahrs 2011a, b).
4. It strengthens their salutogenic abilities (self-efficacy) (Petzold 2013). The low-threshold access to the general practitioner enables members of all social levels to be treated in social-compensatory and competence-building skills (Starfield et al. 2005).
5. The effective features in the psychosomatic primary care are:
 - (a) the doctor-patient relationship as a healing relationship and possible corrective experience of relationships (Roter et al. 1997; Del Canale et al. 2012; Stewart 1995; Thorne et al. 2004; Beckman et al. 1994)
 - (b) the use of patients' information by physicians as experts,
 - (c) the joint effort of defining problems and formulating individual health goals (Bahrs 2011a, b), and the inclusion of patients in deciding the diagnostics and therapy schedule (Schneider et al. 2006; Loh et al. 2007a, b).
 - (d) the increase in the patients' self-efficacy,
 - (e) the experience of empathy and acceptance of suffering, encouragement and care (Beck et al. 2002)
6. It therefore requires the physician's competence in forming relationships and reflecting on dysfunctional patterns in the doctor-patient relationship, (Veit 2010, 2014; Epstein et al. 2007; Hausteiner-Wiehle et al. 1991; Little et al. 2004; Salmon et al. 2005), in order to create a new situation together.
7. For this competence in relationship-building, the prerequisites are self-observation and self-reflection. Self-observation and self-reflection begin with the ability to open oneself up to the situation with the patient. The general practitioners should therefore be attentive to how they deal with themselves.
8. This competence demands the physicians provide for their own well-being. Further areas of competency are self-management and structuring one's own working time.

The remaining six positions describe the verbal and nonverbal interventions, the necessary overall conditions and the cooperation within the team.

Post-graduate and continued educational courses offered by the Institute for Continuing Education in General Practice (Institut für Hausärztliche Fortbildung, IHF) cater especially to these positions. Blended learning is also being offered more frequently in this area.

11.2.4 Understanding Dysfunctional Patterns and Adjusting to Them

Recognizing patterns in patients' relationships and adjusting to them is the central competence in psychosomatic primary care to be conveyed. Why this is so lies in the patient's relationship to the physician. Patients repeat patterns they internalized early on in their development, patterns characterized by whether their early attachment experiences were good enough or not. They include how the patients see themselves and other persons. The physicians, too, will react in different ways to the patterns they have direct access to. In this way, maladaptive relationship patterns could arise between doctor and patient that are comparable to other one-to-one relationships and can be detrimental to both (Position 6). Self-observation allows the physician to think about his/her own manner of forming the relationship (position 7). Relationship-building utilizes transference and countertransference, which in other contexts are referred to as resonance, enactment or common situation. In this way, dysfunctional patterns can be avoided or dissolved and new, salutogenic patterns can unfold.

Here is an example of a patient in an anxious mode:

A 26-year old civil administrator repeatedly returns to his family doctor to request a sick-leave certificate because of malaise, heart palpitations, fear of humiliation, and erythrophobia. The general practitioner is irritated with the frequent spontaneous consultations and sick-leave requests. However, because she dreads a confrontation with him and senses his sensitivity, she does not want to refuse this "weak" patient and at first grants him a few days off. During a vaccine consultation with his wife, the wife mentions the couple's upcoming divorce. At this point the physician recalls having attended intensively to the patient's family 20 years earlier after his mother's sudden death by traffic accident. The patient was 6 years old when he lost his mother. The loss of another important attachment figure is threatening him again. The physician can understand that a feeling of existential insecurity has been reactivated in the patient and he has thus chosen to avoid any and every source of stress in such situations. The physician begins to reflect on the present reciprocal avoidance behavior, which she now interprets as a component in the dynamics of anxiety. This indicates the significance of self-observation (Position 7). She verbalizes her anxiety and her avoidance behavior to the patient, using her feelings in countertransference and the insights gained in the conjoined (shared) case history (Position 5). She succeeds at making the avoidance behavior transparent and through salutogenic communication, she is able to encourage the patient to face his social anxieties (Position 4). Rather than sick-leave certificates, she gives the patient only verifications for his visits to a doctor's office. In this way the anxiety mode with slight social phobia can be modified before it develops to massive functional restrictions and chronification. These interventions help not only the patient but also the physician's well-being as she can prevent her own future aggravation (Position 8).

With reference to the DEGAM positions:

a secure space is sought and found,
basic trust is solicited and
questioned as an enactment;
the physician points out that her own basic trust has enabled her to trust the patient and
guarantees reliability precisely because of the conjoined (shared) case history;
external dysfunctional behavior is made eufunctional inwardly;
the physician observes herself and
is better able to set her own limits;
imbalance in the distribution of power is discussed openly;
by verbalizing it, the suffering can be acknowledged;
treatment methods: This is a matter of perceiving how the process takes shape and
comprises the parameters for BOTH.

11.2.5 Specialty-Related Psychotherapy in General Practice

Situated somewhere between psychosomatic primary care and specialization in psychotherapy, the former supplementary qualification in psychotherapy was modified in 2007 to the “specialty-related psychotherapy” in the model post-graduate ordinance for medical doctors (Linden et al. 2008). In the preceding years, psychosocial medicine had been given a push toward professionalization especially in secondary and tertiary care. This was made possible by the psychotherapist law, by establishing psychosomatic medicine and psychotherapy, and by extending psychiatry and child and adolescent psychiatry to include psychotherapy. Upon the fact that a large portion of patients with psychological complaints are being (or want to be) treated exclusively by general practitioners, one definite advantage lies in the low-threshold access to psychotherapy offered in the family doctor’s practice, imbedded in the common principles of general-practitioner methods. These integrate the other advantages of the family doctor practice, like the physical examination, house visits, the conjoined (shared) case history, the simultaneous attention to the patient’s family or closest ties, psychosocial interventions, and the place the family doctor’s practice holds in the neighborhood and community or borough.

In contrast to the often narrow frame of specialized psychotherapy, especially the classic, analytic setting that demands abstinence and neutrality, interconnectedness and involvement provide the context in which the general practitioner builds relationships. Prescriptions, physical examinations, house visits, simultaneous treatment of other family members or close attachments, attestations for granting social benefits, but also private contact and personal communications broaden the context. Because of the steady flow of potential involvements, it is specifically the intersubjective, hermeneutic actions that play a significant role. The therapist is no longer an independent observer who deciphers the mental material and judges its meaning like a referee, judges what in a patient’s behavior is distortive transference and what is pertinent to reality. From an intersubjective perspective, we can focus on the

“encounter” with the family doctor and its range of interaction. The characteristic features of the family doctor setting are:

the low-threshold access,
 the physical examination,
 the concurrent treatment of those in the patient’s environment,
 the multiple roles offered by the family doctor (advisor, companion, examiner, consoler, navigator, healer, motivator and moderator),
 and the presence of a team to administer treatments. (Herrmann and Veit 2016)

We can perceive patterns of relationships and potential involvements in a variety of scenes and reflect on them as enactments. Cautious confrontation can enable us to accept responsibility and experience the healing effect of a doctor-patient relationship. Specialty-related psychotherapy, oriented toward relationships, is thus gaining prominence in general practice and is capable of integrating an array of physicians’ medical roles and patients’ realms of experience.

11.3 Psychosomatic Medicine in Regional Health Care

Wolfgang Merkle

In April 1996 when I first began my activity of preliminary talks with prospective staff and patients. – no one could have predicted how fortunate the period of development would be for inpatient and partially outpatient care.

Today we are celebrating the 21th anniversary of psychosomatic medicine at the Hospital zum Heiligen Geist. We have published a festschrift (Merkle 2016) in which I point out that in 1996: “Every amount of optimism and confidence was needed. Of course the developments and intermeshing at the time met with resistance; however, the facts that integrated, intensive, multimodal treatment had the potential to prevent diseases from becoming chronic and to thus reduce total costs and avoid greater suffering were too convincing.”

As director of the psychosomatic clinic I have always paid attention to which persons work in our team in order to guarantee a nurturing, consistent attitude and respect toward patients who are often embarrassed about their ailments.

In the course of the past 20 years, the developments have resulted in the seven realities/horizons mentioned in the first section of this chapter (cf. also Socialization):

1. Proscenium, that is, the preclinical events or so-called emerging reality. Today we meet citizens who want to see that psychosomatics is offered in the city of Frankfurt. They want to check whether and to what extent psychosomatic medicine has been implemented. The critical question in the city parliament is: “What are the types and range of diagnostics and therapy of psychosomatic illnesses in the Frankfurt hospitals?” The Hospital zum Heiligen Geist, founded 900 years ago at a site passed by Franconian settlers, pilgrims and also the sick and leprous,

lends itself to the task of closing this gap. A booster club has been organized whose motto is: “Even today a psychological illness is something that people don’t talk about. We have made it our business to change this” (Wetzel, Scholz, *op. cit.*, p. 34). – Physicians, nurses and orderlies can only agree.

2. The stage, that is, the physical complaints, symptoms, illnesses and handicaps: Over the past decades this hospital had gradually become an emergency ward for the city center. Patients with heart attacks, cardiac dysrhythmia, acute bleeding, accident injuries, often in connection to alcoholism had been on the increase, readmission had virtually become the rule. One knew the patients’ faces, but not their biographies, and these remained unknown. They didn’t talk about their backgrounds. They felt ashamed before that medical environment although the staff invested their full energy in the patients, who, whether they had truly or seemingly fallen ill through no fault of their own, subjectively always did find themselves at fault. One of the current three senior physicians says, “Accepting inpatient hospital care means entering a world that allows for what is embarrassing and frowned upon outside: exposing oneself within a protected zone with all one’s needs, injuries, conflicts – ‘here you can’t get lost’” (Kernhoff, *op. cit.*, p. 39).

A ward physician says it in these words: “I discovered that the ill can be treated when their present life and behavior are seen in the context of their biography. To achieve this you need trust, courage and patience on both sides” (Euler, *op. cit.*, p. 32).

A concept for treatment emerged that defines itself by conflict-centered group work and intensive individual therapy, which draws the body into psychotherapy through creative therapeutic techniques. Transition zones were formed within the clinic. These ranged from fully inpatient treatment through outpatient day clinics and on to a gradual outpatient treatment schedule, whether through the general practitioner or combined GP-specialist care. – The medical ...

3. Context, that is, the cognitive surroundings at first remained the same. Only gradually were the existent concepts broadened by corresponding continued education and an increase in multimodal group work. The latter helped to carefully dismantle the barriers between intra- and extramural medicine. Post-graduate and continued education proved to be more and more essential, not only in Frankfurt but also elsewhere (P. Frevert, *op. cit.*, p. 30). From the hospital ward with its 30 beds and from the day clinic with its treatment capacity of 50, it became possible to keep the threshold low for a transfer to specialist fields of medical treatment like pain therapy, psycho-oncology, traumatology, and so on. – Ever more strongly the residential ...
4. Background, the affective activity with all its personal, familial, work-related, biographical references became tangible. These are described by the physicians in private practice under the title “Outward Views”. They highlight the personal account in the discharge reports, which differ markedly from the statements out of other facilities. The difference was noticed especially at the opening of the day clinic: “Those of us from the outpatient environment found the opening of the

day clinic literally groundbreaking” (Chr. Linkert, op. cit., p.23). – Core conflict and problem situations were at first tackled in the inpatient sector in conflict-centered group work. The close contact to private practitioners made it possible to include their conjoined case histories. This led to regular communication between the hospital and the outpatient care (G. Volck, op. cit., p. 26). – “A string of doctors and therapists” begins to form. The surgeon who views psychosomatics as a holistic method will feel a part of it, too (B. Hontschik, op. cit., p. 27; Hontschik 1987).

5. Rhythm, that is, the exchange, the with-and-against-each-other between the generations sets in, characterized by regular meetings of the medical health care staff. Here different generations are involved who contribute their tradition of urban medicine. They establish case seminars, seminars to discuss scientific topics, informational events for advancing health education, etc. What is essential is that representatives of the health care system take part in these events, that is, professionals as well as medical laypersons. Probably the most important single element of supportive and respecting work in a hospital takes form in primary nursing. Here is where the actual patient-nurse-physician triad is created as the foundation for ...
6. Democracy, particularly gender and race equality, and avoidance of class categories in the health care system. Nursing is given a value that is different from the medical value, but stands at par with it. In the festschrift this is illustrated by the photographic double portrait “Chief of Medicine in Anesthesiology and Nursing Director” (G. Schopf, op. cit., p. 46). What is more, the woman is depicted here as an equal counterpart to the man. True democracy is inconceivable without equality between the genders. – Vital to this type work organization are economic considerations, or, introducing new structural measures. This becomes apparent in that, as opposed to earlier planning, the treatment capacities in day clinics clearly outweigh those in the full-time inpatient hospital, that is, at a ratio of 50:30. Both chiefs of internal medicine, C. Genth (the senior) and R. Duchmann (the current head of department), see the once traditionally educated doctors increasingly fulfill a “steering function” through a differentially expanding system of medical care. – That, however, demands a new ...
7. Culture of medical care that pursues the (ideal) pole of self-dissolution (as formulated by the internist Thure von Uexküll).

The editor (H. Leigh) wants me (W. Schüffel) “to add a sentence explaining this rather *fearful* concept.” – Thure von Uexküll, internist and one of the leading psychosomatic physicians in Germany claimed that PM should be delivered by everyone. In that case no PM as specialty would be needed. Of course, he was aware that this will never ever happen. Thus, we needn’t be “*fearful*.” – The surgeon joins at this point, who now assumes a shouldering function. The surgeon sees the “variant” of that school of medicine which refers to itself as holistic, or more precisely, “integrated medicine”. It requires “specific treatment options” (B. Hontschik, op. cit., p. 27).

The above mentioned “string of doctors and therapists” is located in the middle of the city of Frankfurt, which itself is a metropolis in the midst of Germany. It is the environment of Frankfurt’s city center, the banks of the Main River, the so-called Fressgasse (“Food Alley”), the Zeil as the main shopping street in Frankfurt, the Paulskirche (Church of St. Paul) as a symbol of the democratic movement in Germany, the cathedral where emperors of the Holy Roman Empire of the German Nation were crowned, etc. In turn, the three senior physicians fittingly summarize the resulting treatment prospects. “Here you can’t get lost” (K. Kernhoff, p. 39).

This direction in medicine inevitably involves continued and postgraduate training that demands both deepening and broadening the participants’ self-conception. This also requires building a multifaceted regional and transregional system of continued education on the basis of psychosomatic primary care (BÄK/Bundesärztekammer) as it takes place in the Akademie für ärztliche Fort- und Weiterbildung der Hessischen Landesärztekammer Bad Nauheim (Academy of advanced medical education for the Hessian State Chamber of Physicians, Bad Nauheim). – What is expected of the managerial staff, primarily the chief of medicine of the Hospital zum Heiligen Geist, is participation in the self-administrative bodies of the regional State Chamber of Physicians and cooperation with the universities of the Hessian state (Marburg, Giessen, Frankfurt).

What is important and must be stressed here is the fact that this form of psychosomatics is also structurally and concretely embedded in the daily functioning of a general hospital and no longer takes place in a large, specialized hospital situated in the countryside, far removed from the general population of 6 Mio in the State of Hesse.

In this way, within less than 20 years the capacity for psychosomatic hospital treatment has grown from the original 100 to 1400 beds throughout Hesse in 2016 (with a population of 6 Mi.). The effects and influences that this could have on the other somatic disciplines is not yet foreseeable. If we assume that over 25% of all medical cases are psychosomatic disorders (Henningesen et al. 2007), the present specialized education and training of new physicians with its few weeks out of their 6-year education is minimal. The psychosomatic aspects of their daily work they will therefore have to learn in their encounters in counseling and liaison work with their colleagues of psychosomatics, and through their continued and postgraduate training (Zipfel et al. 2016).

Considering that in the meantime the capacity in German hospitals for acute treatment in psychosomatic medicine has grown to over 10,000 cases (in 1990 it was still about 2000) and that these are financed by the public health insurance, it is conceivable that a new approach has been found to halt the threatening loss of the doctor-patient relationship as a healing factor in medicine and the increasing specialization with its tendency to divide the patient into high-tech compatible parts. Curiously enough this has led to the danger that the soul be handed over to a specialist (of psychosomatic medicine) and removed from the standard medical care. This dehumanization in medical practice can only be stopped if psychosomatic specialists carry their knowledge of and their experience with patients back to the “somatic” specialists and reactivate their interest and enthusiasm for the doctor-patient relationship in medical treatment.

Why exactly this development has been possible in Germany is not easy to answer:

One reason could certainly be that after the war, psychosomatics was a new field stemming from internal medicine and thus was not abused by the National Socialists in the same way as psychiatry had been. Furthermore, many of the psychotherapeutic-psychoanalytical physicians, including Freud, had to emigrate during the Third Reich, were banned from Germany, or were persecuted and killed. Therefore, after World War II, psychiatry was at first without psychotherapists. Altogether, psychiatry after 1945 was strongly oriented to somatic-biological factors.

Another reason could lie at a deeper level: Out of the broad social movement of '60s in Germany grew a profound controversy about the silence over the enormous crimes and atrocities committed by the parent generation; this came after the '50s, a period of recovery, rebuilding, economic upswing, suppression and forgetting.

This allowed weakness, illness, regression and psychological illness to be even more highly acknowledged precisely in Germany than in other nations that did not have to endure the same development.

The future:

A great crux of psychosomatic treatment lies in chronification and iatrogenic damage to psychosomatic patients within the modern western medical system. We can already (after only 20 years of activity in Frankfurt) observe that the span of time until patients with primarily somatoform complaints are sent to us from somatic colleagues is shorter than it used to be. This point has not yet been scientifically verified but is a definite impression. When patients with somatoform complaints are transferred sooner from the "pseudo-treatments" of somatic medicine to the specific treatment of psychosomatic colleagues, their abnormal postures and adverse developments are easier to explain, iatrogenic damage (caused by overemphasizing unnecessary diagnoses and over-treating incidental organic findings) has not yet become chronic, and changes in a patient's conflict-related or processing behavior are more feasible.

11.4 Psychosomatic Rehabilitation

Volker Köllner

Rehabilitation represents, alongside out-patient care and hospital treatment, the third pillar in the German healthcare system. The goal is to maintain patients' activity and participation in their work as well as in everyday life in society. In this chapter, the development and significance of psychosomatic rehabilitation in Germany will be described, as will its difference to hospital treatment, its position in the overall treatment plan, and the foundations of social-medical assessment within rehabilitation. On an international scale Germany has a highly extensive system of psychosomatic rehabilitation; nevertheless, this resource is often included in the treatment process when it is too late to prevent chronification, and there are coordination problems with follow-up out-patient psychotherapy.

11.4.1 The Increasing Significance of Psychological and Psychosomatic Illnesses

Psychological and psychosomatic illnesses are a growing problem for the social systems in the western industrial societies (Weber et al. 2006). For example, in Germany the number of sick-leave days due to this category of illnesses has more than doubled in the last 20 years – in relation to a fairly consistent level of sickness absence rates for other categories of illnesses. Since the turn of the millennium, they have also become the most frequent reason for early retirement and reduced earning capacity pensions. Since 2010, nearly as many people have abandoned the work force prematurely because of disorders out of the ICD-10 F-block as those who have because of neoplasms, coronary-circulatory diseases and musculoskeletal diseases taken together. This definitely represents an increase in the diagnosis of mental illness in general. This development is alarming given the increasing lack of qualified health care staff not only in Germany. The German policy of psychosomatic rehabilitation is therefore receiving more and more international attention (Linden 2014).

11.4.2 Development of Psychosomatic Rehabilitation in Germany

To understand why there is a third pillar “rehabilitation” with its own clinics and separate financing within the German health system, one must look back to the second half of the nineteenth century. At that time, Bismarck (1815–1898; Chancellor of Germany) introduced the different pillars of the social system one after the other: the state health, retirement, accident and unemployment insurances. Towards the end of the twentieth century the public nursing care insurance was added to cover the risk of care dependency. What all insurances have in common (except for the accident insurance which is financed by the employer alone) is that the premiums are paid in equal parts by employee and employer and the providers can thus handle cases independently of each other and of state intervention. This resulted in high financial stability within the system (the government could not simply help itself to social funds to fill its own gaps), but also made the individual insurances responsible for maintaining their autonomy and appropriating their funds exclusively for specified purposes. Therefore the public health fund, for example, does not cover measures concerned primarily with maintaining workers’ capability; it covers exclusively the treatment of diseases. This led the social security system to establish its own rehabilitation clinics and to be responsible both for financing and for quality control and admissions.

A special feature of the German rehabilitation clinics is that they are most often removed from the patient’s place of residency and are situated outside urban regions in a more natural surroundings. This reflects the romantic tradition of medicine

whose leading figures, such as Carl Gustav Carus, stressed the significant role nurture and the nature experience (see introduction) play in the healing process. Large psychiatric clinics were located outside urban areas for this reason, too, and less to specifically marginalize the mentally ill.

Sending patients these days to a rehabilitation clinic some place further away from home is meant to disengage them from work-related and family conflicts and thus to open them up to experimenting with new patterns of thought and behavior learned in a specially designed therapeutic environment.

In the 1950s the first clinics for psychosomatic medicine and psychotherapy were founded and university departments were systematically established. Since the 1970s, psychosomatic hospitals, specialized hospital wards, and psychosomatic rehabilitation facilities have been well distributed across Germany. At the end of the '70s and the beginning of the '80s, more and more rehabilitation concepts of superior quality were developed in psychosomatics and differentiated from the concept of the clinical "health spa".

Since the 1990s an extensive design of quality control, evidence-based research and research on the psychotherapeutic process has been introduced in psychosomatic rehabilitation and implemented nationwide. In this way the idea of in-patient psychotherapy within the rehabilitative process was further developed substantially. For example, comparative studies were conducted between the two large psychotherapeutic approaches – behavioral therapy and the psychodynamic treatment programs – and a randomized controlled study was completed on the differential indication for treatments (Watzke et al. 2010).

Psychosomatic rehabilitation's development was inconstant: After a steady phase of growth as of the 1970s, in 1997/1998 the capacities in psychosomatic rehabilitation were markedly reduced due to overall cost reductions in the health system. Admissions fell sharply again as a consequence of the economic crisis in 2006. This was triggered especially by the steep drop in rehab requests as many policy holders feared risking their jobs with an absence from work for several weeks. Since then, however, the number of requests for psychosomatic rehabilitation has been rising steadily. Because the waiting periods before admission to a rehab clinic were getting longer, a considerable number of new capacities were provided as of 2009. What motivated this was also the indication that psychosomatic rehabilitation is highly cost-effective: One euro invested in rehabilitation reduces the costs of treating illnesses and their aftermath by €3,79 (Zielke 2008).

The research of health services has one of its roots in psychosomatic rehabilitation, to which, among others, the long-term research findings from the study group surrounding Zielke (2008) contributed. A meta-analysis of 65 studies on psychosomatic rehabilitation showed a weighted average total effect of $d = 0.51$ from admission to release, and $d = 0.41$ after 1 year of aftercare (46–65 hours) (Steffanowski et al. 2007). Especially coping-related criteria as in the cognitive and functional areas remain stable in aftercare. From this the authors conclude "a successful transfer of the attitudes and modified evaluations acquired in rehabilitation to the coping strategies and behaviors in everyday life after in-patient treatment".

11.4.3 Psychosomatic Rehabilitation in Numbers

In the year 2013, 200 psychosomatic rehabilitation clinics existed with a total in-patient capacity of about 18,000 beds. In 2012, 157,000 rehab-treatments were conducted for psychological and psychosomatic disorders. Among them, the affective disorders constitute the most frequent initial diagnosis at 52%, followed by neurotic, stress-related and somatoform disorders at 40%. The proportion of psychosomatic rehabilitation within the overall rehabilitative treatments climbed from 9% in 1995 to 14% in 2010.

The average length of inpatient treatment is 38 days. Even when the policy holders receive an approval for 5 weeks prospectively, the clinics together with the patient have the option to extend or shorten the length of stay within a time range corresponding to the medical demands.

11.4.4 The Mode of Operation in Rehabilitation, Illustrated by a Case Study

The history of Ms. S.

The 46-year old cashier at a clothing discounter has been incapable of work for over a year and on the initiative of the MDK (Medizinischer Dienst der Krankenversicherung; a medical service of the health care insurers). She has been admitted to the rehab clinic. She reports whole-body muscular pain with an intensity of 6–7 of 10 on the visual analogue scale. The pains have existed for about 3 years; at the time she received medical sick leave she could barely move any more. Around 5 weeks before admission, she was diagnosed with a fibromyalgia syndrome. She also reports an irritable bowel syndrome, a feeling of bloated hands and feet, morning stiffness in fingers and both arms, problems falling asleep, exhaustion and melancholy. Her personal drive is variable, she broods a lot, suffers self-doubt and feelings of guilt toward her children, often worries about her daughter and son. She frequently fears she will receive terrible news (she has currently filed personal insolvency).

A number of examinations were run by various specialized physicians; other than a vitamin-D deficiency, nothing was found. She has not yet undergone psychotherapy.

Diagnoses upon admission are Fibromyalgia Syndrome (FMS), recurrent depressive disorder, arterial hypertension and adiposity III (BMI = 42). Furthermore, there is a massive abuse of nicotine, currently 25 cigarettes per day, 35 packs per year. The Beck Depression Inventory (BDI) reveals severe depressive symptoms, in the HEALTH-49 modules all symptom scales are extremely high (especially somatoform complaints) and in the AVEM (Arbeitsbezogene Verhaltens-und Erlebens-Muster; work related Behavior and Experience Pattern) shows a pattern of resignation with low work commitment and high resignation tendency.

In a meeting with the pain group the patient decompensates and in a crisis session afterwards she tells her therapist about year-long massive experience of violence and sexual traumatization during her first marriage. She married very young to escape the emotional coldness and frequent humiliation from her parents, and she became pregnant very quickly. Out of concern for her children she did not separate from her husband, but endured the situation. Not until her husband became addicted to gambling, fell deeply into debt and endangered the children's future did she find the courage to abandon him and take the children with her. She is at present still paying off the debts accumulated during her marriage. Out of shame she had never spoken with anyone about those times except with the women in the crisis shelter, and no physician had ever asked her about traumatic experiences or other sources of stress.

At the beginning of the one-to-one therapy, the patient could barely open herself up. Not until after the crisis session mentioned above did she talk about her ex-husband's violence, about related intrusions and nightmares, recurrent sweating attacks, feelings of dizziness and impotency, and short-windedness in certain trigger situations. The patient received primarily psychoeducational support and information about post-traumatic stress disorders. Through the psychoeducation the patient developed an altogether better understanding of herself and her complaints, recognized the psychosomatic interconnections and could begin to change her highly negative self-image.

The psychoeducation was accompanied by balneo-physical therapy, i.e. application of hot and cold water, exercises. Kinesiotherapy (exercise), all-round physical training (e.g. Nordic walking). Medical treatment with citalopram was phased out due to lack of effect and replaced by duloxetine in the morning and pregabalin in the evening, which had a positive effect on the fear symptoms and sleep disorders. Nicotine patches helped to wean the patient off cigarettes.

In the final interview, the patient stated that the diagnosis of Posttraumatic Stress Disorder (PTSD) was an important revelation for her. She was gradually able to involve herself in the therapy. Her mood and motivation had improved and she could enjoy things more and more often. She had fewer nightmares and felt more relaxed. The whole-body pain had barely changed, but she knew that she was only at the beginning of a long process. The HEALTH-49 showed a significant reduction in somatoform complaints. She found the group psychotherapy sessions very helpful and informative and the exchange with other victims did her a lot of good. In occupational therapy she was able to rediscover her personal resources and to sometimes forget her pains. She found Qi Gong was good for her and would like to continue with it. Her overall self-reliance distinctly improved and she was able to quit smoking and reduce her weight by two kilograms. She now felt much more motivated to participate in out-patient therapy with a focus on trauma therapy. Because of incessant pain she would have to abandon her former occupation which demanded she be on her feet all day. For this reason she was released still with worker's disability and retraining was initiated for her which would be organized and funded by the statutory pension insurance.

This case study nevertheless exposes one problem rehabilitation in Germany has: its poor networking with outpatient healthcare services. The rehabilitative measures were not suggested by the general practitioner or the outpatient psychotherapist, they came about on the initiative of the mandatory health insurance. The general practitioner then drafted a short medical report for the application. There was no further communication with the rehabilitation clinic (i.e., for setting rehab goals), and generally, the physicians and therapists in the clinic have no time to seek contact with the general practitioner or the outpatient psychotherapist. In other words, a lot of effort goes into providing highly specialized treatment, yet there still is a lack of resources for a strong network and coordination especially with the family doctor.

11.4.5 How Does Rehabilitation Differ from Hospital Treatment?: ICF as a Basis for Rehabilitation

What has helped to form rehabilitation's identity is its orientation to the International Classification of Functioning, Disability and Health (ICF) as adopted by the World Health Organization (2001). This is a model of the effects of illnesses and lends itself in particular to understanding the chronifying processes and determining resources to overcome them. Because psychosomatic illnesses do generally become chronic, psychosomatic rehabilitation assumes a key position in the overall treatment plans when it comes to guiding and managing cases. This applies in particular to patients' work-related problems.

All modern definitions of the term rehabilitation are based on the dimensions given in the ICF. Its primary task is to reinstate or substantially improve functional health (in particular activity and participation) when participation is threatened or already impaired. The ICF is indispensable to rehabilitation for determining its need, for functional diagnostics, rehab-management and rehabilitative treatment plans. The biomedical model of ICD-10 cannot sufficiently describe the effects of health problems on functional health.

The ICF differentiates the components "body functions and structures", "activity and participation", "environmental factors" and "personal factors", all of which are subdivided in separate chapters ("domains"). Especially the components activity and participation are pertinent to rehabilitation (cf. Fig. 11.1). In contrast to the more causal orientation of hospital treatment, rehabilitation is thus more result-oriented: Its goals are directed to how activity and participation can best be restored. One path in this direction can be causal therapy and symptom reduction, but this attempt has often been unsuccessful. Rehabilitation is instead more about developing compensation strategies and a new work-related and personal orientation in order to adapt more easily to life with a chronic illness.

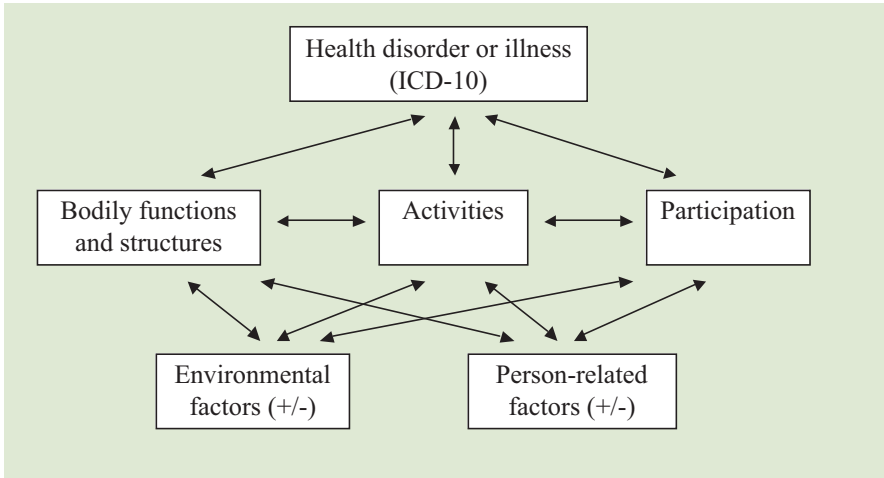


Fig. 11.1 Biopsychosocial illness model of the ICF (WHO 2001)

11.4.6 *Rehabilitation's Standing within the Health Service System*

There is a striking difference in how to enter into the in-patient health care system. Within the hospital sector, a physician recommends admission; in the rehabilitation sector, the patient must apply for admission and the funder must review the application.

A patient's diagnostic spectrum does not clearly distinguish between the different facilities. The psychiatric-psychotherapeutic facilities do in fact treat more cases of psychotropic substance abuse, psychoses and affective disorders, whereas in psychosomatic medicine the affective disorders, the neurotic, stress-related and somatoform disorders, and behavioral and personality disorders predominate; nevertheless, they do greatly overlap. In rehabilitative clinics patients are treated who have very similar diagnostic spectrums, which can also be said of hospitals and hospital wards specialized in psychosomatic medicine. They differ primarily in the stage of illness: Rehabilitation specializes in treating patients with chronic illnesses.

Rehabilitative treatment differs from hospital care in that it focuses on overcoming the effects of chronic illness, reducing functional limitations, and improving participation in both work and everyday life situations. Hence the social-medical assessment and its resulting consequences play a central part in psychosomatic rehabilitation. As a rule, a certain number of medical physicians in rehab clinics have supplemented their education to cover social medicine or the clinics are licensed to offer this type of advanced education.

What is characteristic of psychosomatic rehabilitation is its interdisciplinary approach to treatment. Psychotherapy continues today to be a central aspect of psychosomatic rehabilitation. At the same time the differentiation between psychoeducation, psychotherapy and work-related occupational therapies has become more refined (Köllner 2016; Köllner and Gissendanner 2014).

Another distinguishing feature of in-patient (!) rehabilitation is its allocation to highly specialized clinics. Indication and problem-specific case allocations are regulated nationwide by pension insurance funders. Together with this, the size of clinics (generally with a capacity of 100–250) has made it possible to offer special treatment programs designed specifically for various disorders and target groups (Table 11.1). The indication criteria for psychosomatic rehabilitation are compiled in Table 11.2.

Table 11.1 Differences between hospital and rehabilitation clinic

	Hospital	Rehab clinic
Allocation	Direct admission by physician	Patient applies at insurance, psychotherapist delivers assessment report, insurer assigns patient to a contracted clinic, taking preferences and selection rights into account
Waiting period for admission	A few days to over 6 months, depending on clinic's waiting list	In urgent cases, maximum of 3 weeks, otherwise about 6–8 weeks after application
Length of stay	Open-end. Treatment durations under 12 weeks are also possible	Average of 38 days, treatments lasting over 8 weeks occur only by exception
Goal of treatment	Treatment of acute or chronic illness in terms of ICD-10	Treatment of effects of chronic illnesses in terms of ICF
Range of treatments	Generally entire field of specialization	Particular predefined indications targeted by German pension fund. Often specialized programs for particular disorders, comorbidities. Occupational problems or therapies in foreign languages. ^a
Relation to occupation	Little relatedness to occupation	In many clinics, special therapy programs with relation to work environment; social-medical assessment und guidance at end of rehabilitation.

^aAn overview of indications and treatment emphases can be found in the clinic directory on the homepage of the German association for psychosomatic rehab (Fachgesellschaft für Psychosomatische rehabilitation), www.dgppr.de

Table 11.2 When is psychosomatic rehabilitation indicated?

A cluster of symptoms threatens the ability to work, study, provide for oneself or participate in everyday life in society (e.g., extreme social reclusiveness).
The symptoms cannot be fought with out-patient care alone, the out-patient treatment options (e.g., guideline psychotherapy) have been exhausted or are insufficient.
The multimodal concept of psychosomatic rehabilitation is advisable and necessary in order to maintain work capability or participation in everyday social life
Acute symptoms do not urgently require hospital treatment (i.e., acute depressive episode including suicidal tendencies).
The patient's psychological and somatic constitution allows for a promising and active participation in the rehab clinic's therapeutic options that is. There are no severe motivational disorders, compulsive rituals etc.
The patient shows capacity for the group setting
The goals of rehabilitation can be achieved with the support of clinical in-patient rehabilitation rehab-aftercare if necessary, and further out-patient follow-ups
The patient is sufficiently motivated to complete rehabilitation and achieve the set goals

11.4.7 *Multimodal Concept of Rehabilitation*

Psychosomatic rehabilitation is committed to a bio-psycho-social understanding of sickness and health. It therefore follows a multimodal treatment concept and is supported by a multi-professional team (Linden 2014; Köllner 2016):

- medical and psychological psychotherapists
- medical physicians with a somatic focus
- nursing staff (preferably with advanced schooling in psychosomatics)
- social workers
- occupational therapists
- art therapists (e.g., fine arts and crafts, dance, music)
- sport and physical therapists.

The various elements of the multimodal concept can be seen in Table 11.3. The frequency of therapies should fall in the target range of 22–35 measures and 15–30 hours of therapy per week, among the latter should be five sessions of psychotherapy which is directed towards every-day-life irrespective of disease. In most clinics the patients have a weekly schedule of one individual session and four units of group therapy (usually 90 minutes each). The relatively broad range allows for adapting the therapy schedule to a patient’s individual needs and resilience. Added to this is the medical treatment which includes optimizing psychopharmacological and, where applicable, somatic medication.

11.4.8 *Diagnostics in Psychosomatic Rehabilitation*

Diagnostics in rehabilitation covers not only the medical diagnoses but also disorders in activity and participation and work-related aspects. Special psychometric testing methods, performance tests and work-related assessments have

Table 11.3 Therapy modules (KTL; classification of therapeutic treatments) in psychosomatic rehabilitation

Psychotherapy
Sport- und kinesiotherapy
Physical therapy
Information, motivation, education
Clinical social work, social therapy
Ergotherapy, occupational therapy, functional therapies
Clinical psychology, neuropsychology
Rehab care
Recreational therapy
Special nutritional diets
Physiotherapy

been developed to this end. As a matter of course, the customary general or disorder-specific tests are also conducted. Additionally, instruments are used that also assess limitations and resources as listed in the ICF or that relate to the patient's work.

Depending on the conditions, neuropsychological test instruments for the functional diagnosis of cognitive abilities can enlarge the picture. Another emphasis lies in occupational assessments and screening methods that focus more strongly on specific work-related problem situations and facilitate individual planning with work-oriented intervention modules (e.g., workplace-related performance training, behavioral therapy options for coping with everyday work situations).

Central to rehab diagnostics, however, are not the individual testing methods but the rehab team's conference on the individual cases. The separate findings and observations are compiled to create an overall picture of each patient and their problems and resources; this then guides the team when setting the rehab goals, planning the treatment schedules, and evaluating the social-medical assessment.

11.4.9 Rehabilitation Process

Because of the limited time frame the rehab process must focus on a few clearly defined goals that can be reached within that amount of time. For this reason, setting therapeutic goals and devising a treatment schedule together with the patient occur at the end of the diagnostic phase (usually the end of the week the patient was admitted). It is helpful when the patients are encouraged to think about possible rehab goals in advance, that is, while still in out-patient therapy.

The therapeutic phase of 4–6 weeks then begins, usually with four group and one individual session per week. With the nationwide allocation of cases (see above), rehabilitation clinics can offer disorder-specific groups and additional therapeutic measures aligned to them (e.g., patient education and kinesiotherapy specifically for fear or obesity patients). Group therapy generally lies at the core, which is a very good supplement to the usual individual setting found in out-patient therapy, especially when interactional difficulties or social reclusion are relevant problem areas. In comparison to psychosomatic hospitalization, patient education and modification of health behaviors play a greater role, and as a rule, rehab clinics are more highly competent in tobacco withdrawal, behavioral-medical treatment of obesity, diabetes or arterial hypertension. Social counseling and work-related therapies can be added where they apply to the patient's problems. Rehabilitation stands especially for the "social" aspect in the bio-psycho-social model. During the final week before release, the focus is on transferring what has been learned in rehabilitation to life outside and, when required, organizing rehabilitative aftercare.

To ensure the long-term success of rehabilitation it is possible to refer patients to special follow-up groups that meet locally and usually cover about 20 double sessions. It is also becoming more common now to offer follow-up care via email.

11.4.10 Social Medical Assessment

During their stay in rehabilitation clinics, patients who have been referred by the German statutory pension insurance (Deutsche Rentenversicherung (DRV) 2011, 2012a) must undergo a social medical assessment conducted with a synopsis of the entire rehabilitative process (DRV 2012b). Two questions must be answered here:

1. Can the insured patient work full time or at least three to 6 hours a day in the previous occupation or profession?
2. Is the insured patient capable of working full or part time (3–6 hours a day) within the general job market?

In addition, a positive and a negative work performance overview is drafted that describes possible qualitative limitations (e.g., no shift schedule or public business). With a classification “work disability” upon release, the clinic’s social service organizes a step-by-step reintegration into the working place, or recommends how the patient can regain working capability within a reasonable amount of time (6 months). If long periods of work disability persisted before rehabilitation but a return to the former working place is still possible, it is of utmost importance to restore working capabilities during rehabilitation or to begin with gradual reintegration along an ordered path. These patients often return to a structured daily schedule or emerge from their social isolation only after they have begun with rehabilitation, which means the chances for successful reintegration into working life are particularly high in the phase after release. What is important here is good cooperation between the rehab clinic and the out-patient therapists.

If the capability to work in the former occupation cannot be achieved within a reasonable period of time, or if one can expect the patient’s health condition to deteriorate upon return, occupational support measures can be recommended. These can be, for example, an in-house transfer or a retraining program funded by the German pension fund DRV. Engaging the special integration service can also facilitate occupational re-entry.

If the working potential no longer exists within the general job market as well, the patient may qualify for a reduced earning capacity pension and apply for it with the designated insurer or fund.

11.4.11 Conclusions for the Practice

For patients with chronic psychological and psychosomatic illnesses, the psychosomatic rehabilitation is a valuable resource for the overall treatment program. With its mainly group-therapeutic setting, its multi-modal concept with therapeutic units not available in out-patient care (e.g., art therapies, sport- and kinesiotherapy, social counseling) and with the focus on maintaining activity and participation, it

represents a good supplement to out-patient psychotherapy and hospitalization. Particularly with long-term work disability and occupational problems, psychotherapists in private practice should help the patient seek a rehabilitation program before the illness becomes chronic. Clinical reports from physicians and psychotherapists are highly valuable here, which is why basic knowledge of indication and the course of rehabilitation are indispensable.

11.5 Socialization for Psychosomatic Practice, Research, and Teaching in Germany: Undergraduate Education and Postgraduate Training

Wolfram Schüffel

“However, because the physician’s goal is not to eliminate the sense of pain but to master the treatment of pain, and because this mastery involves a chain of decisions, work without the goal of making decisions is inconceivable and impossible to perform. Which goal is meant and which is the right one?”

Viktor von Weizsäcker (1926): *“Die Schmerzen – Stücke einer medizinischen Anthropologie”* [Pain – Thoughts on Medical Anthropology]; in: *Die Kreatur*; GS 5:27–47, Frankfurt/Main: Suhrkamp 1987.

An individual’s flashforward to the primordial experience is seen as a way to gain more insight in the process of undergraduate, post-graduate and continued education. – In order to achieve this in a consistent and sustained, that is, coherent manner, a medical doctor must at any time remain as open to bodily sensations as possible. – In the encounter between physician and patient, the doctor recalls the primordial experience and uses it in a perceptual-affective, cognitive and behavioral sense to build upon a leitmotif. – What has been happening over a lifetime boosts the physician’s disposition to bio-psycho-social medical treatment. The physician is treating the patient in the sense of an integrated medicine that, when successful, has the word become flesh (manifests experience/dwelling).

How will future physicians be prepared to treat those patients presented as case studies in this book? This I ask with the fourth pillar of socialization for the psychosomatic physician in mind (after the outpatient, inpatient and rehabilitative pillars). – The three people concerned are a 26-year old male civil service administrator (of the section family medicine) a 43-year old saleswoman (of the section rehabilitation), and a 57-year old male physician Dr. E. of (cf. the sections “General medicine” and “Rehabilitation” in the chapter “History of Psychosomatic Medicine in Europe”). – In addition, how can future physicians address the consultation-liaison work (as presented by Wolfgang Merkle) originally developed in Anglo-American countries? (Lipowski 1969, 1991; Lipowski et al. 1977)– Furthermore, how do they pursue the demanding research programs in concerted research efforts

that Martin Teufel lists in his section? – The section “Socialization” has been placed between the section on rehabilitation medicine and university medicine because the differentiation between these two medical spheres produces the sharpest contours for the profile demands on the future physician in Germany – family medicine being in between.

The topic of socialization is presented here upon the groundwork of experience gathered as director of an integrated psychosomatic department at the Center for Internal Medicine in the Medical School of the Philipps University in Marburg. During this time the department had eight beds, four each in the gastroenterology and in the cardiology wards. The overall internal medicine hospital consisted of six departments, one of which was psychosomatics, and had a total capacity of approximately 250 beds. The average hospital stay for psychosomatic patients was 28 days, for the gastroenterology and cardiology patients it was approximately 5 days. If necessary (for example, in a case of acute gastrointestinal hemorrhage or complicated cardiac arrhythmia, or a case of acute anxiety and adaptive disorder), the patient remained in the same bed, that is, in the same ward, whereas the medical discipline of the attending head physician changed. We were thus able to achieve maximum integration by listening to the “Founding Internist and Psychosomatic Physician” Dr. Utz Schairer (1983). We referred to this form of integrative psychosomatics as *the bed-to-bed system*. Each year psychosomatics treated about 100 inpatients. The physicians in internal medicine rotated through these two wards during their 5-year specialization. In this way they fulfilled essential requirements of psychosomatic basic care.

The introductory quote from Viktor von Weizsäcker on mastering the treatment of pain while not eliminating the perception of pain as the goal of a physician’s work is the guiding thought throughout the section “Socialization”. – The study “Die Schmerzen” (The Sense of Pain) was published in 1926, that is, 8 years after World War I and 12 years after Freud published “Remembering, Repeating, Working-Through” (1914). Von Weizsäcker was a physician in sickbay during the first world war which forced him to witness the most severe conditions of pain. Around 1926 he turned his attention to Freud who spoke of long recurring childhood images that must be considered in lengthy therapeutic treatment (cf. the chapter “History of Psychosomatic Medicine in Europe” in this book). In a language of imagery Viktor von Weizsäcker describes not his war experiences but explicitly early and general childhood memories including those not unknown to himself – a method which should play a central role in the education of each physician. The “goal” the author sets is to continually address the individual doctor’s attitude, his/her conscious awareness. Which realm of consciousness is meant here, conscious of what?

Medical education in Germany takes 6 years after a total of 13 years at school (elementary, High School, College); this period is divided into 2 years of preclinical and 4 years of clinical studies. The two levels of education are sharply divided by the Physikum, a medical pre-exam. The exam primarily covers the subject areas of anatomy, biochemistry and physiology. The subjects medical psychology and medical sociology are also tested, although only marginally.

This pre-graduate education is followed by a 5-year postgraduate training in individual medical disciplines. Psychosomatic medicine offers a three-stage post-graduate program; first in psychosomatic primary care, second in discipline-specific psychotherapy (cf. Herrmann, Veit), and third in a 5-year advanced training program for the specialization as physician of Psychosomatic Medicine Physiotherapy. The first two postgraduate stages are offered to physicians of all disciplines. The third stage educates doctors in an independent discipline. They have to fulfill demanding requirements in patient care, teaching and research, as Zipfel and colleagues have described with particular attention to the institutional developments for this in the German universities (Zipfel et al. 2016). The critical factor along this continuum from basic to advanced education is that in all three stages the experience of self applies, which begins in and is fostered by the four subjects – psychosomatics, psychotherapy, medical psychology and sociology of medicine. The first stage involves a self-experience that is strictly related to the working place; in the second stage a more personal (less individual) self-experience begins; in the third the self-experience is individual. This usually occurs within the setting of a group self-experience, but is also possible as individual self-experience.

The experience of self makes it possible to recognize the four moving phenomena of the primordial, “at any time”, leitmotif, and finally in the sense of manifestation, “dwelling”. A lifelong lasting self-experience is concerned with *the courage* to recognize the situation in the present, the NOW (here), and to form it. With this I return to the Introduction in which I spoke implicitly of the experience of self, but explicitly referred to the four phenomena, the four times, the four manners of approach, and the seven realities (horizons). The main emphasis of the following considerations lies in the four moving phenomena. They will be discussed with reference to the seven realities or horizons. This always takes places in connection with an implicitly occurring experience of self.

11.5.1 The Four Moving Phenomena and the Seven Realities

The four moving phenomena represent the structural emphasis of the following contemplations. The seven realities (or value horizons) mentioned already in the Introduction and again by Wolfgang Merkle will be set in the context of these four moving phenomena. They are also discussed in the chapter “History of Psychosomatic Medicine in Europe” (Schüffel, in this book).

Primordial experience: Heidelberg and London; Realities 1 and 2

Proscenium (emerging reality; reality 1): Reality surrounds us, and we immediately perceive and describe it in a natural language.

When this reality is described by people who are ill, long before their first visit to a doctor, they describe in standing and in their natural (!) language how they move. Whether in a joint, in the chest while breathing, in the head at a sudden turn, or so on, the movement is in some way inhibited. The afflicted person has not yet become a patient, but notices limitations that are a hindrance in the usual, personal environment. This person gradually perceives a reality that leads to seeking help: The physician is seen as the fitting helper. The patient then expects the doctor to be able to comprehend this reality and to put it into words and treatment.

Similarly, into this reality the Approbation Ordinance (State Medical Licensing Law) was assigned in 1970, like the toss of a stone into the stream of education, to modernize the 6-year curriculum in Germany. It consisted mainly of introducing four new subjects together with a so-called experimental clause. These subjects were: medical psychology, medical sociology, psychosomatics and psychotherapy. This unfortunately took place additively, that is, concentration on medical treatment was not required. The question what medical treatment actually is was passed on by the government and Parliament to the faculties. The Approbation Ordinance is specifically for examination regulations and not for curriculum regulations; this means the state demands quality control but does not get involved in “how” quality is conveyed. This was not so with the preexisting Prussian commission to medicine, which was adopted by all German states by 1865 at the latest. Its purpose was to define not only “what” but also “how” medical knowledge was taught and conveyed. It was a “training regulation”. The approbation ordinance became a “license to practice medicine”. The Prussian commission was based instead on a curriculum compiled substantially upon the ideas of Boerhaave in the eighteenth century. It prescribed strictly subdivided pre-clinical and clinical phases of 2 and 4 years, respectively. Under the influence of new technological and, as we see them today, pseudoscientific medical developments, the Philosophikum examination, conducted up until 1865, was replaced by the Physikum, which is still in effect today. That is, comprehensive exams were no longer conducted in the humanities but in the natural sciences in accordance with the nineteenth century ideas.

One could also say: It seems this step brought the romantic notion of medicine as described in the history-related chapter of this book to an end, and the corresponding instruction in medical faculties as well. Medicine was taught in a style and context referred to at the time as “natural-scientific”. This conception was aggravated by the two catastrophic world wars that demanded maximally technical-mechanical conduct from its medical corps. Yet the most horrifying scenes were in the Holocaust (MacGregor 2014).

Stage (reality 2): The stage comprises henceforth the encounter between the patient in his or her natural language, the physician in his/her professional language, and both in their sensitivity for what takes place in the interaction beyond verbal commonalities or discrepancies, for what is not verbalized but “enacted”. To illustrate this, I will describe my own subjective experience.

The Approbation Ordinance of 1970, more than 100 years after the Prussian commission to medicine was established, signified a turning point in German medical education. From then on it was compulsory to test psychosomatic knowledge, competence and attitude of prospective physicians. At least equally, if not even more important, however, is this period of a half a century since, during which the approbation ordinance has been prepared and implemented.

In this context I must refer to my own subjective experience. I was hired in 1968 as a young resident doctor at the University of Medical and Natural Sciences in Ulm founded in 1967. My superior Thure von Uexküll, director of the Clinic for Internal Medicine and Psychosomatics, was the doctor-in-chief reigning over a capacity of 120 patients within the internal medicine ward (with a total capacity of 350 beds in the Center of Internal Medicine at the same university). Thure von Uexküll had become well-known by this time through his book “Fundamentals of Psychosomatic Medicine” (von Uexküll 1963). Because of my own experiences as a student in the London Royal Free Teaching Hospital (under the guidance of the hepatologist Sheila Sherlock (1963) who, recognized worldwide as a specialist, oversaw “only” 30 patients), later in Heidelberg, I had to learn by comparison how different education was between Great Britain and Germany. Here (Britain), the clinic and its realities without prescribed division into subjects; there (Germany), subjects and more subjects, that is, a pseudoscientifically prescribed division; here team, there separation of individuals; here imperative connection and feedback between the “houseman” (intern) and the “registrar”(resident), there practically nonexistent guidance and no instructor-student dialogue in the sense of tutorials; here lively exchange between the professor and the consultant in extracurricular everyday care, there isolation of the university from everyday primary care.

To witness the difference between Heidelberg and London was a kind of primordial experience, although I wasn't able to label the experience in this way at first. Not until Ulm, 6 years later, and in the environment of a reform university did I recognize the differences. I began to see a turning point in the German education with the new Approbation Ordinance. This also gave me an idea for a topic of research within the area of academic didactics. It was certainly a very motivating event when Michael Balint came to Ulm in the years 1968/69 and arranged for a meeting with us. He ordered our senior physician (quite a provocation in those days of paternalistic medicine) to lay aside the file of the patient about to be presented and to reduce his report to his impressions and images. “Put all that paper down,” he said in an authoritative-commanding tone unknown up to then; I found it convincing.

I suggested to Thure von Uexküll to take advantage of the moment, that is, the concurrence of the new Approbation Ordinance and setup of a reform university (founded 1967), a concurrence of an opportune time and a favorable venue. – The primordial experience of a London-Heidelberg comparison had alerted me to assess my environment much more closely in order to set an exemplary stage. From today's point of view it is in fact an almost 50-year old experience. However, at the same time, for me it was an experience in the NOW (here) that is still as immediate in 2017 as if it had just been made. – I will continue my report:

I drafted a research proposal on socialization with the focus on “Affective Learning Objectives in Medical Education, their Integration and Evaluation.” – Thure von Uexküll, who strongly influenced the long overdue modernization of medical education in Germany, took a look at my ambitious efforts, voiced his judgment in a friendly and reserved way, and said: “A specialist should look over the text.” What he meant with these few and tactful words I reword for myself in retrospect: “All of this has nothing to do with professional academic didactics. But I personally cannot give you any advice. That a specialist must do who can tuck the topic into the context and background of academic didactics while taking other aspects into consideration.”

At any time: Venture approaching one’s self; Realities 3 and 4

Context (reality 3): This reality refers to concepts and programs we consciously have at our disposal. Corresponding to the medical curriculum, the concepts and programs are almost exclusively mechanic-etiologic in nature. However, in the clinical phase of education, the resultant positivistic expectations are at first deeply shattered. The clinical student and to a greater extent the young doctor experience the patients in their movements and breathing, through their symptoms as altogether encumbered.

– At this point it is important that both student and doctor refer to the existing concepts and programs, that is, they should position themselves. They are in a similar boat as I was when I was advised to look at myself critically.

The specialist Thure von Uexküll had in mind was Hannes Pauli, director of the Institute of Educational Research in the University Medical Department in Bern. I sent him the draft. I then traveled to Bern and was prepared to have the proposal handed over to me, spotted in red with question and exclamation marks. When I arrived, there was nothing in writing, no paper whatsoever on the desk in Hannes Pauli’s office. Instead, a friendly elder gentleman sat across from me who asked me in the Bernese dialect to explain the purpose and goal of my visit. This confused me somewhat, but I did as asked. When I had finished outlining my intention, a period of silence set in. Then Pauli said with deliberation: “You simply have to state how you plan to behave as a psychosomatic physician. If you are working with students, you have to have them find out what psychosomatic behavior is and how one learns it. And then you should allow for discussion about what the most efficient procedure would be.” And he added: “This would have to take place over and over again, at any time.” – This made me think about the educational methods I had experienced myself in London and Heidelberg. For the first time I looked back even further: how I could speak with students all the way back to the times I played in the sandbox.

Then, after a pause: “I believe I’ll give you the book by Mager (1962), a book that explains how one can formulate learning goals. Learning goals are set in such a way that one recognizes them in an individual’s behavior and can thus define to what extent they’ve been learned and trained.” – After another pause: “The best

thing would be for you to read through Mager, transfer his approach to your group work and discuss the wording with your colleagues. Then revise your proposal. If you feel the need, send it to me.”

At first I was completely dumbfounded. I had expected the expert to wield his red pen and slash through my written proposal. – ... Strangely bewildered, I bade good-bye and set off for the trip back. In the train I read “the Mager” and transferred the ideas to our group situations. I dared to admit to myself how I actually had imagined myself behaving before the patient without so far having put it into words.

I ventured the approach – to myself: I then gave my experiences in Heidelberg and London, my impressions in Ulm and the advice of von Uexküll more in-depth thought. Those were very personal, today I would even say individual perceptions, feelings, contemplations that arose. They usually entered my mind whenever – at any time – I returned to Ulm from another German university or from another country, when I found myself in an ungoverned space of the kind, for example, the hematologist Herrmann Heimpel advocated. Together with him, in a series of meetings and extensive seminars at Reisenburg (the conference site belonging to the University of Ulm), we succeeded in introducing the general clerkship of Rochester/ NY (USA) to my newly founded university (University of Ulm 1972). I had become acquainted with this clinical traineeship during a visit with Georg Engel.

Hannes Pauli in Bern and the ungoverned space in Ulm helped me in the early phases as resident doctor to reflect on fresh impressions of my own socialization during 1 year of substituting for the owner of a private practice in general medicine. This was in Dortmund, still a mining area in those days, during an influenza epidemic in autumn of 1967, and the majority of the patients were miners with pneumoconiosis (black lung) and pulmonary hemorrhage. When the owner returned, he contacted me and went through the patients’ files and their histories with me. “Well done,” he praised. “But one thing you should keep in mind in the future: administer less valium!” – I had been unable to bear the miners’ complaints about their poor sleep and problems with the foreman, and they had reported nothing about their dyspnea. This was actually nothing but their survival fears, which they tried to push aside in order to avoid clarifying the underlying mechanisms (cf. Ways of clarifying symptoms with the formula $2 \times W, 2 \times S$; see below, Moving Seminar). Therefore I issued valium, which was considered highly effective at that time, in order to quiet my own fears. – Of course this was absolutely counter-indicated, but I allowed myself to be misguided to prescribing it. In retrospect I see how a group practice with regular meetings could have helped (cf. the section “Wagner versus Tolkien” in the introductory section on Psychosomatic Medicine in Germany, the part about the general practitioner with her two male colleagues). The symptom sleep disorders (falling asleep or not sleeping through) was a simple analogy to survival fears. I learned how to appreciate the meaning of symptoms. To appreciate them as one of the most creative bodily functions, of the ensouled body in its spirituality. The same applies for symptoms like pain, rash, hearing impairment, stomach complaint, tachycardia, dizziness, gait disorder, just to name a few everyday symptoms besides sleeping disorders. Looking at and

interpreting symptoms applies to any case of sickness, the acute and the chronic (see below, Culture).

The background (reality 4): This reality relates to unconscious forces beyond the consciously perceived context, in other words the experience of self and here at the core of the concept of transference and countertransference.

– How anamnesis, or peer groups on history-taking, originated can best be understood with the background (Welton 2003, 2012). What is meant by background is the occurrence of semi-conscious, partially unconscious events. Martin Teufel will go into these groups and their work nearly 50 years later in more detail (see next section). Today his text reads as if the peer-groups on history-taking were a matter of course. As if they had spontaneously appeared without a plan from the midst of the student body. As if the peer work between students in preclinical and clinical stages were self-evident. The opposite is true: It was the result of a purposeful coordination of time and place that I described above as a resident doctor at the reform university of Ulm (Schüffel 1983a, b; Schüffel 1988; Schüffel et al. 1998). Creating and leading a peer group on history-taking was and is for student (!) tutors a satisfying task, but it is also problematic. The individual is always intimidated when fellow students cannot agree with his/her interpretations. A process of insecurity will invariably unfold that must be overcome anew. The idea in the groups is self-experience, or to face up to oneself and to the affective disorders listed by Volker Köllner, among them the neurotic, stress-related and somatoform disorders of people. – Within their environments the participants of the history-taking groups make similar experiences as those described during the flu epidemic in Dortmund in 1967. Physicians in the respective wards are uncertain because they believe they might upset or even psychologically injure their patients. Confronted with serious somatic sicknesses, they often voice fears that “unprofessional” interviews by students could elicit a colitis or asthma attack, or cardiac arrhythmia, etc. Under the influence of such fantasized, unjustified medical (!) impressions, students are refused contact with patients. In these cases it was and still can happen that the senior resident or even the chief physician asks the tutors to leave the ward immediately. In the late 1970s and the beginning of the ‘80s I officially received the message by post from one of my department director colleagues at the Center for Internal Medicine at the University of Marburg, “History-taking groups unwanted in my wards.” – Furthermore, the tutors were and are told that preclinical students had no business being in such groups. Because the tutors are students themselves, they run into loyalty conflicts with their fellow students. This kind of work is only possible when the student tutors enjoy regular supervision.

The “at any time” of the section “background” could end with this. However, one must consider the instructor’s point of view who attempts to support this kind of student activity and, for example, receives a message of the sort mentioned above from a colleague. Therefore:

Not only does the student tutor of a history-taking group require supervision. I, too, the director of a research project of this type, needed supervision. I depended on project supervision for what I was participating in as much as my medical, psy-

chological and student staff were participating. We were extremely fortunate in finding an accomplished supervisor with both clinical and academic-didactic experience, the British physician and psychotherapist Heinz Wolff, University College London (Wolff 1986; Schüffel 1983b). He gave us the decisive impetus we needed to develop the project further. When he first came to us in my office in Robert-Koch-Street in Marburg and we were sitting at a round table with 12 persons, Heinz Wolff stopped in his tracks on the threshold of the door. He looked at us, smiling but also inquiring: “What kind of a group are you?” We didn’t know how to answer in a way that satisfied him. Then he said: “Which gender do all of you have who are sitting here?” There we were, 12 men and not one woman among us. In the following we were able to work out that we had viewed this project from the start as something for “tough guys” who were writing their doctoral theses in the midst of a doubtful environment

One of the most remarkable experiences for me personally was: This gender imbalance was noticed neither in the two inspections conducted by assessors from the German Research Foundation (Deutsche Forschungsgemeinschaft DFG), nor during the 14-day supervision outside of the university. In other words, this was a collective national perceptual failure. I would like to go into this event more deeply under “Culture” the 7th reality

In our case, the immediate consequence was to engage the peer groups on history-taking more strongly in “female” topics and in how the genders work with each other. – As project director, the experience and implication made me understand that supervision is indispensable and must be conducted at all levels. The supervisor, on the other hand, should also maintain very close contact to an influential member of the faculty. This insight is an example of self-experience “at any time”. With the term “at any time”, that period of time is meant that repeatedly guides an individual anew to his or her primordial experience. It happens at any time, just as I am experiencing it while writing this chapter.

I have just received a Christmas greeting from a former tutor in the history-taking group and then organizer of the 20th May meeting of the German speaking Peegrohits which took place in Marburg in 1989. Now a days he is 50 years old and chief doctor of Psychiatry in Hadamar, one of the most important psychiatric care centers in central Hesse, the region between Frankfurt and Kassel (Bender 2012). He reported on five history-taking groups currently running parallel in Marburg, whose tutors he supervises. He himself was engaged in establishing a memorial site in Hadamar, more precisely in the institution he directs which offers a series of continued education seminars. Hadamar is the regional psychiatric hospital where 15,000 people were murdered during the Nazi regime, similar to what happened in Pirna on the Elbe (cf. History of Psychosomatic Medicine in Europe).

For me as 80-year old psychosomatic physician and former project director of the academic-didactic research program “Integration and Evaluation of affective Learning Goals in Medical Education”, the past history-taking group work has extended far beyond the efforts in the 1970s and 80s to become an instrument of self-experience with lifelong quality control. The groups induce contemplations in two directions:

- How can salutogenesis be encouraged as a mandatory principle and
- How to cope with trauma recognized in its true significance?

Obviously, these two main thoughts have to be seen in the context of trans-generational developments.

Leitmotif: Recognize values and trace their change; Realities 5 and 6

Rhythm (reality 5): This reality relates to the exchange between the generations, their encounters, confrontations and their boundaries. Group work becomes central. Only here can members of various generations engage in problem-oriented dialogue. – The need for extensive, holistic medical care was felt in the turmoil of 1945, but at the time impossible to realize in the sense of the leitmotif symptom-based psychosomatic care. Unlike the intact, centrally governed Great Britain, in Germany individual persons within the medical profession began to actively work on psychosomatic medicine. In Great Britain, the NHS was introduced instead. The convulsions that began in 1914, partially evolved to a civil war in Germany after 1919 (Haffner 2000), then erupted in national socialist barbarism and the second world war had isolated the people of Germany from one another. Nevertheless, practicing physicians who formed regional groups which in 1974, 30 years after the end of the war, enabled the German College of Psychosomatic Medicine to be founded (Deutsches Kollegium für Psychosomatische Medizin/DKPM). The College was essentially a merger between three groups, those of Heidelberg, Hamburg and Ulm. – The Ulm group (under the leadership of Th. Von Uexküll formed a close working alliance with representatives of General Medicine/Family medicine around Siegfried Häussler (Mader 2016). They paved the way for introducing a new medical curriculum and for developing the concept of psychosomatic basic care (PBC) in 1988. In a parallel effort, induced again by separate initiatives, the door was opened to reforming the medical curriculum and developing outpatient care in a psychosomatic sense. There was a close cooperation between the family physicians Häusler (DEGAM) representatives of general medicine in Ulm, the Psychosomaticists there, and the German Balint Society (Mader 2016) Questions concerning education brought about a cooperation with K. Jork of Frankfurt (Jork and Schüffel 1987).

After WWII and under the pressures of the Cold War, the political development had the following 4 years ended in 1949 with the two-state solution on the terrain of the former Third Reich. The Federal Republic of Germany (West Germany) and the German Democratic Republic (East Germany) were created. Accommodations and employment had to be found for the 12–15 million displaced persons (within a total population of about 80 million). Among the German physicians the majority had either endured or actively supported the terror regime (Mitscherlich and Mielke 1949, 1960; Mitscherlich and Mitscherlich 1967). Entire medical faculties such as in Hamburg and Giessen were at first shut down because of their national socialist implications.

It took 25 years for progressive and untainted physicians to be able to formatively articulate and effect legislation of the Approbation Ordinance mentioned above. (initially, of course, without speaking of its realization). There were three figures who not only picked up on the German psychosomatics tradition but also

actively shaped it: Arthur Jores (1960, 1981) was a former Gestapo prisoner in Hamburg. After liberation he became the first Medical Director of the University Clinic in Hamburg-Eppendorf after it reopened in 1945/46; Paul Christian (Christian and Haas 1949) in Heidelberg as successor to Viktor von Weizsäcker, and Thure von Uexküll (1963, 1973, 1979) in Giessen, soon after in Ulm, and speaker for this group. Thure von Uexküll was author of the popular book “Fundamentals of Psychosomatic” published in 1963 which is still worth reading today. Colleagues, who at first were unacquainted with each other, gathered around these three personalities. What they had in common, however, were their origins in internal medicine: in Hamburg Dolf, Meyer and Freyberger; in Heidelberg Kütemeier, Hahn (Hahn, Petzold, Deter and Herzog); in Giessen and Ulm Cremerius, Wesiack, Soon followed by Köhle, and Schüffel, Joraschky.

On Thure von Uexküll’s initiative, together with six other colleagues (Hahn, Lohmann, Meyer, Molinski, Wesiack, Wittich), they founded the German College for Psychosomatic Medicine (DKPM) in 1974. It grew rapidly and its members, reached a maximum membership of 550 (currently 450), and felt its first main task was to put the Approbation Ordinance into effect in cooperation with the so-called “psycho-subjects” (disciplines). Namely psychosomatic medicine, psychotherapy, medical psychology, medical sociology. The connecting link was the desire to establish holistic care and research into psychosomatic medicine.

From a formal methodological perspective, the education and training for psychoanalysis was in a kind the “hidden curriculum”. It had been practically new when introduced after 1945. The qualification solely as analyst was in turn considered its ulterior ideal goal. This demanded too much of the younger generation and led to intense divisiveness that threatened to split the DKPM. Finally, in 1993 the threefold postgraduate training in psychosomatic basic care, a psychotherapeutic supplement title or subject-specific psychotherapy (cf. Herrmann, Veit), and specialization in psychosomatic medicine and psychotherapy defused the situation. How critical this situation was is described in a four-part article written for the European Conference on Psychosomatic Research (ECPR) in Vienna, 1972 in which, to my knowledge, the results from studies on integrated psychosomatics and consultation-liaison-medicine in Germany were presented for the first time (von Uexküll 1973).

In East Germany the development was influenced by persons like Klumbies (Jena), Crodel (Halle), Hoeck (Berlin), and Michael Geier (Leipzig). They succeeded much earlier than their West German colleagues in setting up a medical specialization for psychotherapy; this could be acquired as a secondary medical specialization. The formal training was deeply rooted in group work and included a guided process of self-experience (Geyer 2011). After the reunification, this accomplishment proved to be highly beneficial to adopting the specialization in psychosomatics within Germany as a whole in the year 1993.

In the wake of the divisions and conflicts between 1970 and 1993, actually a quarter of a century of debilitating but also productive dispute, out of the peer groups on history-taking groups emerged the Moving Seminars. They are in the best sense of the term “rhythm” – the result of a dispute between the generations. The generations exchange ideas about the meaning of symptom. The symptom is not

interpreted as a causal factor, nor is it simply removed (for example by pain killers), but is appreciated as a creative act of the organism.

The symptom is not (!) categorized as a psychoanalytical conflict to be unearthed (as the generation of medical students after 1945 learned while psychoanalytical postgraduate institutes were being established), but treated as an affective-cognitive or psychodynamic-interactional indication containing a health message. Reading of Shem (1980) was strongly advocated!! – Landmarks along the creation of history-taking groups have been: First, the members of peer groups on history-taking found their transregional identity as equals alongside the psychoanalytical participants and lecturers of the international Balint seminars in Ascona 1975–2000, organized by Boris and Wilma Luban-Plozza. Second, the still growing identity as “anamneslers” locally and trans-regionally was boosted by the annual “May meetings” and through tutorial seminars at varying locations in Germany and Austria. This was supported later by the psychoanalytically trained and regionally practicing colleagues as well (for example Klaus Spiess (2008) in Vienna, Helmut Kächele in Ulm). Here, too, an “intergenerational blending” ensued. However, any efforts to form an association were avoided (unconsciously!). – Third, the peer groups on history-taking groups contributed and still contribute vital incentives to further developing the Balint group idea by participating in the competition for the best patient-oriented work in the German and the international Balint Societies (Stubbe and Petzold 1996; Petzold and Otten 2010). – Fourth, one impetus is decisive because it is repeatedly renewed; that is the impetus between the generations given by group therapists from outside the university. They conduct supervisions both during the semesters and during the May meetings when they actively participate in seminars. “May meetings” because in the German-speaking countries, Ascension Day, always a Thursday, is a holiday and by adding the following weekend, there is a free period of a half a week without university duties (Schüffel 1983b; Loew 1989; Loew and Joraschky 1998).

In the year 1998 it was estimated that about 20.000 German-speaking physicians had gone through this form of group work (Köllner and Loew 1998). In 2019 a rough estimation would be 30.000. History-taking groups are continuing to progress nowadays (2017). In Dresden in 2019 the history-taking groups will celebrate their 50th anniversary, young as always. They can be accredited to a great extent with the fact that since 1969/1970 the idea of group work has become widely accepted in German medicine and its value considered comparable to symptom treatment. Symptom and group have emerged as leitmotif. They have become values in themselves.

Democracy (reality 6): This reality refers to styles of aggression-free exchange between equals in order to develop creative forms of cooperation and coexistence. A primary factor in this is equality between men and women.

That psychosomatics could be established in 37 university departments was made possible by a Parliamentary Act. Psychosomatic rehabilitation clinics can be viewed as indirect federal provisions, much the same as psychosomatic wards in community hospitals (cf. Merkle) and outpatient care can be. The latter has been offered in Germany within the mandated guarantee of public health care since

Bismarck's times when the medical profession as a whole was given the task of ensuring medical care for the entire population (cf. Köllner).

It was certainly no casual stroll through the labyrinth of national institutions. One could simply not back down in any act of persuasion. This is aptly described by the founding dean of the Medical School in Witten/Herdecke: "Europe was at that time as undisturbed about the need for a change in medical education as American Indians were about Christianity before 1492." (Wiedersheim 1989). The choice of words may sound drastic, although they do hit the target: It is not enough to scrutinize curricular developments in medicine consistently across two or three generations; it is a century-long task. One must question figures with highly affective connotations, those that have been considered obvious up to a time. The example from Heinz Wolff's supervision in Marburg concerning women's heart attacks attests to this: According to medical teaching, heart attacks among women were a rarity up until the last decades of the last century. About 10–20 years after the supervision period, this assumption was questioned in Great Britain and taken up in general in medical research over the next years. Today one can find very similar distributions between the genders when the curves are corrected to cover women's longer lifespans in comparison to men's.

The article cited above from Wiedersheim is accompanied by 42 other contributions. They form a festschrift in honour of Hannes Pauli (Saladin et al. 1989). The epilogue was written by a woman, a medical student at the time (Sandberg-Tschopp 1989). For those days the gender distribution among the authors is surprising: ten women can be found among the 42 authors. For the medical field at that time, when 95% of the directorial positions were occupied by men, that ratio was almost out of this world. One must consider that the topic was "Integration and Evaluation of affective Learning Goals", the research project mentioned before on socialization of medical doctors. In the section Democracy the purpose is to demonstrate how out of the history-taking groups a sensitivity grew that tied in the verbal relationship between two people but also the aspects beyond verbal exchange (Loew and Joraschky 1998; Loew et al. 2006; Petzold 2015). To put this process in other words, the participants of a developing, undisturbed verbal exchange trace their own sensations and connect them to existing concepts of how they understand (or perceive) symptoms in order to prepare the next step or to take it, meaning to act. This kind of process can be followed through four constellations of group work that have formed themselves over the last four decades: first, the history-taking group; second, the psychosomatic primary care; third, the Wartburg dialogue; fourth, the Health Group. The total of these four group constructs will be summarized under the term "MOVING SEMINAR" (Schüffel and Schiltenwolf 2011; Schüffel, Leydenbach and Hashizume 2019).

1. In the peer groups on history-taking group (Schüffel 1983a, b; Schairer 1983) preclinical and clinical students perceive how they observe the dialogue between a fellow student and a patient and what the underlying realities can be. They notice how clinical and preclinical students have different perspectives depending on the level they've reached in their education and also depending on the

attitude and gender. The question is therefore not only about one interpretation of a symptom, but also about how to form an agreement between the participants' various interpretations and to acknowledge the participants in their individuality.

2. In the psychosomatic primary care, general practitioners and other specialists come together in a situation when the attending physician and the patient are both physically present. However, the attending physician and his/her patient have the opportunity here to distance themselves from one another and observe the other as a personally (!) responding individual. This takes place in a circle of forty physicians from various disciplines, both genders, and different age groups (Schüffel 1988, 2006, 2009). Creative therapists are also present to support the process of identifying different realities; they sketch a so-called life-parabola during the discussion or illustrate a situation within the session in moving pictures and draw these pictures into the discussion. With a parabola, a seemingly simple technique is used to illustrate the annual routine in a person's life in the form of a parabola, or V-shaped, by plotting the life events on the exterior and the illnesses in the interior. The outside and the inside are highlighted in colors that reflect a predominant mood. Patients can then accept long rejected suggestions of a connection between biography, illness and mood. They accept their corporeality.
3. In the Wartburg dialogues, the discussion on primary care and a Balint group dialogue are compared on two different days (Petzold 2008a, b). The goal is to put preferably salutogenic expectations and attitudes in effect within the next year (Leydenbach 2012; Petzold and Schüffel 2018). The comparison of the group discussions takes place in an auditorium holding about forty participants, about the same size as the discussion in psychosomatic primary care. It is of utmost importance that the work is balanced as well as possible between the genders, between medical disciplines and extra-medical facilities, and between the generations. An environment like this can promote the physical reference of self-experience with more impact than in the history-taking group or in psychosomatic primary care. The dialogue takes place once a year, unlike psychosomatic primary care which is distributed across the year in four blocks of 20 hours each (the Balint group work is an integral part of this!). It is a matter of acknowledging salutogenesis (Antonovsky 1987; Prywes 1994; Schulz-Jander 2008).
4. The Health Group: In groups of 12–16 participants, students around the age of 20 meet with senior citizens of an average age over 70 to discuss the course of their health over the past week. This is an elective course whose grade is calculated into the cumulative grade of the federal Medical Board exam. The students report about the progress of their studies and about their private lives; the senior citizens speak primarily about their health condition, which is naturally much more unstable than that of the students. The leitmotif is always the physical well-being, which by now is connected to life events and symptom or bodily sensations in the context of the parabola described above. This differs from the psychosomatic primary care and the Wartburg dialogues in that the senior citizens have now internalized perspectives, enabling them to guide the students in a physically descriptive way to various realities. The health group in turn partici-

pates in the yearly Wartburg dialogues and thus provides for a high degree of continuity. This in turn is most conducive to strengthening the sense of coherency as described by Antonovsky (1987).

Thus, over the decades (Deter and Schüffel 1988), the working process has evolved into four phases based on physical self-experience within the group. It is self-guided without losing sight of the organism “health care” it belongs to. Most importantly, it has developed among the institutions of university, state Chambers of Physicians, the Association of Statutory Health Insurance Physicians and the associations of medical specialist fields, and notably inspired from the start by the cooperation between psychosomatics and general medicine (Mader 2016). It is a matter of appreciating the generations and their succession (Fenner 2012; Maoz 1998; Maoz et al. 1992, 2006; Martin 2003; Spies 2012).

Dwelling: Culture, i.e. Reality 7, – Overcoming a Philosophy of the 17th Century

In the 1980’s, or one generation ago, G. L. Engel already voiced the demand that medicine should abandon a philosophy of the seventeenth century (Engel 1988, 1997). This includes the call to see medicine as a cultural institution. At the same time he pointed out that the medical field of the twentieth century was deeply rooted in this obsolete philosophy. Engel was speaking in the same voice as his German colleagues, the neurologist Viktor von Weizsäcker and the internist Thure von Uexküll, both introduced above. Engel’s publication set a precedent as he described how fundamental affects from both physician and patient were assessed during an exchange between them, and how these affects became signposts for the dialogue’s direction. The exchange lasted 18 minutes at the time. It made both the diagnostics and the start of a trusting relationship possible. Engel achieved this by focusing exclusively on the complaints and observing how the patient dealt with them in an oscillating, affective manner of approach and avoidance. It was the experience as an identical twin he used to introduce this process to the reader. Engel’s identical twin brother Frank (1913–1963), with whom he had grown up in an extremely close relationship, suffered a fatal heart attack. George (1913–1992) was struck by the same fate 6 months later, within the same year as his brother’s death. However, as internist in his own clinic, he survived because he was under 24-hour surveillance with pulse-reading and could be revived in case of another emergency. George survived his heart attack by nearly 30 years. I speak of “his” heart attack to emphasize the psychosomatic understanding that “the” heart attack is nonexistent (just as little as there is the depression or the gall bladder infection; instead, the depressive individual or the gall bladder individual). – The 30-year period of survival was part of a highly productive life during which George L. Engel became one of the most renowned and influential psychosomatic physicians of the past century whose work extends into the present.

How does one understand George Engel’s reality? Although Engel’s biography has been available in written texts, it has not yet been interpreted in any satisfying way. – The explanation is in my opinion that George Engel allowed himself to be guided by his affects that he perceived and interpreted in the form of countertransference (cf. History of Psychosomatic Medicine in Europe). One could say this

enabled him to link at any time the symptom with the seven realities described here. This he did by tying in the four moving phenomena. In doing so he traced the symptom with utmost precision (Morgan and Engel 1969) and recognized the affects in all their consequences. Engel's most serious affect was deeply rooted in lifelong coping with the loss of his twin brother, which spilled over to the most diverse areas. This perhaps can be comprehended best with the help of works of Western world literature gathered under the term "Mimesis" (Auerbach 1946, 2003). – H. Leigh, editor of the present book, uses the expression "memes" as a substitute for the word "mind" (Leigh 2010). His purpose in doing this is to render the misleading, because implicitly divisive term "psychosomatic" dispensable. "The term meme was coined by Richard Dawkins (1976). – For the future, considerable conceptual study is still needed to clarify the mutual relationship between the two terms (cf. Outlook of this book).

What can we conclude from this? No one can expect the participants to expose their personal phantasies in all their affective shades or to behave like an identical twin toward a patient. What indeed is possible is to provide the space for partial phantasies and "part-enactments" and most of all "part-sensations" to take effect. Instrumental to this is that physicians engage themselves individually and collectively with their patients to the extent that they live through the doctor-patient dialogue and convey their own impressions of it as freely as possible. In the presence of the other group members the individual doctor-patient dialogue becomes the topic of a group-specific, or more precisely a group-individual reflection. Besides the two factors "individual, symptom-accepting dialogue" and "individual group situation", the physical presence of the attending physician is the third and the location the fourth factor of particular pertinence.

In his time, Engel did not have the resources for this kind of group work. He was the pioneer who together with Arthur Schmale and often against the fierce resistance of traditional psychoanalysts and (pseudo-scientifically trained) medical colleagues, comprehended the importance of psychodynamic-psychoanalytic behaviors and conceptualized them.

Over a generation later this situation has been thoroughly transformed: Group techniques enable us to implement the dynamics of a doctor-patient relationship as described above and apply them in a medical sense. To understand this we must look back at the situation in the Fifteenth/sixteenth century, the period that leads into the seventeenth century Engel spoke of. This is the Age of Humanism and the profound awareness of a human being's autonomy for which oneself is responsible (cf. History of Psychosomatic Medicine in Europe; esp. about Luther and Zwingli) (Carrasco and Neebe 2015).

Decisive here is the phantasy and simultaneous experience of dwelling, or, that the word becomes flesh. Admittedly, this is expressed at first in a theological context (John 1:14). However, the idea appears at the start of a development that eventually leads to the Enlightenment and then to German Romanticism. The latter in turn influenced psychosomatics at the beginning of the twentieth century as a counter-movement to the ideal of a purely (natural)scientific medicine primarily in Germany

in the second half of the nineteenth century which was greatly admired at that time (Watson 2010). This came to an abrupt stop with the rise of National Socialism.

At the end of the war in May 1945, Germany and its entire culture lay in shambles. A mourning phase was hardly or not at all possible. The first task was to rebuild. An illness like PTSD was frankly out of the question: Each person had learned to appear courageous and seemingly unscathed, to show oneself unmoved. The effects of stress-related illness or even the acceptance of affects in the sense of illness surfaced only after delay, as described in the chapter “History of Psychosomatic Medicine in Europe”. Only gradually did the term PTSD find its way into the German vocabulary (Arbeitsgruppe Stolzenbachhilfe (Study group Stolzenbachhilfe) 1992; Schüffel and Schade 1998; Schüffel and Schunk 2001), and after some time the German-speaking Society for Psychotraumatology (1998) took form, although a European society for scientific research in traumatic stress had long since existed in the cooperation of Western European countries. – Thanks to the favorable conditions of a new reform university in Ulm, the promotion through Thure von Uexküll, later through Hannes Pauli (Schüffel and Pauli 1997), and a continuous cooperation with the Heidelberg Group under Paul Christian and Peter Hahn (successor to Viktor von Weizsäcker) (cf. Chapter 3.2: Elisabeth Church, drawn by P. Hahn), it was possible to turn to the topic of socialization. At the core of the insights gained thus far lies what in the following.

Moving Seminar

In a literally epochal way Viktor von Weizsäcker spoke of the “manifestation of a truth” (1926). The gist of his statement at the time was that pain indicates a disturbance in a person’s life, and added: “Along Ariadne’s thread of pain one can trace through the fabric of a life, the cut of fabric that reveals a manifested truth, the manifestation of a truth, of a life reality; for pain can only appear where a genuine belonging is threatened, a genuine sacrifice is made”. To this I add: Pain is but one of the many symptoms cited above that can be assessed in this way.

The Moving Seminar: Embrace Moving Phenomena, Take the Next Step

In the section “Family Medicine” of this chapter, we speak of “dysfunctional” patterns in bodily-physical behavior and about how it is possible to develop new salutogenic patterns (cf. Herrmann, Veit). Dysfunctional patterns can be resolved in a crisis situation as described in the section “Rehabilitation” (Köllner). In the “History of Psychosomatic Medicine in Europe” chapter in this book, I describe how a dysfunctional pattern of back pain was endured a lifelong, nearly half-century, was treated medically many times over, and was finally converted into the eufunctional pattern of a somersault (Petzold 2015). For the reader with German language knowledge, a detailed description of the appropriate way to proceed is available (Schüffel and Schiltewolf 2011; Petzold and Schüffel 2018). – In the section on family medicine is a case of affective disorder in a 26-year old civil administrator; in the section on rehabilitation is the case of a 43-year old patient as an example of chronic PTSD. The 57-year old colleague Dr. E. suffered somatoform disorders with iatrogenic components.

To comprehend these three clinical pictures, the studies in new phenomenology following Edmund Husserl's works play an important role. Herrmann and Veit have also pointed them out already. The fundamental premises state (Welton 2012): Each symptom has a "*truth-bearing function*". To explain this function, both origin and goal of the symptoms' bearer, the sufferer, must be considered. As an example, we can trace the symptoms of fear and turning red in the face observed in the 26-year old civil administrator's performance (cf. Herrmann, Veit) in contact with his doctor and her (the doctor's) affective behavior in the group work. This takes place in a four-step process according to the acronym $2 \times W, 2 \times S$ – wishing, warding off, suspending, solving:

First: The civil administrator wished himself to be a man full of vigor. – Second: He warded off feelings of weakness, failure and anger. At this point the physician perceived only the anger, but could interpret it further as countertransference. – Third: The etiological work was then suspended to focus more strongly on setting the goals. The physician thus spoke and behaved in a salutogenic way about how the patient could justify his absence with medical treatment and issued the required verification. Then she could go through the patient's situation and real life connections to determine at which levels he experienced anger. – Fourth: From this point on the work was focused on solving the set of problems. This would certainly have a bearing on the still-married couple's relationship. In his bonding behavior the patient still felt impotent, like a 6-year, as was the author's impression. Furthermore, in view of his mother's death in his sixth year he was completely powerless; again, he felt impotent. His present situation revived the "old" situation of the six-year-old's with overwhelming force, so that the situation was no longer in the past, but immediate and currently effective without his being able to verbalize it. – The physician, on the other hand, sensed this situation consciously without wanting to interpret it as causal. Instead she took a goal-oriented approach to the set of problems and in the subsequent work with the patient, pointed out his experiences in dealing with helplessness. The task now – as a form of permanent solution – is to work through the infantile images in a cooperative context as described by Freud, thus to formulate the problem in a four-step process, to position oneself, to role play the situation in trial enactments, and finally to anticipate in a subsequent step. To formulate the problem essentially means to define and delimit. To position oneself is to step over a threshold. Role playing means becoming a gate keeper. Anticipation is ultimately forming attachments to oneself and to others. It also shows the certainty the next breath – attachment – will come (Donn Welton, in collaboration with Wolfram Schüffel, 2012).

The next step will always involve a partial solution. This applies as much to treatment in regional care provision as it does to rehabilitation. With unresolved partial problems the patient will return to his/her general practitioner. The treatment here will continue on a different level. Psychosomatic medicine as a conviction is nothing other than the need to accept partial treatment and to provide for its validity. – Psychosomatic medicine as a discipline is to develop the respective means and create the space in which the patient can achieve goals.

Anticipating the next step within a psychosomatically-based treatment is nothing more than knowing: “I will be able to breath”. We could also say: “Breath the fear away,” also breathe away depression (Schüffel et al. 2019).

Psychosomatic diagnostics, therapy, rehabilitation, research and finally prevention will stand or fall with the question whether we can succeed in the future in creating that ungoverned or little-governed space within which the patient will verbally participate. This is not at all comparable to the “shared decision” commonly referred to. Rather, it is a space in which democratic forms are accepted and the next step is taken only with continuous, reciprocal reflection. It is a space where we are prepared to accept the basic matrix of our lives that was woven in intrauterine and prenatal, and ultimately perinatal experience. A matrix that ultimately implicates anticipating some point at which we will not be able any more to breath for COPD, heart failure, fatigue or some other condition of suffering. Yet at the same time it tells us that when we consider the two end points of our lives, we can always develop that individual autonomy that we have collectively achieved in the European culture.

11.6 Relevance of Psychosomatic Medicine at Medical Faculties in Germany

Martin Teufel

11.6.1 Medical Education and University Medicine

In 1970 psychosomatic medicine became an essential discipline in the education of medical students at the 37 official medical faculties in Germany. The majority of medical faculties then decided to establish departments or clinics of psychosomatic medicine at university hospitals (Herzog et al. 2014; Kruse et al. 2014; Zipfel et al. 2016). The curricula of these departments not only cover the topic of psychosomatic medicine – their disorders, diagnostic methods and treatment methods – but also communication skills within the framework of a competence-based medical curriculum (NKLM) (Weidner et al. 2015). Psychosomatic medicine became a core subject in medical education in Germany. The university departments of psychosomatic medicine became involved in the development and evaluation of modern teaching formats (Deter and Schüffel 1988; Deter 2004).

Longitudinal communication curricula addressing patient-doctor interaction and relationship are most often implemented by the department of psychosomatic medicine. Teaching psychosocial skills begins in the preclinical medical education, is followed up through the whole major course and culminates in the elective (last year of education) (Zipfel et al. 2016).

Peer-groups on History in medical education: a way to implement psychosomatic thinking and acting in future physicians.

The model for practicing medical interviewing in peer-guided history-taking groups emerged from a student initiative to support patient-centered approaches in undergraduate medical education. Beginning in Germany in 1969, history-taking groups spread across Europe. Today, peer-guided history-taking groups are offered at medical faculties in Germany, Austria, Switzerland, and Denmark. These group courses were likely to occur in the context of students' self-organization and apart from the regular curriculum. Yet, they have increasingly been offered as elective courses embedded within a longitudinal communication skills curriculum (Keifenheim et al. 2014, 2015, 2017).

History-taking groups consist of about six to eight student participants from both preclinical and clinical backgrounds, as well as two peer tutors who are at least in their second year. At some medical schools, medical students and psychology students attend groups together, both as participants and peer tutors. If possible, tutors work in mixed-gender pairs. Group sessions take place once per week, typically in the evening. In the first session, peer tutors address the structure and content of the medical interview as well as basic techniques for interviewing. In each subsequent session, one of the students takes the medical history of a real patient, an inpatient from a different hospital ward each week, in front of the group of students. By having a patient from a different ward (e.g., internal medicine, surgery, psychiatry, orthopedics, and gynecology), interview models offer a broad perspective. The interview is followed by a feedback session and group discussion without the patient. Feedback sessions focus on not only technical aspects of the interview but also student–patient interaction and the student's management of the patient's emotional demands, for example, anxiety, grief, and responses to chronic disease. Peer tutors involved in the process are trained in special workshops and are supervised regularly.

In history-taking groups, learning objectives include improving students' interview skills, enabling them to foster confident relationships with patients, increasing their awareness of patient-centered approaches, facilitating empathy, and encouraging self-reflection. Additionally, students gain awareness of interpersonal dimensions and learn how to actively and authentically participate in conversations with patients. Beyond improving interview management, history-taking groups also support medical students' development as professional physicians. During this process, students may acquire and refine fundamental professional values as well as ethical and social attitudes (Keifenheim et al. 2015)

11.6.2 Research

In the first two decades after the nationwide implementation of psychosomatic medical departments at university hospitals in 1970, research was not a high priority. In 1986, the government's central scientific advisory board criticized the state of

research in the field of psychosomatic medicine. Since this attention alert a focus on psychosomatic research has developed steadily. Down to the present day profound changes have taken place. Today, German psychosomatic medicine plays an active role in all areas of medical and clinical research fields (Herzog et al. 2014; Kruse et al. 2014; Zipfel et al. 2016).

11.6.2.1 German Psychosomatics and Clinical Research

Over the last years the conception, implementation and evaluation of manualized disorder-oriented psychotherapies in various psychosomatic and mental disorders emerged as a strength in clinical psychosomatic research (e.g., the SPIRR-CAD study (Albus et al. 2011) in depressed patients with coronary heart disease and chronic heart failure (Lossnitzer et al. 2013), the PISO study (Sattel et al. 2012) in somatoform disorders, the ANTOP study in anorexia nervosa (Zipfel et al. 2014 (A)), or studies in social phobia (Leichsenring et al. 2013)). Psycho-oncology is a rapidly growing research area of interest in psychosomatic medicine, from diagnostic to interventional studies (Schaeffeler et al. 2015). Most of these multi-site RCTs have been carried out according to strict regulatory requirements to provide for quality clinical practice.

11.6.3 German Psychosomatics and Basic Science

There is a long-standing tradition of basic research in the domains of psychophysiology, stress and mechanism-oriented research. Activities in neuroscientific research (neurocognition, neuroimaging, and neuroimmunology) are on the increase. Animal or wet laboratory research is in its early stages but developing. The importance of the German psychosomatic collaborative research networks is growing (Zipfel et al. 2016).

11.6.4 Psychosomatic Medicine Societies and Academic Development

The German College of Psychosomatic Medicine (DKPM), founded in 1974 by Thure von Uexküll and colleagues, is an interdisciplinary scientific professional association for physicians, psychologists, and other professions and has about 450 members. In this society research and interdisciplinary academic activities are coordinated and represented to the public. The German Society for Psychosomatic Medicine and Medical Psychotherapy (DGPM), the medical association for the field of psychosomatic medicine, was founded in 1992 and has about 1300 fellows.

The close relationship between the two societies (each of them addressing complementary issues) represents a relevant basis for a successful and well performing development in university medicine, medical education and research (Herzog et al. 2014; Zipfel et al. 2016).

11.6.5 *German Psychosomatic Medicine: A Timely Model?*

The integration of psychosomatic medicine in medical faculties, university medicine, and medical education as a distinct discipline, not only as CL-Psychiatry, represents a relevant reason for the successful development over the last decades. Productive psychosomatic research as well as the repeated contact of medical students to the institutionalized discipline “psychosomatic medicine” led to an affirmative self-understanding. As pointed out by Zipfel et al. the German model is “a strong advocate for psychotherapy in medicine and thus more than ever a strong partner for a bio-psycho-social medicine in the 21st century”.

11.7 Summary and Conclusion

The **six authors** present five pillars promoting Psychosomatic Medicine (PM) in Germany namely (1) Family Medicine, (2) Regional Health Care, (3) Transregional Rehabilitation Medicine, (4) Medical Socialization, (5) PM at Medical Schools. The authors proceed from the consensus that health care adheres to both the bio-psycho-social concept and the concept of integrated care. This is officially implemented in the advanced education policy of psychosomatic primary care (PPC) that is mandatory for family physicians and for gynecologists/obstetricians and increasingly accepted in medical practice altogether. PPC comprises 80 hours of advanced education through: 30 hours group work (Balint/interactional), 30 hours verbal intervention, 20 hours theory of PM. Emphasis is laid on experience of the self.

The contents were compiled in the German College of Psychosomatic Medicine (DKPM) in agreement with the German Balint Society and were accepted by the German Medical Association in cooperation with the [Kassenärztliche Bundesvereinigung](#) (KBV; National Association of Statutory Health Insurance Physicians; NASHIP).

In **General Medicine** PM signifies a transition from paternalistic giving advice to an accompanying interaction (Hermann, University Magdeburg; DEGAM, WONCA; Veit, Herne; DEGAM). It pursues to overcome the deeply rooted occidental separation of mind/body medicine of the West. It emphasizes the early origins of bonding behavior and case-related personal relationship as seen from a phenomenological point of view.

This phenomenologically based view is contained in the *position paper* of the Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin, the association

of family physicians in Germany (DEGAM). This society has been in favor of combining practice and research since its foundation in 1964. Their ongoing research reveals a growing satisfaction with PPC on the physicians' side. This development seems to be connected with a reduction in expenses amounting up to 30%.

There were eminent members of DEGAM who in cooperation with DKPM established PPC as a groundbreaking method of further education in PM. Among them were Häussler of Ulm then president of NASHIP and Kerger of Frankfurt and Bad Nauheim resp. who became the first president of DEGAM. It had to be established at a time (in the mid 60ies) when the word "experience of the self" (Selbsterfahrung) sounded odd.

Nowadays there is the position paper of the society containing 14 fundamental positions that describe the family physician's domain of competency. It includes psychosomatic and psychosocial primary care and is based on salutogenic as well as on a team approach (download: www.degam.de/festschrift.html).

Regional Health care and PM: The Heilig Geist Hospital of Frankfurt may be taken as an example its PM being established in 1996. The head physician (Merkle, Frankfurt) comments: "No one could have predicted how fortunate the period of development would be for inpatient and partially for outpatient care". – A concept for treatment has emerged that defines itself by conflict centered group work and intensive individual therapy which draws the body into psychotherapy through creative therapeutic techniques. Nursing has been given a value that is different from the medical value, but starts at par with it. Regular communication between the hospital and the outpatient care has been established. A "string of physicians and therapists" began to form around the hospital.

This direction in medicine inevitably involved continued and postgraduate training that both demanded deepening and broadening the participants' self-conception. It required building up a multifaceted regional and transregional system of continued education on the basis of PPC as it has taken place under the auspices of the Hessian State Chamber of Physicians, Bad Nauheim/Frankfurt.

In this way and within less than 20 years the capacity for PM treatment has grown from the original 100 to 1400 beds throughout Hesse (6 Mio inhabitants) in 2016. Considering that in the meantime the capacity in Germany (80 Mio inhabitants) for acute treatment in PM has grown to over 10.000 beds (in 1990 it was approx. 2.000) and that these beds are financed by the public health insurance it is conceivable that a new approach may have been found to halt the threatening loss of the physician-patient relationship as a healing factor even within high tech medicine. There seems to be a reduction of chronification and iatrogenic damage even within a relatively short time of 20 years' follow up.

Rehabilitation Medicine and PM in present Germany (Köllner, Berlin-Teltow; DRV; Charité) is far beyond the classical health spa. Instead it is based on ICF (international classification of impaired function), on high quality research, on (a modified) continental tradition of rehabilitation with proven efficiency. The striking difference in how to enter the inpatient health care system is that the patient has to apply and the physician (usually the GP) assists. – The histories of people with ICD

diagnoses are *transformed* into histories of ICF. The therapeutic core elements are balneotherapy, group therapy and the team approach of the personnel.

In 2012 approx. 157.000 rehabilitation treatments were conducted in 200 clinics for psychological and psychosomatic disorders. Among them the affective disorders constituted the most frequent initial diagnosis at 52%, followed by neurotic, stress related and somatoform disorders at 40%. The proportion of PM rehabilitation within the overall rehabilitation treatments climbed from 9% in 1995 to 14% in 2010. This is more than coronary heart, neoplasms and musculoskeletal disorders put together.

Research shows that coping related criteria improve and remain stable after discharge (average inpatient treatment of 38 days). Each Euro invested in rehabilitation saves 3.8 E paid for sickness, disability, premature pensions. Traumatic and post traumatic conditions are of major importance although usually not known at the beginning of the stay. As shown in a clinical vignette the most important advantage of rehabilitation is working through long standing traumatic sequelae and getting “fit” for a postclinical therapy at home, i.e. the goal is “*coming home*”. This formulation seems to be most appropriate in a world of 55 million refugees according to WHO.

Socialization and PM is based on the (student-) physician’s awareness, i.e. on the “experience of the self” (Schüffel, Marburg). The experience of the self is geared towards an understanding of the patient’s symptom. The symptom is soaked with a *truth bearing function* trying to transmit to the environment how the individual copes with the situation he/she has to adapt to. The physician in a very subjective way may be sensed and experienced to represent the environment. This is a highly affective process which can be accompanied by the physician’s understanding of the four phenomena of primordial experience, reflection at any time, leitmotif, dwelling.

A “flash forward” to the *primordial experience* of the individual will help to identify elements both of salutogenesis and helplessness, even hopelessness within the self. This is seen to get more insight into the process of transforming and being transformed during undergraduate, postgraduate and continued education. – In order to achieve this in a consistent and sustained, that is coherent manner, a physician should *at any time* remain as *open to bodily sensations as possible*. – In the encounter between (student-)physician and patient the physician recalls the primordial experience and uses it in a perceptual-affective, cognitive and behavioral sense to build upon a *leitmotif*. – What has been happening over a lifetime boosts the physician’s disposition to bio-psycho-social medical treatment. The physician is treating the patient in the sense of an integrated medicine that, when successful, has the word become flesh (manifests experience/*dwelling*).

The four moving phenomena represent the structural emphasis on contemplating on seven realities they are closely interconnected with. – The primordial experience is interconnected with our daily language and how this is turned into a medical language filled up with a verbal, speechless “enactments” (proscenium, emerging reality; realities 1, 2). – Reflection at any time shows that mechanic-

positivistic thinking needs to be weighed against unconscious forces in the background beyond consciously perceived context (context, background; realities 3,4). – Leitmotif is interconnected with the intergenerational view of the symptom and with a male/female exchange on the covered meaning of the symptom. Generation and sex dependent views may be loaded with deep affects and can only be dealt with in problem oriented dialogues between the generations and the sexes provided they are geared toward a “Next (small) Step”. Symptom and group have emerged as leitmotif. They have become values in themselves both united through salutogenesis. It is the salutogenic approach to symptom treatment that is suggested. This is exemplified by working with pain prone patients and their traumatic histories. By this pain becomes a problem of democracy (rhythm, democracy; realities 5, 6). – Dwelling or the word becomes flesh: This is the last, the most original and decisive phenomenon. It decides whether we rely on symbols or a deep transformation of our outer world into our inner world. This again may be exemplified by the biographies of the identical twin brothers Frank (1913–1963) and George L. (1913–1992) Engel. Frank and George both had a myocardial infarction within 6 months. Contrary to all traditional medical and extramedical thinking and expectations George survived his brother Frank for almost 30 years. He led a most productive life (culture; reality 7). It included the introduction of the giving up-given up complex into medicine by George Engel together with Arthur Schmale. This ultimately led to today’s traumatology still to be unearthed in German psychosomatics (Stolzenbachhilfe 1992). – George Engel lucidly asked the even more important and most far reaching question: When will medicine free itself from a philosophy of the seventeenth century and develop a philosophy of its own, i.e. belonging to OUR time? What are the conditions allowing us to work for the future? (Prywes 1994; Schulz-Jander 2008; Geyer 2011)

Medical Faculties and PM: This is the place where the relevance of PM at medical faculties and in universities comes in (Teufel, Essen). In 1970 PM became a core subject in medical education in Germany. The university departments of PM became involved in the development and evaluation of modern teaching formats. In 1969 (1972) a major research project started on the “Integration and evolution of affective learning objectives into the medical curriculum”. It resulted in a group format called *Peer Groups on History Taking* (Peegrohits). They focus on not only technical aspects of the interview but also on student-patient interaction and the student’s management of the patient’s emotional demands like anxiety, grief, and response to chronic disease. During this process, students may acquire and refine fundamental professional values as well as ethical and social attitudes. This original learning format is independent of the regular curriculum but may be modified and included into a longitudinally planned curriculum.

In the late eighties and down to the present day profound changes have taken place in advancing PM research. Manualized disorder-oriented therapies were implemented and evaluated. Emphasis was laid on coronary heart disease, depression in CHD, somatoform disorders, anorexia nervosa, social phobia, psychooncology. There is a longstanding tradition of clinical research but also of basic research reaching back to the twenties and the thirties of the last century.

The German College of Psychosomatic Medicine (DKPM) was founded in 1974 by Thure von Uexküll and colleagues as an interdisciplinary scientific association for physicians, psychologists, and other professions and has about 450 members. It has been in a constant interchange with the European Conference on Psychosomatic Research founded after the war by J.J. Groen and D. Leigh (now the European Association for Psychosomatic Medicine/EAPM) and with the ICPM (First President: E. Wittkower). In this society research and interdisciplinary academics activities are coordinated and represented to the public. It closely cooperates with the German Society for PM and Medical Psychotherapy founded in 1992 and having about 1300 members. Their annual conference takes place in Berlin, March every year having an English speaking track (www.deutscher-psychosomatik-kongress.de).

In conclusion, the *zeitgeist* in present Germany allows for the *experience of the self*. Both the physician and the patient are seen as individuals who are asked what they expect of each other in the NOW (here). The NOW (here) is embedded in past, presence, future.

Seen from outside the expectations are filtered differently. They are filtered, i.e. evaluated either according to ICD or to ICF. ICD is the official system to classify disorders and diseases in outpatients as well as in (acute)hospital patient care. ICF however is the official system of rehabilitation medicine to classify not disorders or diseases but *functions*.

The *zeitgeist* allows to take a closer look at the filters mentioned. The symptom having a truth bearing function may be seen not as a (semi-)permeable membrane but as a living filter, a kind of organic skin. ICD and/or ICF may be seen as the living filters of the physicians and their coworkers.. The future will show how the thread of biography, transdisciplinary exchange, and trauma beyond biography will lead to using both classification systems and come to an agreement how to construe the next step.

Meme, Memesis, and MOSE. – It may be helpful to consider the concept of meme as defined by Dawkins and adapted by Leigh in the context of mimesis (Auerbach 1946, 2003). Mimesis helps to understand how man interprets narratives, i.e. History. MOSE stand for the four forms of the Moving Seminar (Schüffel). Dr. E., the clerk, and the cashier and their histories introduced within the text are living examples how PM may be developed with the next step. This is particularly true in the case of Dr. E. who is going to take over the leadership of the Wartburg Dialogue by saying: I do nothing else but leading health talks the whole day long.

Questionnaire Response

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry in your (or your chapter's) Country.

Please return this as an attachment to your email

Country on which you are reporting:

Your Name: Prof. emeritus Dr. med. Wolfram Schüffel, Marburg, Germany

Institution: Department Psychosomatic Medicine and Psychotherapy, Philipps University

City & Country (e.g. London, UK): Marburg, Germany

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?
 Yes (x) No () In some sense ()
 - a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes (x) No ()
 - b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes () No (x)
2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?
 Yes (x) No ()
3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?
 Yes () No (x)
4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes (x) No ()
 - a. If YES, which?
 Psychosomatic Medicine (x) Consultation-Liaison Psychiatry ()
 - b. If YES, the status of such certification is:
 - i. Independent Medical Specialty (x)
 - ii. Subspecialty of Internal Medicine ()
 - iii. Subspecialty of Psychiatry ()
 - iv. An independent non-medical discipline, as Psychology, Social Work ()
 - v. Other (Specify):[]

5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No ()

If YES, please list names of the organizations and the websites if available:

Deutsches Kollegium für Psychosomatische Medizin (DKPM) - German College of Psychosomatic Medicine; Prof.Dr.S. Zipfel; stephan.zipfel@uni-tuebingen.de www.dkpm.de
Deutsche Gesellschaft für Psychosomatik und ärztliche Psychotherapie (DGPM) www.dgpm.de
info@dgpm.de

6. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:

Ärztliche Psychotherapie und Psychosomatische Medizin - Balint Journal - Zeitschrift Psychosomatische Medizin und Psychotherapie - Psychodynamische Psychotherapie - Psychotherapie, Psychosomatik, Medizinische Psychologie -

7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in your country? Yes () No ()

a. If YES, where does it occur? Check all that apply:

Medical School () Residency (ca. 120) Fellowship (ca 120)

8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes () No ()
9. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)

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Chapter 12

Psychosomatic Medicine in France



Pascal-Henri Keller and Theo Leydenbach

12.1 Introduction

Contrary to their counterparts in certain European countries and Germany in particular, French practitioners and theoreticians in psychosomatics have not obtained institutional recognition and academic status. There is thus in France no official Chair of Psychosomatic Medicine, nor are there hospital departments officially dedicated to psychosomatic medicine. Nevertheless, there exist within France a number of personal or collective initiatives that consider and help to promote the psyche-soma dynamic in clinical situations. The following pages, dedicated to psychosomatics in France, develop the subject first on the historical plane, then on the epistemological one. Presented here are the principal movements and authors in their particular contexts, as well as the debates they provoked and continue to nurture.

12.2 History of the Psychosomatic Approach in France

Pascal-Henri Keller

Since Antiquity, the model proposed by Greek medicine has spread throughout Europe. However, if one considers that the ancestors of European medicine – Hippocrates in particular – had intuitively used a pre-psychosomatic model in which the mind was rooted in the body (Kamieniecki 1994), one must admit that the

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hypotheses established in psychosomatics since the twentieth century were quite different from these Ancient intuitions.

The Greek influence has manifested itself throughout the years in medical thinking in France where, over centuries, the theory of the four humors present in the body was taught (blood, phlegm, yellow bile, black bile, a balance of which guaranteed good physical and moral health). For example, the melancholic state was explained by an excess of black bile.

This historical effort to rationalize the understanding of physical and psychic illnesses did not prevent the development of irrational beliefs and practices in the field. In the Middle Ages, it was thus believed that the king, sacred by coronation as he was, possessed the power of healing. The first king to exercise this miraculous power was Louis VI (1108–1137), called “The Fat”, healing the ill by touching and blessing them. Later becoming a true ritual, this royal touch was named “the Touch of the Scrofula” after lesions that were common at that time. As legend goes, the King Saint Louis (1214–1270) added the phrase “*the King touches thee, God heals thee*”, which his successors associated to the ritual. Thus, during his reign, Louis XIV (1638–1715), “The Sun King”, touched almost 200,000 ill people. One of the final miraculous touches occurred in Jafa in March 1799, when the General Bonaparte, future Emperor Napoleon, placed his hand on the plague-stricken. The famous painting by Antoine-Jean Gros in 1804 immortalized this gesture at his demand, recalling Christ healing the lepers.

During the Renaissance, the principle of an interaction between corporal substances and psychic manifestations was still present in medicine. Leonardo da Vinci was the first to observe the effect of emotions on physical postures and facial expressions, as well as to study the impact of illnesses – rabies, for example – on emotions. The analogy between mind and matter nourishes these reflections, sustaining the idea of the obvious influence of one on the other: “*Iron rusts from disuse, stagnant water loses its purity, and in cold weather becomes frozen; even so does inaction sap the vigors of the mind.*” (da Vinci, *Notebooks*). This representation of the physical and psychic spheres acting on one another would play an important role until the eighteenth century when, just before the Revolution, Franz Anton Mesmer (1734–1815) would announce his discovery of “Animal Magnetism”, which would allow humans to heal each other.

Furthermore, in the period preceding the invention of the word “psychosomatic” by Heinroth in 1818, the influence of the French philosopher René Descartes (1596–1650) should be remembered. Already in 1637, through proposing to study the body and the mind separately, Descartes paradoxically opened the door to the hypothesis on their reciprocal influence, at least in theory.

However, the first true expression of the medical psychosomatic model took place in the nineteenth century. Born in 1801 in Tours, Armand Trousseau was a medical doctor suffering from frequent asthma attacks. One day, surprised by the magnitude of one of these attacks, he formulated for himself the first psychosomatic hypothesis: he supposed that the presence of dust and pollen in suspension in the atmosphere was not in itself sufficient as an explanation. Through methodical introspection, he discovered the circumstances of its initiation and came to

the idea – quite revolutionary for his time – that a “moral emotion” had, as he wrote, “disturbed his nervous system”. He supposed that, when he had discovered that morning his coachman stealing from him, holding back his anger instead of expressing it was the condition of emotional constraint at the origin of this “nervous disturbance”. Lacking any real posterity, this self-observation nevertheless described the schema which, in France, would later structure the psychosomatic approach. In the previous century, another medical doctor, physiologist and philosopher, Pierre-Jean-Georges Cabanis, had distinguished himself during the French Revolution through his materialist conceptions, which inspired a series of writings published in 1802: *On the Relations Between the Physical and Moral Aspects of Man*. From his lecture given at the Academy of Medicine, posterity retains: “brain secretes thought like liver secretes bile”. Unwittingly, Trousseau and Cabanis had anticipated psychosomatic thinking in France, the first through his introspective approach, the second through his attempt at the materialization of thought.

It was only at the beginning of the twentieth century, with the successful introduction of psychoanalysis in France, that Michael Balint would leave his mark on the interaction between medical sciences and psychoanalysis. Balint, a Hungarian-born medical doctor and psychoanalyst who spent most of his life in England, helped to create the link between psychoanalysis and medicine (Balint 1996), thus orienting psychoanalysis towards the psychosomatic field (Moreau Ricaud 2007). We know the importance he gave to the doctor-patient relationship, underlining its unconscious dimension, suggesting that when the doctor gives a prescription, he unknowingly prescribes *himself/herself*.

Contrary to other medical specialties, where the increase of knowledge produces a more homogeneous practice, the development of psychosomatic practice became very heterogeneous.

In general, the development of the psychosomatic approach followed the initial division between the adherents of the humanistic psychosomatic approach, which takes into consideration the hypothesis of the unconscious in the psychic functioning, and those who defend the principle of a body-mind structure common to animals and man. While the first derive from the psychoanalytic movement, splitting into its different theoretical currents, the second situate themselves in the continuation of Pavlovian research and explore in an analogous way the body-mind disorders in animals and humans (Muchielli 1961). In France, this double movement means the separation between, on the one side, the psychoanalytic studies of Pierre Marty, Sami-Ali, Joyce Mc Dougall, Marie-claire Célérier or Jean Guir, and, on the other side, Henri Laborit, Robert Dantzer, Louis Perrin or Marilou Bruchon-Schweitzer.

The practices of the psychosomatic field also follow this double orientation: on the one hand, exploring the life of the psyche (relational isolation, psychotherapy, psychoanalysis, narrativity, meditation, etc.), and, on the other hand, insisting on the physical aspect of the troubles (sleep therapy, thermal therapy, hypnosis, coping, etc.). However, some approaches use techniques from both domains (relaxation, biofeedback, Gestalt therapy, etc.).

This heterogeneous ensemble also manifested itself through a conceptual heterogeneity. It was thus only in 1960 that the first congress of psychosomatic medicine took place, with the title: *Theoretical and Practical Aspects of Psychosomatic Medicine* (Delay 1961).

12.3 French Theories and Notions in Psychosomatics

Pascal-Henri Keller

As Jean Delay wrote in 1961: “The contemporary psychosomatic movement represents the convergence of numerous research approaches which claim to be representative of tendencies as heterogeneous as those of Canon, Pavlov and Freud, followed by works as different as those of Selye, Bykow and Alexander”. For Delay, this diversity reflects the attempt to integrate the different data belonging to the individual understood as a whole, i. e. the very basis of the questions raised in psychosomatics.

In the second half of the twentieth century, attempts at theoretical elaboration began to develop in France, mainly from psychoanalytic framework. All of these attempts did not explicitly claim to be representative of “psychosomatic medicine”; their authors, however, worked with notions that fused organic symptomatology with partially defective psychic functioning. Thus, Valabrega (Valabrega 1954) tried to develop ancient psychoanalytic notions in order to give them life in this new field of clinical investigation: “What we understand as conversion, is embodiment, a universal rootedness in the body, not only in every symptom, but in every drive, in every dream, in every language, in short, every and any psychic or psychosomatic production” (Valabrega 1980, p27). Medical doctor and psychoanalyst, Françoise Dolto proceeded in different texts to the same actualization of the psychoanalytic corpus, through the actual symptomatology (Dolto 1984). She stated, for example, that in hysteria like in psychosomatics, “the ill person truly suffers and is hindered in his or her psychosocial activity” (Dolto 1984). Psychosomatic problems, in her opinion, would in part find their origin in childhood, because that which is “spoken” or “silenced” by the parents may have its effect on the actual body of the child and trigger symptoms, often benign but occasionally serious. Referring to her work with children, Françoise Dolto thus considered that the infantile body had particular status on the psychosomatic plane: “the body [...], in its disorders and in its order, greatly precedes verbal language, is an expression of truth in its healthy or ill functioning” (Dolto 1979). The *Green Houses* which she put in place were thus destined to protect children not only from early neurosis, but also from psychosomatic illness (Aubry et al. 1988). Not so much a place of therapy as one of conviviality, *Green Houses* allow small children, accompanied by their parents or caretakers, the opportunity to be heard and feel at home, the goal being to prevent relational and functional disorders.

In the 1970s, the physician and psychoanalyst Pierre Marty, former companion of Jacques Lacan, founded the most important school of psychosomatic medicine in France: The Psychosomatic School of Paris ([Institut psychosomatique de Paris](#)). Marty's primary objective was to "work out a system in psychosomatics analogous to the metapsychology in psychoanalysis", trying to hone in on a "metapsychosomatology" (Marty et al. 1963). He wanted for this new discipline to find its "own nosographic criteria", in order to become autonomous. According to Hanna Kamieniecki, a historian of this current, psychosomatic medicine should aim at "the unity of the human person, in the singularity of its being" and thus "reflect psychoanalytically on the relationship between the subject and its body" (Kamienicki 1994, p 123).

In his new approach of "psychosomatic investigation" (Marty et al. 1963), the founder of the Paris school distinguished himself from the practices of Franz Alexander, his predecessor in the United States, founder of the Chicago school and author of the first official manual of psychosomatic medicine (Alexander 1977). Notably, Marty opposed one important notion, the psychosomatic specificity. Contrary to the teachings of Alexander, Marty considered that the psychosomatic symptom did not depend on a congenital anomaly revealed by a serious psychic destabilization, nor on a psychic conflict which was reflected in the functional impairment. Marty taught that "a specific somatic illness, belonging to the classical medical nosography (bronchial asthma, for example) may occur in different conditions from one individual to another, sometimes different even within the same subject at different moments. The knowledge of the structure of the subject, as well as the appreciation of any variations in this structure, are always necessary to establish a diagnosis, to estimate a prognosis, to decide on a therapy" (Fain and Dejours 1984). The term "structure" used by Marty refers to the ways in which character neuroses are structured, favorable to the disorganization which Marty himself described. The specific psychosomatic structure should thus be examined on the psychic plane and not in reference to a congenital organic fragility. The founder of the first French institute of psychosomatics thus mentioned a "robot-portrait of the psychosomatic patient" as a psychological description. He summarized this in the well-known formula which aims to keep the psychosomatic clinician away from the physical location of the illness: "the psychosomatic symptom is stupid".

Throughout his work, Marty tried – without success – to establish the notion of a psychic life specific to psychosomatic patients: operational thinking (*pensée opératoire*). Although this mode of thinking has been clinically observed (factual discourse, oneiric poverty, non-existent fantasy life, semantic field restrained to the concrete, limited relational curiosity, etc.), we know today that this is not exclusive to patients with psychosomatic problems. And if in some patients there does exist a kind of "operational interior life", this does not necessarily reflect a defective mental functioning. For example, operational thinking could reflect life conditions which don't allow much self-reflection. In addition, in order to clarify what he believed to be the "structure" of psychosomatic patients, Marty hypothesized the existence of an "essential depression" which would explain "a reduction in the tonus of life instincts on the plane of mental functions" (Marty 1980, p 59).

Some of Marty's followers, such as Christophe Dejours, have carried on his work in this sense. For this medical doctor and psychoanalyst, psychosomatic medicine is a medical specialty which proposes a "specific reading of the illness [...], such as in cancer where one could simultaneously propose an immunological, virological, cytological, biochemical or biophysical understanding" (Dejours et al. 1980). Delving more deeply into Marty's theoretical work, Dejours brought forth his own conception, giving for example to the libido the status which had been progressively forgotten by the Paris school. Thus, proposing to add the notion of "subversion" to that of "anaclisis" (attachment) in the first Freudian drive theory, Dejours showed that the physiological functions could be diverted from their first objective by the libido, as in anorexia. He went even further, estimating that, in reality, the "biological body" as a whole could thus be diverted, in favor of the constitution of the "erotic body". Subversion was thus understood as the reversal of an established order – that of biological laws – in favor of another order, that of libidinal economy. Dejours stated that "thanks to the development of the psychic sexuality and of the erotic body, the subject succeeds in partially freeing himself from his physiological functions, instincts, automatic behaviours and reflexes, even biological rhythms" (Dejours 1989). The repercussions of these conceptual rearrangements were of interest to the psychosomatic clinic: "if certain perturbations occur in the psychic functioning, which alter the economy of the erotic body, a risk of psychosomatic illness appears at the same time". This hypothesis suggested that "if the libidinal subversion doesn't grant so to speak an additional solidity to the physiological functioning, in any case the loss of attachment seems to be of some danger to the health of the body" (Dejours 1989). While refuting any "hierarchy of the functions" between the physical and the psychic, Dejours described nevertheless the following general process: the destabilisation of the psychic function (under the influence of the libidinal economy) may entail disorders of the physical function (under the control, however, of the laws of nature).

At the same time, opposing the whole of the French psychosomatic thinking, another psychosomatic school elaborated its own theorization, drawing on other notions, taught by Jacques Lacan. A lecture held by Lacan in 1975 in Geneva marked the historical beginning of this theorization. Lacan stated the following: "the psychosomatic has to be targeted through the means of the specific *jouissance* which it has in its fixation" (Lacan 1975, pp. 81–23). Based on this statement, the pupils of Lacan would proceed to isolate the elements constituting this "specific *jouissance*", as well as the modalities which allow the understanding of the "subjective position" of the so called "psychosomatic subject". Ultimately, it appears that this *jouissance* (*jouissance*, whose dictionary translation is "pleasure, joy, rapture" is usually left untranslated by Lacanians, because for Lacan, it is much more, which is untranslatable) reveals its singularity through having been heard by the analyst, thus through having been the object of a discourse addressed to another. Inside the discourse of the patient, Lacan identified a specific dysfunctioning, which the psychoanalyst Jean Guir described in these terms: "The fundamental problem of the psychosomatic phenomenon [PSP] is the following: the paternal metaphor operates in certain parts of the discourse, but not in others. Only certain specific moments of

the discourse trigger a disturbance in the body [...] A failure in this paternal function initiates the psychosomatic phenomenon” (Guir 1986, pp. 57–71). Conducting his research in the context of Lacan’s teachings, Jean Guir searched for recurrences within the organization of the subject’s significance in order to conceptualize their impact on two levels.

On the one hand were “frozen” signifiers (Guir 1983, p. 152) which could not find their place in the “chain of signifiers” which “represents” the subject. These particular signifiers would be thus in some way “imposed” through certain external circumstances, in this sense leading to the failure of the very identity of the subject. The subject, thus constrained to “express” differently his failed identity, does it in the real body through the formation of the PSP.

On the other hand, in regards to the localization of the PSP, the lesion corresponded in Jean Guir’s opinion to “the aberrant inscription of the signifiers of the subject’s filiation, [...] the psychosomatic inscription in the patient’s body retrac[ing] the history of someone else’s body”. Based on the words of his patients, Guir presumed that their lesions constituted themselves mimetically in relation to the other’s body, suggesting that the affected organ thus functioned “like an organ stolen from an other, [which] tries to have its *jouissance* as if it belonged to this other” (Guir 1983, p. 18).

Jean Guir tried, like all clinicians/theoreticians in psychosomatics, to solve the problem of a lesional phenomenon appearing during analysis. Lacan compared this phenomenon to a “hieroglyph”, a “cartouche delivering its name” (Laurent 1986, p 33), an elegant expression which allowed to designate, on the one hand, the unsolved part of the PSP enigma, and, on the other hand, its irreducible singularity.

Despite its declared intention to distinguish itself from the other psychoanalytic theories in the psychosomatic field, the Lacanian current revealed itself to be confronted by the same two obstacles: the logic of causal medical reasoning and the dualist logic which allows the presumption of the influence of the “psychic” on the “somatic”. One could see that language, as the expression of the psyche, was seen in this theory as endowed with a kind of autonomy. In the form of these “erratic signifiers”, ready to “crystallize” in the body, the psyche was considered the cause of the PSP. The notion of a failure in the symbolic function of the signifiers demanded once more the isolation, in psychosomatic research, of the markers proving the dysfunctioning of the psyche.

A few years later, Joyce McDougall tried to break from this double logic. She hypothesized that psychosomatic disease doesn’t reveal a neurotic conflict, nor a psychotic conflict, because the sense of the disease is to be found on the “pre-symbolic level and short-circuits the representation of the word”. Every human might possibly somatize at some point. She considered that for some of her patients the state of being ill corresponded to a kind of capacity or competence that allowed them, in a moment of crisis and thanks to the experience of their bodily limits, “to establish for themselves a minimum of separate existence from any other significant object”. Without a strict typology of somatization, McDougall nevertheless identified different psychic traits which she detailed in her book, “Theaters of the

Body” (McDougall 1989). She thus postulated, based on her clinical activity, the reality of “psychosomatic disease”. MC Célérier, another psychoanalyst, came to similar findings. In her opinion, psychosomatic patients have psychically formed themselves to relate to themselves only through the body, a “disaffected” body, i. e. lacking affect.

The link between these two female psychoanalysts is two-fold. On the one hand, the existence of “psychosomatic patients” meant for both of them a clinical reality that corresponded to a physical weakening, which was itself in part connected to a partial fading of the protective function of the psyche. On the other hand, in order to explain the occurrence of their illnesses, each proposed to her own patients a different model of psychic functioning. For McDougall, it is the “collapse of the oneiric function [which] blocks the release of tension through hallucinatory satisfaction [...]. When these releases take the shortest way and the closest to the physiological, [...], the psyche then releases its tension without language!”. In contrast, for Célérier, it is the physical “disaffection” that makes the patient’s body vulnerable “more than any other [...] to moral wounds, to aggressions and separations” (Célérier 1989, p 47). As for the therapeutic approach, while for Célérier it is comparable to McDougall in the case of those patients who “are strangely similar in their behaviour, their personality traits and that which appears in their relations to others and to themselves” (Célérier 1989, p 89), McDougall required “long years of psychoanalysis for some [of them] to understand that in situations of stress they revealed themselves to be alexithymic or operational” (Célérier 1989, p 41). In the French context, Joyce McDougall was close to the Paris school and to its theory of a deficiency of the preconscious as the cause of a psychosomatic disorganization. However, she clearly distinguished herself in refuting the notion of the “phantasmatic poverty” of “somatizing” patients. On the contrary, she identified the presence of specific phantasms in their discourse, such as the phantasm of “a body for two”, the occurrence of which she strongly favored in transference (McDougall 1986, pp. 95–43).

This reference to psychoanalytic transference in the case of “psychosomatic” patients was of fundamental importance yet rarely evoked by psychoanalysts. More concentrated on their theoretical concerns than on the handling of transference in their work with psychosomatic patients, French psychoanalysts sometimes used certain literary texts just to validate their theories. This was the case of *Mars* by Fritz Zorn, published before his death. In his book, the thirty-year-old Swiss bourgeois described in great detail that which he believed to be at the origin of the incurable illness that seized him. He opened his story with these words: “[...] with what I got from my family during my hardly cheerful existence, the most intelligent thing I ever did was to get cancer” (Zorn 1979, p 33). All throughout this deeply moving account, the author developed this personal interpretation of his cancer, a malignant lymphoma located at the base of his neck.

Although the author of this novel offered his own interpretation, many psychoanalysts who concerned themselves with psychosomatics looked into Zorn’s writing through the lens of their own theories. After having examined and translated certain of the author’s “signifiers”, Jean Guir, for example, affirmed that they tes-

tify Zorn's phantasm on the cause and familial responsibilities of his illness ("Zorn" means *anger*; "Hals", *neck*; "Tränen", *tears held back*, etc.). For M-C. Célérier, on the other hand, Zorn's story testifies the junction in psychosomatics of two severe pathologies: the somatic (cancer) and the psychic (psychosis). As for the psychoanalyst Sami-Ali, whose theory will be expanded on separately, Zorn's account has a paradigmatic status in the context of his "multidimensional model of somatization". He aimed to single out in Zorn's writing that which could validate his own theoretical approach. For example, Sami-Ali emphasized the appearance of an insomnia resistant to all treatment when young Zorn left the family home. Later, he observed another strange behaviour: each new literary work destroyed by fire as a ritual by Zorn himself; according to Sami-Ali, this behaviour reveals the "the repression of the imaginary" from which this young man suffers (Zorn 1979, p 17).

Confronted with different psychosomatic theories within his speciality, the oncologist François-Bernard Michel published in 1987 a work called: "Cancer, Who Is to Blame?" His first chapter also deals with Fritz Zorn's book, and, for the French oncologist, this kind of book simply means that cancer patients are all "looking for the sense in their illness" (Michel 1987).

In examining all of the propositions representative of "psychosomatic medicine" in France, one comes to the conclusion that they all conform to an implicit "defectological" theoretical model (Keller 1995, pp. 153–176). The major psychoanalytic currents have elaborated different models to explain the appearance of physical disorders mainly through the study of the psychic life of the patients. It can be observed that the patients have themselves provided the explanatory schemas of their pathologies to the clinicians. Addressing the psychoanalyst or medical doctor, the patients most often describe a psychic and physical functioning, which, for them, can explain the symptoms: first, they have experienced significant traumas in childhood (death, aggressions, etc.); second, they have specific psychic characteristics related to the conditions of their personal development (inner conflicts, inhibitions, etc.); third, they have undergone particularly strainful and disorganizing life experiences (breakup of a relationship, unemployment, existential crisis, etc.). Based on the interpretations of their patients, French clinicians have built different theories to describe, each in their own way, one or more failures of the psychic apparatus. These psychic failures would be themselves the cause of the failures of the organism, giving rise to the notion of a "defectological" model (Keller 1997, 2008).

The French psychoanalyst André Green qualifies the theory of the "Paris School" as "fictional biology" ("biologie-fiction"). This expression, however, could just as well be applied to the other theories which, without having provided any proof, postulate the existence of causal relations between clearly identified biological phenomena (somatic disorders) and psychic phenomena, revealed by the patients themselves (what they patients say about their suffering). The French clinicians who refer to psychoanalysis are working towards a model which would allow them to abolish this disjunction between the body of the patient and the mind. In reality, however, they have only succeeded in conjoining two words to invent a new one, in

order to point to their professional ideal, no longer only medical doctor, nor only psychoanalyst: *psychosomatician*.

Unable to impose monism in medicine, their initial intention, these practitioners have nevertheless succeeded in mobilizing, in both patients and caregivers, a true interest in language, previously neglected in medicine. At the same time, introducing language into the symptom, they have disqualified its subjective importance and have occulted that it corresponds to a psychic operation which testifies the truth of the subject (Preljocaj 2001).

In conclusion, the theories elaborated in France suggest that only a completely balanced psyche could protect from organic disorder. Thus, in a recent work, the “psychosomatician” Jean Benjamin Stora presents a mathematical model that allows to postulate the non-repercussion of traumas on an organism equipped with a “*quasi perfect psychic apparatus*” (Stora 1999, p 285). Among all of the psychosomatic practitioners, this psychoanalyst is the only one to portray such an ideal for his patients suffering from psychosomatic disorders.

Sami-Ali, however, seems to escape the general reification of the psychic apparatus.

12.4 The New Approach of Sami-Ali

Theo Leydenbach

In his œuvre, Sami-Ali attempts to confront the ultimate complexity of psychosomatic reality. Originating from Egypt, he moved to Paris to pursue his psychoanalytic training and became a member of the Paris Psychoanalytical Society. He became rapidly involved in psychosomatics and collaborated with P. Marty at the Paris Psychosomatic Institute. Over the years, Sami-Ali began to feel uneasy within the confines of the psychoanalytic model and became increasingly critical of certain key Freudian notions and their relevance in psychosomatics. He progressively distanced himself from the Paris Institute and ultimately created his own school: the International Center of Psychosomatics.

Over three decades, Sami-Ali, continuously reworking his theoretical framework and clinical setting, developed an alternative model, which he ultimately named “Relational Theory” (Sami-Ali 2004). It is impossible to give a full account here; however, some key notions could shed light on the fundamental issues.

Relation Relation is “the unifying principle *par excellence*”, intrinsic to existence itself. It is the very core notion because of its essential preexistence and preeminence: we are always and *a priori* in relation, just as we are always and *a priori* in a gravitational field. This means a fundamental difference with object relation theories where the relation to the object has to be constituted.

The imaginary This notion exceeds by far that which is normally understood as ‘imagination’. The imaginary, in polar opposition to rational thinking, is to be considered as a free-floating processing, a kind of fundamental presence and background in human existence. We may accept the full deployment of its capacity, or we may be afraid of its expression and restrain it either partially or entirely. In the case of the latter, Sami-Ali speaks of “repression of the imaginary as a function”.

The dream Freud distinguishes the manifest from the latent content of the dream: the manifest dream being the dream-story as it appears; the latent dream, the true meaning behind that story. Thus, the dream must be interpreted in order to seize the hidden meaning. By contrast, Sami-Ali considers dreams as they appear, as the subject’s creation, his true expression in all of its richness. Dreams must be, so-to-speak, understood at face value and in relation to the subject’s life experience; in this sense, they must not be interpreted. Sami-Ali lists different forms of “oneiric activity”: the absence of dreams, their presence, their presence after absence, their absence after presence; a fifth form responds to “the instability of the oneiric functioning, as if the person has not yet decided to live or not with his dreams.”

Dream equivalents Dreaming has to be extended to the notion of “dream-equivalents” in waking-life (phantasms, day-dreaming, art, emotion, etc.), all opposed to rational, aim-oriented processing. Both dreams and dream equivalents define what Sami-Ali coined “oneiric conscience”, intimately related to the notion of projection.

Projection Dreaming means the very essence of projection: the creation of an imaginary space and time through the mediation of the corporal experience. Dreams (and dream-equivalents) are *objectivations* of the inner experience through projection. Projection is no longer considered for Sami-Ali a defence mechanism, as it is mostly understood in Freudian theory.

Impasse “The unsolvable conflict is what we call impasse, existing in several forms which have to be precisely defined, according to logical as well as temporal criteria [...] What we should consider [in therapy] is the possible existence of a relational impasse behind the clinical picture.” This implies discovering “the kind of trap in which the subject is already caught and, at the same time, that the personal functioning has to be determined in relation to space, time, dream and affect, in order to identify the potential that is available from the start. The impasse being by essence a situation with no way out, the only question is how it gradually came into existence throughout an entire life, thus allowing it to be identified and to appear for the first time in front of the subject, not overbearing him and absorbing all of his vital energy.” (Sami-Ali 2014, p 26).

“In practice, the relation indicates a connection between two variables: the psychic functioning and the situation in which the person finds himself. (...) The link is to be found through the whole person where only circular causality is applicable. We are not trying to explain, but to understand and help others to understand, how a particular pathology of the real body finds its place in a unique whole which is life itself. Every therapeutic work starts and ends with this aim in view, thanks to the oneiric activity which constitutes the main axis, connecting the present to a past which emerges beyond the conscious memories.”

Relational psychosomatics aims to establish “a new epistemology” which is “meant to provide a different answer to the question of how somatization occurs, i. e. what Freud calls ‘the mysterious leap from the psychic to the somatic’.” Although somatization is accepted in all current theories, the process “differs from one theory to the other: alexithymia, operational thinking, dysfunction, incapacity to attain the symbolic level, etc.” According to Sami-Ali, all of this remains within the context of “a body-soul dualism which constitutes a major epistemological obstacle, just as its opposite, monism. Relational psychosomatics strives to transcend dualism as well as monism (...) It means finally that the organic and the functional belong to a sole theoretical model, (...) in which the relation appears as the unifying principle *par excellence*.”

Sami-Ali fundamentally distinguishes himself from historical approaches in French psychosomatics, nearly all in the sphere of influence of Freudian theory and emphasizing the notion of *deficiency*. His approach could call to mind those of Swiss psychiatrist and philosopher Ludwig Binswanger (1881–1966), German philosopher Karl Jaspers (1883–1969) and his notion of *limit situations* (Leydenbach 2013b), and French philosopher Paul Ricoeur (1913–2005) with the notion of *narrative identity* (Leydenbach 2013a).

Sami-Ali’s oeuvre is indissociable from his Egyptian roots. He has always lived at the frontier of two cultures. Trained in philosophy, while integrating Western thought, he also saw psychoanalytic theory through the lens of a different social environment and a different language. He was the first to translate Freud to Arabic and, more importantly, he translated different mystic Arab poets to French with introductory comments on their works. In these comments, he emphasizes the fundamental unity of poetry and thought, thus stressing the fundamental unity of the human being and starkly contrasting Western dualism. “Although trained in philosophy, I do not believe that rational thought can give an answer to the great questions of mankind. In my opinion, art is the only way to confront the enigma of being (...): art does not ask questions; in art, there is no need. Art *is*; as light *is*.” (Tarantini 2004, p 95).

Faced with the limitless complexity of human reality, Sami-Ali sees but one way to approach it as a therapist: to be in resonance, the very core of Relational Theory. According to Sami-Ali, Wittgenstein conveys this best: “Things are immediately there before our eyes, no veil covers them.”

In the same vein, it could be similarly stated that relation *is*, like art and light, and thus may represent the major gateway to the imbroglio of ultimate complexity...with ultimate simplicity.

Important Works by Sami-Ali:

- Sami-Ali (1974). *L'espace imaginaire*. Paris: Gallimard.
- Sami-Ali (1980). *Le banal*. Paris: Gallimard.
- Sami-Ali (2004). *Corps et âme. Pratique de la théorie relationnelle*. Paris: Dunod.
- Sami-Ali (2011). *Penser l'unité. La psychosomatique relationnelle*. Paris: L'esprit du temps. (*Conceiving Unity. Relational Psychosomatics.*)
- Sami-Ali (2014) *Convergences. Essais de psychosomatique relationnelle*. Paris: EDP Sciences.

12.5 The Experimental Approach in Psychosomatics

Pascal-Henri Keller

While the study of the human body has always been a complex and risky activity, psychosomatic research has only increased these difficulties, as it must explore not only the body but also the psyche. The law forbids the intentional production of disease in humans, and it is impossible to study their psyche without their participation. Thus, scientific psychosomatic research must rely on animal experimentation. This major domain in psychosomatic research has two characteristics: considering the organism only in its biological dimension and seeing psychic activity in neurological terms.

Long before the twentieth century, experiments were conducted on animals in order to try to better understand the functioning of the human organism. Thus, the resemblance between certain human and animal organs inspired a part of Leonardo da Vinci's work in anatomy and physiology (*La mente di Leonardo*, Florence, 2006). As medicine, in its different specialities, generally drew on this animal/man modelization, it was logical to do the same in psychosomatic research. While the analogy is striking between human organs and some of their animal counterparts (lungs, stomach, bowels, nervous system, etc.), it is quite hazardous to consider their respective "psychic" activities as also analogous. Numerous researchers, however, have not hesitated to use the modelization of animal behaviour in order to study the human psyche. They postulated that *human and animal species share the activity of thought*. Thus, French psychosomatic research split into two opposite options: either to consider the human psychic experience, in its rootedness in language, as fundamentally different from that of the animal; or to treat man and animal as comparable considering their psychic life.

At the beginning of the twentieth century, psychosomatic experimentation chose the second option, seeing the experience of disease as equivalent in humans and animals.

Although it has become banal to refer to Pavlov's work on the conditioned reflex, this remains the starting point of this kind of psychosomatic research. The

Russian scientist aimed to propose a physiological explanation for the very existence of the psyche, named for the occasion “superior nervous activity”. In an exchange with Pierre Janet, Pavlov acknowledged his ambition to compete with the Freudian theories on psychic activity: “I have decided to take another path [than Freud’s] and to give it a physiological explanation” (Muchielli 1961, p 71). For Pavlov, subjecting the animal organism to different constraints provokes reactions that represent, in the form of physical symptoms, authentic “experimental neuroses”. Based on this experimental schema, the Russian scientist applied his conclusions to humans. According to him, if the human being is subjected to excessive constraints, like the animal, he/she will rapidly suffer from physiological and behavioural disorders. The psychic life of a human subjected to such conditions is dominated by the feeling of constraint, and his/her incapacity to escape from it provokes in the organs of the body not only different troubles, but also diseases (respiratory dysfunction, bowel syndrome, heart lesions, etc.). These anatomo-physiological localizations led the Pavlov school to the “cortico-visceral theory”, which aimed to relate the interaction between body and mind.

Less than half a century later, this hypothesis would resurface in the “stress” theory, that shares certain aspect with Pavlov’s theory, in particular postulating in living organisms – animal or human – identical reactions when faced with environmental constraints.

The “stress” theory was developed by Hans Selye, specialist in the physiology of adaptation. He noticed that, in cases of abrupt stimulation of any kind, the organism reacts as a whole and sets off what he called a general “alarm reaction”. Faced with a particular source of excitement, the organism, reacting as a whole, mobilizes itself a *contrario* in a specific defense mode. This first general alarm reaction, strictly physical, has two possible outlets: either the organism reacts to the very nature of the stimulus and succeeds in adapting itself in a specific way, or it remains as a whole in this state of physiological arousal and ends up exhausting itself. In this second outlet, Selye considered that the pituitary-adrenal axis responds in an inappropriate way to the alarm and thus needlessly exhausts the organism’s resources, exposing it to a certain number of diseases.

Based on numerous animal experiments, do the theories of Pavlov and Selye allow for a better understanding of the general mechanisms implicated in the apparition of disease in humans? If these theories predict a higher risk of disease in a disoriented and unnecessarily exhausted organism – human or animal – than in an organism able to put into use all of its resources, then one can say that they have made some progress. Nevertheless, the *psychic* participation of the patient in the appearance, and in the evolution, of the illness remains obscure because, in Selye’s research in particular, there is no real differentiation between psychological and physiological stress. In spite of all this, forty years after its creation in 1957, one of the most important international journals of psychosomatic research still publishes papers that essentially draw on Selye’s experimental schema (*Journal of Psychosomatic Research*, New York).

Does applying the experimental approach, as described above for animals, to humans with disease give more significant results? Generally, experimental psycho-

somatic research in humans aims to isolate the *psychic* part from the *physical* illness suffered by the patient, both aspects of the condition being distinct yet complementary. One of the most spectacular and well-known experiments, aiming to validate this method, was conducted in the 1940s in the United States and was widely commented on, notably in France (Haynal and Pasini 1997). Two physiologists, English and Weiss, proceeded to observe simultaneously a sick organ and the psychic life of the “owner” of that organ, a patient named Tom suffering from a gastric fistula. The principle of the experimental setting suggested the equivalence of the observations both on the biological and psychological levels, thus postulating that it is possible to evaluate at once a person’s words and the physiopathological events in that person’s organs. During the visits from his family and friends, as well as his caregivers, Tom’s personal reactions were recorded, and those of his “accessible stomach” were monitored in real time “from the interior”, via the orifice produced by the fistula. As reported by Kamieniecki, this observation provided a great deal of data on the quasi-simultaneous production of physiological markers of the digestive system, and on the particular psychological state described by Tom himself (Kamieniecki 1994). *Finally*, all of this data revealed a certain number of constants in the interaction between physical phenomena and psychic life. For instance, the increase of gastric acidity and of secretory activity accompanied various changes in Tom’s state of mind, which the authors referred to as “unsatisfied desires” such as “anger” or “indignation”. The decrease, on the other hand, of these physical markers accompanied other states of mind, referred to by the authors as “sudden fear”, “resignation” or “depression”.

However, the generalization of these observations is problematic as the gastric mucosa reactions varied considerably depending on changes in the environment or simply in Tom’s state of mind. Serge Bonfils commented on the experiment in the following way: “the effect of desires or deceptions on the vascularization of the mucosa and on gastric secretion [is] diminished, stanchied, or even entirely reversed depending on the affective environment and Tom’s variations in mood” (Bonfils 1996, p 137). One has to admit, however, that this kind of experimental setting – which is not a psychotherapeutic one – does not provide an answer to the initial question. In other words, recording a patient’s words in order to better understand their interaction with the biological events produced in the organism does not give access to the true meanderings of psychic life, nor to their true repercussions on physical life.

In the continuation of this initial experimental research concerned only with humans, another current in psychology took on the development of more precise research tools. Based on statistical data collected, these tools, mainly questionnaires, allowed for the significant correlation between the patient’s words and the state of the pathology. In France, this current of “health psychology” was mainly represented by M-L. Bruchon-Schweitzer in the 2000s (Bruchon-Schweitzer 2002).

Alongside research in health psychology, a new discipline developed at the frontier between animal and human experimental research: *psychoneuroimmunology*. Assembling the specialities of psychology, neurology and immunology, this new field began to produce results, mostly quantitative. Numerous experimentations

observed the interaction of physical chemistry and biology, on the one side, and psychic life (affects), on the other side. Three examples will shed light on the issues of this new discipline, which aims to gain a better understanding of the psychosomatic field (Perrin 1997).

The first example recalls studies previously conducted on stress, in which the analogy between human and animal prevails. As the question of the proximity between the psychic lives of humans and animals had not yet been resolved, “frustration”, for example, was tested as though there was a common nature. Thus, Perrin recounted an experiment in which two rats were subjected to a strictly identical “stressor” (calibrated electric shock) and either did or did not develop a gastric ulcer depending on whether or not they had an available “outlet” (a piece of wood to chew, a running wheel, food, drink, etc.). For Perrin, when humans are subjected to “stress” and therefore “frustration”, they would go to “substitution activities” in the same way, such as leisure activities, but also alcohol, tobacco or coffee, of which consumption increases significantly in times of intense frustration. These pathological consumptions would thus act as a sort of prevention of psychosomatic disease. To emphasize the human/animal comparison, Louis Perrin describes a second experiment in three phases. First phase: a rat in the same situation can avoid the electric shock by pressing on a lever; in this case, the ulcer no longer appears. Second phase: when the lever is removed, an ulcer develops that is more severe than in the first experiment. Third phase: when the lever is returned, but made inefficient, the rat uses it as though it still worked, and the ulcer does not appear. Hypothesizing that he had thus modeled the battle between “despair” and “impotence”, Perrin concluded: “the rat thinks that if he doesn’t press on the lever, things become worse”. Humans who were not able to foresee what would happen to them or who had lost control of a situation would thus be exposed to the same pathology as the rats tested here, according to this first type of research.

The second example concerns humans directly, without animal modelization. In the study of the functioning of the immune system of people placed on extended leave, the researchers identified irregularities in the immunological constants without, however, any real disorders in the organism (no revealed pathology). To verify the legitimacy of the hypotheses suggested by this type of observation, the researchers produced in healthy volunteers real “experimental lesions” for the sole purpose of the demonstration. In a sample of 26 adult women, Kiecolt-Glaser created a small wound of a few millimeters on their leg in order to study the rapidity of the cicatrization process. The women, all living with a partner, were split into two subsamples, equal in number: the first group led a “normal” family life, while the second consisted of women living with a partner suffering from Alzheimer’s disease. It was observed that the total time of cicatrization had been longer in the second group than in the first, which the researchers considered evidence of “the influence of the psyche on biological processes” and of the existence of psychosomatic phenomena (Kiecolt-Glaser et al. 1995, pp. 1194–84).

This experiment followed previous studies whose goal was to study closely the variations in the immune system throughout life, more specifically during important events (exams, marriages, deaths, unemployment, etc.). While the variations were

indeed observed, the thoughts that accompanied these events were not taken into consideration, as if the life event alone mattered in the occurrence of the immunological “event”. In a way, one could say that this psychology is more “factual” than “mental”, strictly speaking.

The third example deals with studies revolving around the question: “do thoughts really affect health?”, and claiming to have psychosomatic implications. Founded on a naive vision of human existence, their philosophy can be summarized in one sentence: *positive thinking is good for health in general, and for the immune system in particular; feelings of potency are more valuable in difficult situations than feelings of depression*. Numerous observations, carried out in the most varied of situations, corroborate this postulate. For example, the showing of a movie that praises the merits of abnegation and devotion in love of others increased the production of immunoglobulins in the viewers. Another observation concerns a group of Harvard alumni, studied medically and psychologically over the course of 45 years, who “naturally” divided themselves into two sub-groups. On one side were those who had always been optimistic and were in good health and, on the other side, those who had always been pessimistic and were frequently ill. A third study that followed a hundred people daily over a period of three months found that “small stresses” (reprimands at work) had negative effects on the immune system during 24 hours only, while positive events had beneficial immune effects for two to three days. A fourth study showed that among the 200 leaders of a large American company that had been through a serious crisis, a hundred of them remained in perfect health, while the other half presented various illnesses. The personality of those in the first group was described by psychologists as “enduring” and “protected”; during interviews, they described themselves as very family-oriented, and the crisis as an enriching experience. On the other hand, the personality of those in the second group was the opposite and appeared to be responsible for their pathologies.

All of these studies entail important methodological precautions in order to claim a scientific validity. However, the criticism that could be addressed to them operates on a different plane. In combining animal and human experimentation without much epistemological precaution, these studies limit the scope of the psychosomatic approach. They give words, considered a “product” of the psyche, the status of reliable witness to the so-called “psychic factor”. As to the ties that unite psychic and organic life, presented in terms of simple causality – the psychic supposed to act on the organic – they lose their dynamic function. In these conditions, the subtle relations created from the origin between the psyche and the organism, unique to each human being, are described in voluntaristic and/or incantatory terms, as seen in Perrin’s conclusion, which recommends, in order to improve health, putting aside negative thoughts and “favoring positive thinking” (Kiecolt-Glaser et al. 1995, p 101). Although, in psychosomatics, psychoneuroimmunology shows to what extent “human nature” is rooted in biology, it also allows to envision the extent to which its symbolic existence must be taken into account.

Overall, it is regrettable that such complexities of interaction have been, on the one hand, reduced in this context to their most simple expression and, on the other hand, approached scientifically in such a cursory fashion. Should the complexity of

such a somato-psychic functioning defy all types of experimental scientific research? Will all efforts to access this complexity ultimately fail? Will it one day become possible to untie even slightly the elements of this psycho-neuro-immunological imbroglio?

12.6 Conclusion

In France, psychosomatic conceptualization has been fundamentally shaped by psychoanalysis much more than by animal experimentation. Thus, psychosomatic patient care deals fundamentally with the patient's words and existential condition rather than focusing on physical symptoms. As a result, the word "psychosomatic" came to be understood in daily language in a reduced way, qualifying a kind of linear action from the psychic to the organic. Furthermore, in spite of the monistic aspirations of a large number of French "psychosomaticians", this layman's usage of the "psychosomatic" notion continues to underline the psychic/soma division, suggesting the influence of the former on the latter. Opposing this evolution, however, French medicine has maintained its interest in the psyche-body dynamic in another form, for instance by establishing new types of collaboration between practitioners of disciplines concerned with this dynamic, such as the Balint groups mentioned above, medical psychology (Moor 1977; Keller and Senon 2007), or consultation-liaison psychiatry (Zumbrunnen 1992), present in the Anglo-Saxon world. Moreover, in recent years, the French psychosomatic field has expanded to new research in sectors previously considered outside of its limits, such as the placebo effect (Keller et al. 2013) or hypnosis and its derivatives like hypnosédation (Bioy and Keller 2009). Such research intends to better study the coexistence of simultaneous psychic and somatic phenomena, not so much focusing on explicative logic as on a more phenomenological approach.

Questionnaire Response

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry in your (or your chapter's) Country.

Please return this as an attachment to your email

Country on which you are reporting: France

Your Name: **Keller Pascal-Henri ; Leydenbach Theo**

Institution: **University of Poitiers ; Département de Psychologie Médicale, Faculté de Médecine de Créteil, Université Paris XII**

City & Country (e.g. London, UK):

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?

Yes (X) No () In some sense ()

- a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes (X) No ()
- b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes (X) No ()

2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?

Yes () No (X)

Is teaching of psychosomatic medicine in medical schools required by law or health care system in your country? YES () No (X)

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?

Yes (X) No ()

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No ()

- a. If YES, which?

Psychosomatic Medicine () Consultation-Liaison Psychiatry ()

- b. If YES, the status of such certification is:

- i. Independent Medical Specialty ()
- ii. Subspecialty of Internal Medicine ()
- iii. Subspecialty of Psychiatry ()
- iv. An independent non-medical discipline, as Psychology, Social Work ()
- v. Other (Specify):[]

Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes (X) No ()

If YES, please list names of the organizations and the websites if available:

a/ <http://www.asm13.org/Le-Centre-de-psychosomatique-pour-adultes-Pierre-Marty-67>

b/ <http://cips-psychosoma.org/> Centre International de Psychosomatique

- c/ <http://cresmep.com/modele-theorique/>
 d/ <http://www.univ-paris-diderot.fr/sc/site.php?bc=formations&np=ORGANDIP?ND=41>
 e/ <http://www.psychosomatique-integrative.net/index.php/formation-de-psychosomatique-integrative/77-formation-psychosomatique-integrative>
 f/ <https://sante.u-bordeaux.fr/formation/2014/PRSUA11/diplome-d-universite-medecine-psychosomatique>
 g/<http://www.scfc.parisdescartes.fr/index.php/descartes/formations/medecine/psychiatrie-addictologie/di-u-psychiatrie-de-liaison-et-soins-somatiques-en-sante-mentale/%28language%29/fre-FR>

5. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:

–https://www.puf.com/collections/Revue_francaise_de_psychosomatique
 – http://www.indexsavant.com/index.php?title=Champ_psychosomatique

6. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in your country? Yes () No (X)
- a. If YES, where does it occur? Check all that apply:
- b. Medical School () Residency () Fellowship ()
7. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes () No (X)
8. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)
- a. It is insignificant (X)
- b. Some subgroups (e.g. ethnic, religious) practice it (no)
- c. A significant part of the general population practice it (no)
- d. Is the most prevalent healing method used (no)
- e. It is often used in combination with Western medicine (no)
- f. More widely used methods are as follows (Please list, e.g., spiritual healing, meditation, herbal, etc): **homeopathy; herbal; magnetism;**
9. Please add any comments to your response here:

Besides some courses in a few medical schools, there is no specific and organized teaching in France of psychosomatic medicine leading to a final qualification as a specialist in this field. Thus the training in psychosomatic medicine is mainly proposed in different private institutions.

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Translations of philosophical books from German to French (Adorno, Kant, Nietzsche).

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Psychosomatic Medicine: Theoretical Aspects and Therapeutic Approach (in preparation).

Chapter 13

Psychosomatic Psychiatry in Spain: Historical Notes and the State of the Art



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José Manuel Menchón, Mercedes Navío, Gemma Parramón,
and Tirso Ventura**

13.1 Brief History of Psychosomatic and Liaison Psychiatry in Spain

13.1.1 Introduction

Psychosomatic Psychiatry (PP), or Psychosomatic and Liaison Psychiatry (PPL), is the increasingly used denomination in Spain for Consultation-Liaison (C-L) Psychiatry (Lobo 2014; Vázquez-Barquero 1980; Lozano and Lobo 2005). It has previously been argued that both medical humanism and empirical, or evidence based science are crucial philosophical ingredients in present day psychosomatics in this country (Lobo 1986). Both sides have important historical roots.

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Humanism in medicine has a long tradition in this country, the one that built the first mental hospital in the Western world in 1409 in Valencia. And humanism is certainly the main spirit that pervaded the Spanish “psychosomatic movement.” Letamendi, a medical professor in the late nineteenth century, is often credited to be a pioneer of the movement in a country often in a crossroad of many different national orientations. French, German and other central European perspectives influenced the medical field at the turn of the nineteenth century, and in more recent

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years, American ideas have been paramount. While Spain went through a long period of decadence and “generalized depression,” all of which culminated in a psychological crisis that climaxed in 1898, when a secure Europe proudly began a new era of scientific and technical progress, some bright men, such as Santiago Ramón y Cajal, the Nobel Prize winner who made possible much of the present-day knowledge about the central nervous system, rebelled against the view that Spaniards somehow were not capable of original scientific thought.

13.1.2 Some Pioneers in Academic Medicine

Historians have shown that the influential textbook by R. Novoa Santos reflected the state of the art in Spanish medicine in the initial years of twentieth-century. It was influenced by the “eclecticism” of Krehl, and Osler. However, despite the splendor and achievement of a scientific medicine based on the naturalistic nineteenth-century model, there was a feeling among some physicians that the individual was being lost as an object of scientific study. It was from this time on that the impact of philosophers such as Kierkegaard, Nietzsche, Dilthey, Buber, and Heidegger came to be felt, and man as an object of study was rediscovered. Spanish philosophers such as Ortega y Gasset and Zubiri are credited with introducing and developing these views, which eventually influenced medical thinking. It was in the period between the two world wars that the study of “persons” as such began and questions about the “who” of a person as well as the character of an illness were first raised. Freud is sometimes credited with having introduced psychosomatic principles into scientific medicine. Ortega y Gasset published the first translation of his writings in 1923, and influential academics have shown that, in fact, several authors anticipated Freudian ideas in suggesting that the individual “makes” his own clinical picture (López Piñero and Morales Meseguer 1970).

Still, in the twentieth century, different trends influenced Spanish medicine, including the application of psychoanalytic concepts to somatic illnesses by authors such as Groddeck and other European and American authors; the contributions of “psychophysiologists” such as Cannon, Selye or Wolff; the reflexological and “cortico-visceral” contributions of Russian schools or, more recently, the American behaviorism. Official, in particular academic Spanish medical circles often displayed ambivalence and rarely enthusiasm for these theories. On the contrary, the position of Karl Jaspers was particularly influential in Spanish psychiatry, much before it made an impact in American psychiatry (McHugh and Slavney 1998): human beings not only need “explanations” (*Erklärung*), they also need “understanding”: (*Verstehen*). In consonance with this position, pure natural science and exclusively causal explanatory theories have been rejected in Spanish psychiatry, and this has certainly influenced psychosomatic psychiatrists.

13.1.3 *The Influence of “Anthropological” Medicine and Other Theories*

In Spain, the so called “anthropological” perspective, derived from European sources and not well known in the United States, has also been influential in the development of psychosomatic medicine in some academic circles. Krehl, an internist in Heidelberg, was credited by Spanish psychiatrists with having introduced “anthropological views,” especially through one of his disciple von Weizsäcker. For von Weizsäcker, man is a totality, man is “somebody,” not “something,” and man creates his own life, his future, which constantly becomes the present and gives the present meaning. In such a context, illness is a biographical event. He acknowledges the unconscious, irrational mind, but also the spiritual, free mind, the creator of standards and goals. While von Weizsäcker’s thought is complicated and difficult, and his attempts to transform medical science into a “pathosophy” have not been very successful, many regard this general approach as an ideal, a guiding star, viewing man as a totality in health and disease, as the basis for medicine (Lobo 1986).

Cabaleiro, an influential psychiatrist, particularly in Galicia was a representative of the “anthropological”, unitarian, integrative conception of men. Morbid anomalies occur in men and should be understood not as purely somatic or psychic anomalies. Illness is a process that affects the total personality. Unilateral orientations are insufficient. Then, the clinical side of both, psychiatry and medicine is to discover the evolutionary laws of illness, its causes and the structure of its manifestations. He also underlined the direct relationship between how the patient feels understood by the physician and the therapeutic outcome (Cabaleiro 1973).

Laín Entralgo, is broadly considered a leading “medical anthropologist” in this country. He was professor of history of medicine in Madrid, a writer, philosopher, and intellectual, and president of the Academy of Language. A number of his works, including an important history of psychosomatic medicine, have been translated into English (Laín Entralgo 1968, 1970). For Laín Entralgo, human disease, apart from being an organic disturbance, is always and in its essence a *modo de vivir* (a way of living). He underlined the fact that the progress in somatic/biological medicine has increased the power of physicians but has also added to their perplexity. Internists and somaticists constantly see an increase in the number of “problem patients,” know some bodily disturbances are produced by psychological factors but do not understand how, and seem to be unable to overcome their discomfort with and distaste for psychogenetic or psychophysiological theories in what they consider their field and domain.

Existential philosophy was as well an influence on authors who seek to grasp the totality of man. In this respect, the views of the Spanish philosopher Zubiri on the mind-body problem were adopted by some: “Spirit, mind, and body are essentially inseparable in man; but rather constitute a single human reality... Their unity is neither a causal interaction nor an idealistic parallelism...but a primary and radical unity.”: all biological events, not only those associated with the nervous system, are mental, and all that is mental is biological. At a theoretical level, the dialectic

between dualistic “psychosomatic” views (the psyche influences the soma and/or the soma influences the body); and monistic, holistic, or unitary “anthropological” views, called “European,” are observed in Spain, although they do not necessarily influence the clinical practice or present day research.

Other important influences in the psychosomatic field have been apparent in Spain. Rof Carballo, an internist with psychoanalytic training, gave the first seminar in Spain on psychosomatics, in 1947, and wrote an encyclopedic book on the subject in 1949. His work was quite influential in introducing psychosomatic views to Spanish psychiatrists and other physicians. (Rof Carballo 1954, 1984). As a humanist in the best tradition of Spanish physician-writers (he was also a member of the Academy of Language), he saw psychosomatic medicine as a defense against the risk of dehumanization. He was an encyclopedic writer, reviewing almost everything in the field: biological data, sociological and psychological contributions, but also his own philosophical views, influenced by Zubiri. He was critical of the “autistic thinking and imaginative exaggerations of many psychosomatic physicians”, accepting the more empirical research-supported approach, although he also alerted about “a tendency toward statistical scientific rigor at times more apparent than real” even in the most prestigious journals in the field. One of Rof’s main points was his original concept of *urdimbre afectiva* (*affective warp*): the warp or network of transactional relationships that the infant has with his or her mother when the organism is not yet totally formed, suggesting the possibility that morphological structures might be modified by psychological events. He also contributed to the development of the concept of *pensée opératoire* or alexythimia.

Montserrat i Esteve (1910–1994) was the first to create a psychiatric outpatient clinic in a general hospital in Barcelona. In 1932 he agreed with Agustí Pedro i Pons, Professor of one of the departments of internal medicine in the Medical School, to create the Psychosomatic Medicine and Psychiatry outpatient clinic, located in the basements of the University Hospital Clínic. One of the objectives of this clinic was to serve as an instrument to care for the psychiatric problems presented in the other hospital clinics or departments. Montserrat was inspired by his experiences in Vienna, where he stayed between 1933–34 and 1935–1936. At that time Vienna was an important scientific and academic center of psychology and psychiatry. Montserrat applied the knowledge he got from Charlotte and Karl Bühler, Pötl, Hans Hoff and the school of Alfred Adler. He subsequently created the Psychosomatic Department at the Hospital de la Vall d’Hebron (at that time it was called Residencia Francisco Franco), when he moved following Professor Pedro – Pons. Montserrat considered that every Internal Medicine department should have a section of Psychosomatic Medicine to meet the considerable needs this pathology entails. The scientific and academic contribution of Professor Montserrat was quite relevant. Apart from being the introducer of Neuropsychology as an area of knowledge, he also did studies about the psychiatric comorbidity in hematological and other diseases.

Cortico-visceral medical models were introduced in Spain by the Madrid’s psychiatrist A. Colodron, who was also an outstanding president of the Sociedad Española de Medicina Psicosomática (SEMP) and published two relevant books

(Colodrón 1966, 1969). These models were likewise proposed by Montserrat's disciples such as JM Farré, who has also been an introducer of the behavior therapy in the country. They were influenced by Pavlov writings and considered the cortico-visceral models could be appropriate to substitute dualistic models such as the psychosomatic ones. In particular, they were influenced by Colodrón's books and by the translation of the Pavlov's disciples K.M Bykov y I.T Kurtsin (Bykov and Kurtsin 1968). The Spanish psychiatrists adopted the views of the Russian authors suggesting that the external and internal environment interact and follow general conditioning laws, allowing a closer approximation of experimental work and clinical practice. They were very much impressed by multiple Russian experiments showing the interaction of brain, viscera and the external environment; under conditioning laws the organism always acting as a whole, with the cortex in the role of analysis and synthesis; the function of nervous pathways, as well as the influence of neurohormonal mechanisms were clarified. They were similarly influenced by American authors such as Porter and Brady, working with this model to show the cortico-visceral origin of different, experimental visceral diseases. Whilst acknowledging the relevant contribution of the cortico-visceral model, the Spanish authors recognized that it did not explain all aspects of illnesses observed in clinical practice nor provided a full, explanatory theoretical model and, in particular, admitted that the model did not provide a convincing therapeutic strategy to implement.

13.2 Other Academic Psychiatrists and Psychosomatics

In general, the chairmen of Psychiatry in this country favored a psychological approach in medicine and most dedicated some comments to the psychological aspects of medical practice but, with few exceptions, they had no experience with medical patients. López Ibor, in Madrid, basically considered psychosomatics a perspective from which to change medical practice into a more psychological or anthropological approach. He also was a phenomenologist who warned of the danger of not paying enough attention to clinical observation, and stood vigorously for an original view of neuroses and of some psychosomatic conditions. On the bases of his observations, he described the *Vital Anxiety (La angustia vital)*. He considered that this clinical phenomenology of anxiety, as well as what he called "thymopathic equivalents" (which includes a variety of pains, paresthesias, vertigo, etc), come from what he called a "thymopathic" (or "endothymic") stratum, an "intermediate strata that exist between the purely noetic and the purely somatic one (López Ibor 1969)." One of his disciples, López Ibor-Aliño continued his work on "depressive equivalents" (López Ibor 1970).

The so called, non-compromised "bio-psycho-social" model has often been supported by Spanish psychiatrists, but few among the professors were involved in psychosomatic psychiatry, clinical responsibilities. One of the exceptions was A. Seva Díaz, who previously held the chair in Zaragoza, and was a consultant for a gynecology department for some time. He was also one of the authors introducing

psychiatric epidemiology in the country and, in this position he documented in populations the considerable prevalence of so called psychosomatic symptoms and the influence of socio-cultural factors (Seva 1979). He also edited a two-volume, international textbook of psychiatry, which included specific chapters on psychosomatics (Seva 1991).

The traditional humanistic style of internists-that is, the interest in human beings rather than in the animal parts of patients- was only partially altered by psychosomatic or anthropological modern scientific views. Nevertheless, the humanistic view is apparent in the introduction of the most prestigious medical textbooks in Spain, which also include specific chapters dedicated to psychosomatic medicine and psychosomatic psychiatry (Rozman and Cardellach 2016).

Some contemporary professors of psychiatry have shown specific interest and dedication to psychosomatics. For example, González de Rivera (1980) edited a book on psychiatry and was one of the pioneers in describing C-L Psychiatry in general hospitals (González de Rivera and Moreau-Hennings 1975). He has argued about the scientific dimension of psychosomatic medicine and has been involved in empirically based research related to stress and other psychosomatic aspects (González de Rivera 1980). Valdés, in the University of Barcelona, has been one of the main proponents of psychosomatic medicine in Spain. He has extensively written related books, also chapters in medical textbooks (Valdés et al. 1983). This author has certainly supported the influence of psychological factors in somatic disease, and has argued that specific psychological factors have specific biological consequences. However, he has been quite critical of speculations in the field and, as a bright critic of present day psychiatry, which includes strong criticism of the DSM classification as presently used, argues vigorously for the need in the discipline for “intellectual rigour..., scrupulous auto-criticism and avoidance of complacency” (Valdés 2016a). He is expert in the field of stress, which he defines as “a dysphoric state of autonomic and neuroendocrine activation, which implies an adaptive failure, with immunologic and behavioral inhibition”, and considers the stress and the psychobiology of adaptation are indispensable, crucial teaching early in the medical training. His views are described in a recent, influential book (Valdés 2016b).

13.3 Current Dominant Trends in Psychosomatic Psychiatry

13.3.1 General Hospital Psychiatry in Spain

Psychosomatic Psychiatry in Spain has important connections with general hospital psychiatry and this one has a very relevant tradition in this country. It has been shown that as far back as 1404, mental patients were admitted in the Hospital de la Santa Cruz in Barcelona, and, mental hospitals and asylums, including the one in Zaragoza, the Hospital de la Virgen de Gracia, founded in 1425, were conceived of as departments of general hospitals. By mid-nineteenth century, Spain had 17

psychiatric institutions, but only 3 of them were exclusively psychiatric. Nonetheless, there was little development of special psychiatric units until recently. In the early 1970s, 25 out of 223 general hospitals had psychiatric beds, most of them in psychiatric buildings associated with the central hospital. The national health system (NHS) at the time had more than 50 general hospitals, many of which had high standards, but psychiatric beds existed in only two or three hospitals. However, a crucial development occurred in the 1970s, with the building of excellent university hospitals associated with the NHS, since these hospitals had to incorporate the university psychiatric departments, and thus special psychiatric units. The review of the available literature suggests that the pattern of American general hospitals also occurred in this country, as a natural clinical development: as soon as psychiatrists were available in nearby wards in general hospitals, they received consultations from medical colleagues (inter-departmental consultations). Nonetheless, most consultations were intended to solve immediate, urgent problems (Lobo 1986). Modern views of interdepartmental consultation were already apparent in the 1970's in some chapters related to general hospital psychiatry (Ayuso and Calvé 1976). The first specific C-L units, following models of American authors such as Lipowski or Strain were first organized in university hospitals both in Madrid and Zaragoza in 1977. The unit in the university hospital in Zaragoza was named "Psychosomatic Service," with its humanistic flavor (in Spain), and the name was demanded by administrative needs, but in the meeting of the Sociedad Española de Medicina Psicósomática (SEMP) that same year and later, in other meetings, a clear philosophy was made explicit: as psychiatrists we could contribute, along with our medical colleagues, to holistic care (Lobo and Seva 1980). The American experience was explicit in the initial philosophy: there is high prevalence of psychiatric morbidity in medical floors; this morbidity is frequently under detected, undertreated; identification and treatment of this morbidity improves the patients' psychological state, improves the course of somatic illnesses and also decreases medical costs. Little time was allotted to the philosophical speculations in some European theories; as physicians, we considered action fundamental to solving problems of patients and gaining our colleagues' respect. Teaching of the medical staff was also considered to be crucial in these units, and was included in its philosophy, again supported by empirical literature showing the potential benefits (Lobo and Seva 1980).

The relevance of the PLP Units in Spanish general hospitals very soon became apparent, as shown by the sharp increase in the number of patients referred by medical colleagues as soon as specific Units were organized (Fig. 13.1) (Lobo 2014). The general lack of psychiatric or psychosomatic training in physicians was soon indicated by the contrast between the reasons for consultation, and the psychiatric diagnoses. Moreover, the interest in the new psychiatric philosophy in general hospitals in this country was apparent by a progressive organization of specific units, and also by international conferences such as the one organized in Madrid in 1983 (López Ibor 1983). However, it very soon was also observed that funding of psychiatric consultation services would be problematic: a limited number of hospitals organized a specific unit in that decade and even in university hospitals in Spain the suggestion is that psychosomatic or consultation units were understaffed.

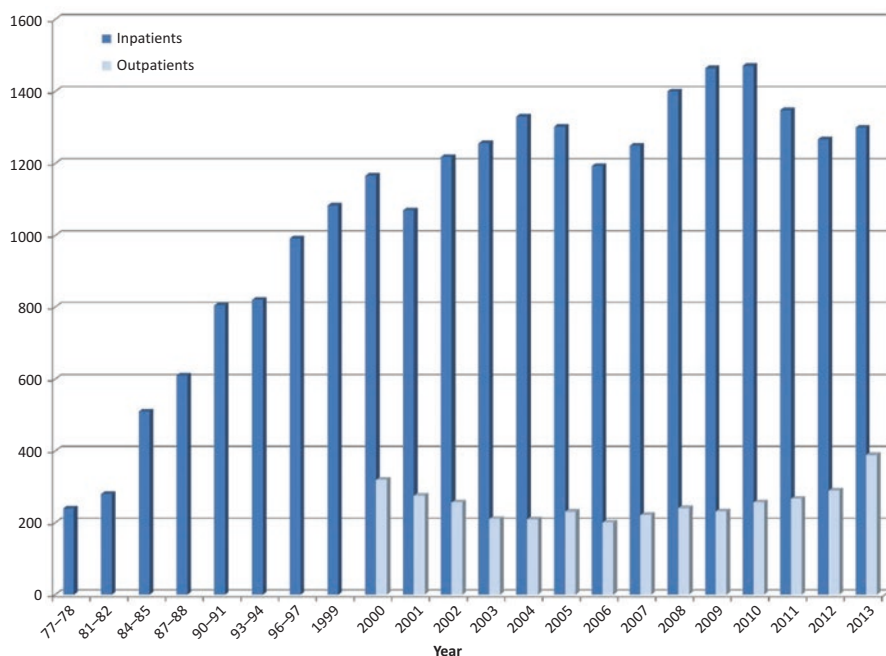


Fig. 13.1 Evolution of referrals per year in a new Psychosomatic and Liaison Psychiatry Unit in Spain

13.3.2 *Early Research in Psychosomatic Psychiatry*

There were some relevant, early studies in Spain in relation to psychosomatics, such as the pioneering work of Marañón, in 1924, documenting the effect of adrenaline on emotions, which is one of the first accounts of endocrinological bases of emotions. Similarly, Rodríguez-Delgado, working in the USA, reported empirical data showing neural mechanisms of emotions. However, it was in the 1970's and early 80's that clinical researchers gave an impulse to empirical research, as observed in the national meetings of the time. Turning away from philosophical speculations and theoretical discussions they conducted mainly epidemiological type of studies showing the high prevalence and the characteristics of psychiatric morbidity among medical patients. The arrival of young psychiatrists to the SEMP, which was founded in 1955 by Rof Carballo and was having a rather languid life on the hands of predominantly internists and non-psychiatrists with a humanistic orientation, generated a turning point. With few exceptions, such as the work of Salvatierra and Cuenca (Salvatierra et al. 1985), those non-psychiatrists had limited experience in empirical research.

In those years, the psychiatrists standardized and validated screening and assessment instruments, not available before, to conduct different type of studies. Some of them also built original instruments, including standardized interviews (Lobo et al.

1993). It was possible to conduct for the first time two-phase epidemiological studies related to psychiatric and psychosomatic morbidity in representative populations, including medical populations. Many good studies were reported in national journals, and many good doctoral theses were produced in the Universities (Vazquez-Barquero et al. 1997). It was in those years that the mortality associated to delirium was probably reported for the first time (Lobo et al. 1988). Moreover, some papers started to appear in high impact international journals. The medical populations studied included oncological, hemodialysis, military personnel, gastrointestinal and many other types of patients, and certainly patients in primary care. More than 20 medical schools actively participated and presented papers in an international C-L meeting held in Madrid (Lopez Ibor 1983). Other relevant work those years was reported by authors involved in experimental psychophysiological models (Carrasco et al. 2008), and Massana made some contribution related to psychosomatic problems (Massana et al. 2001). The philosophical approach to the mind-body problem in research was the subject of one special, international issue of *Advances*, a journal of the *Institute for the Advancement of Health* (Fox and Temoshok 1986). The authors concluded that Spanish clinical research in the last decade of the twentieth century occupied a philosophic orientation midway between the *ultra-Western* (very biological) and *non-Western* (very psycho-social) traditions, meaning that they were positioned midway in the dimension biological-behavioral-psychological-social.

It was obvious in all these studies the commitment to the scientific method, away from earlier psychogenetic theories related to medical illnesses which had stirred bitter critiques from empirically oriented researchers (Shepherd 1978). In relation to the psychiatric aspects in medical patients, some of us have argued strongly in favor of the use of different psychiatric models, and specifically the Johns Hopkins “perspectives” (McHugh and Slavney 1998): while the “medical”, the “disease model” is also essential in this field, “perspectives” such as the dimensional one or the “life story model” are indispensable (Lobo 1996).

A crucial event was the founding in 1987 of *Cuadernos de Medicina Psicosomática y Psiquiatría de Enlace* (*Cuadernos*), the first journal in Spanish language dedicated to this field, which has been official journal of the C-L Psychiatry section of the *SEMP*, and more recently of the *Sociedad Española de Salud Mental Perinatal* (*MARES*). *Cuadernos* has now initiated a new, digital age with a new denomination, *Psicosomática y Psiquiatría*. The journal was founded under the initiative of Antonio Colodrón, who was the first director, but mainly of JM Farré (who has been Chief Editor since 1996), with the support of several psychiatrists and some non-psychiatrists expert in the field, including several distinguished international experts.

Since the founding of the journal, the general philosophy has been influenced by a great longing for progress in the field, for the reflection, imagination, and scientific innovation. It has intended to provide service to the scientific associations supporting the journal as well as to the professionals, including Ibero-American professionals of both Portuguese and Spanish languages. More recently it has included articles in English language. All areas of the psychosomatic field are covered, with some emphasis in Behavioral Medicine and Health Psychology, and dis-

tinguished national and international psychiatrists, but also health psychologists and other experts are members of the Scientific Committee. Some special articles and issues made history, including the first editorial in the Spanish literature underlying the relevance of nursing in the field; the editorials related to important international meetings celebrated in Spain; the Spanish translation of the APA eating behavior disturbances; the two issues, also pioneers, dedicated to “Psychotherapy and New technological developments”; or the section on “Duet interviews” with outstanding Spanish experts in psychosomatics. An Editorial in the 25th anniversary (Farré 2012) of the journal inserted the following comment: “In 25 more years the psychosomatic field will advance almost beyond recognition. It is probable that the whole environment will change but, as Humphrey Bogart would say in the movie *Casablanca*, “Cuadernos will always remain...”.

13.4 Current Practice of Psychosomatic and Liaison Psychiatry

The progress of C-L Psychiatry in Spain was soon apparent, as shown when exploring the developments in a national enquiry. While the first Units were organized in the late 70's, by 1999 specific Units, while modest, were detected in approximately half of the 40 teaching hospitals participating in the survey (Lozano et al. 2000). During the study conducted by the European Consultation-Liaison Workgroup for General Hospital Psychiatry and Psychosomatics (ECLW), it was possible to document relevant aspects of the discipline in Spanish hospitals. The ECLW study was a European multicentered C-L service delivery investigation unique in its kind, as it allowed the comparison of very different C-L units (Huyse et al. 1996). It was a collaborative effort made by 226 consultants from 56 psychiatric C-L services, with a thorough description of close to 15,000 patients recruited in 11 countries. The advanced methodology included a multicentered international approach, rigid training for all participating consultants, and the development and testing of new instruments (Lobo et al. 1996a). The overall hypothesis tested in this study was confirmed: the most developed services see (as well as more patients) a wider variety of clinical problems than small services, the implication being that the absence of well-developed PLP Units in a general hospital may mean that there are patients with unmet mental health needs.

The contributing Spanish units in this study were quite active, more so than the average unit in most European countries. The referral rate in the three Spanish hospitals was approximately 3.0, higher than the average 1.4 in Europe. The important service provided by these units was apparent, but also the difficulties, as in most European hospitals, since the staff was generally considered to be insufficient to provide adequate service. Moreover, as in most European units, a high proportion of referrals were urgent, different from what was considered to be the ideal of a well-planned service (Huyse et al. 2001a). It is also relevant to underline the fact that the

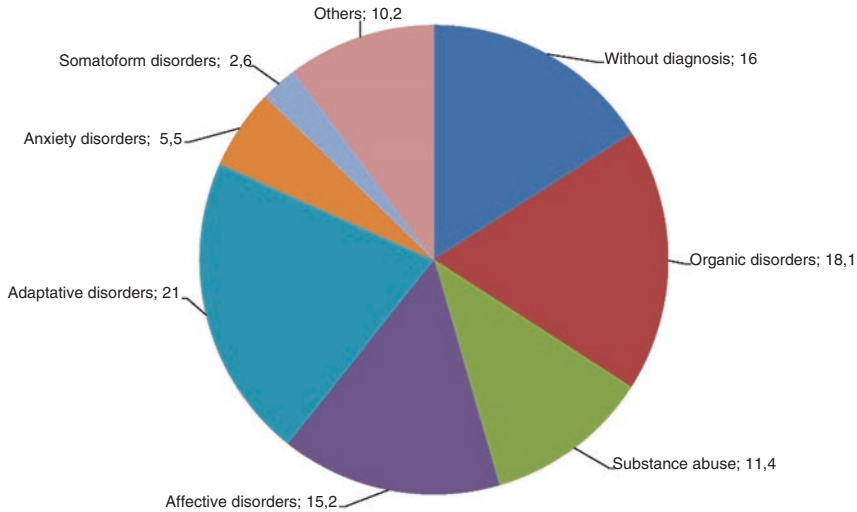


Fig. 13.2 Diagnostic distribution (ICD-10 criteria) of patients referred to Psychosomatic and Liaison Psychiatry Units in Spain. Multicenter, national study

participating Spanish hospitals in the ECLW study provided quite a balanced service, since they got referrals from a wide diversity of medical services; they assessed and treated a wide spectrum of psychiatric diagnosis, as shown in the subsequent study conducted in Spain under the auspices and methods of the ECLW study. Figure 13.2 shows the ICD-10 diagnostic distribution of patients seen in the Spanish hospitals (Valdés et al. 2000). This was in contrast to a general view of European hospitals, since some of their PLPUs were very much polarized towards ‘organic’ kind of patients (mainly delirium and dementia) while others received predominantly patients with ‘neurotic’ and ‘psychological type’ of diagnoses; contrary to the Spanish hospitals, some of the European PLPUs got referrals from a very limited number of medical services, but wide inter-hospital differences were documented (Huysse et al. 2001a).

The development of Psychosomatic Psychiatry in Spain has recently been shown to be remarkable, as documented in the last national enquiry (Lobo 2017). More than 100 hospitals provided data, although the geographical distribution is not well balanced. Close to 60% of them have a PLPU, although most of them are staffed by only one full time psychiatrist. Clinical psychologists are often included in the staff, but the presence of nursing and social work staff is quite limited. Some PLPUs receive more than 1500 referrals per year, and 2/3rds get out-patient referrals. Most units have specific liaison programs, the most common being Oncology, Neurology and Bariatric surgery. Most units train psychiatrists in the national residency program, and half also train residents from non-psychiatric disciplines, including primary care physicians.

The progress of the discipline in this country has recently been described by relevant psychiatrists (Parramon Puig and Aparicio Español 2015). The consider-

able expansion has been underlined, as well as the fact that other specialties have increasingly required the psychiatrist for the differential diagnosis and treatment of mental disorders that may appear in the course of diseases. The challenge for psychiatrists, posed by new symptoms resulting from new medical pathologies affecting the central nervous system or the adverse effects of new treatments that cross the blood-brain barrier has also been discussed. In relation to this, the participation of a psychiatrist is increasingly required in the clinical trials of some new drugs producing side effects unknown until these days, some of which are indistinguishable from those derived from primary mental illness.

There is a growing movement in this country in favor of specialized training and subspecialization in view of the complexity that medicine is acquiring. The consultation in psychiatry is considered to be indispensable in most modern hospitals, but also the liaison with many specialties, which may require the permanent and integrated participation of the psychiatrist in the therapeutic team. In relation to this, it is emphasized that the indications and contraindications of the psychotropic drugs used in particular pathologies, especially those affecting the brain, require very specific knowledge. There is an especial interest in this country in the psychoneuroin-mundoendocrinology, which is considered by some a crucial field to integrate between the biological model and the biopsychosocial model; and in future developments of biological theories to explain how the environment affects our health. Other specific area of interest relates to the management of women with mental illness who take the option of maternity, since the course, prognosis and treatment of psychiatric conditions during pregnancy and the puerperium have specific characteristics requiring a very specialized approach. It is also considered that some other diseases, as well as surgical programs such as those related to morbid obesity, transplantations, etc., require very focused approaches (Parramon Puig and Aparicio Español 2015).

13.5 Current Education in Psychosomatic and Liaison Psychiatry

13.5.1 Training in Psychiatry

In Spain, as part of the official, national training program for Residents in Psychiatry, a 4-month rotation period in Psychosomatic and Liaison Psychiatry, during the third or fourth residency year, is part of the nuclear and compulsory program (Ministerio de Sanidad y Consumo 2008). This program was initially developed in 1996 and has been improved. However, it still has poor objectives' specification or activities to cover, despite some improvement over the original program, such as the duration requirement (minimum 4 months) and the year of training (third or fourth year residents). The program makes a distinction between basic and advanced skills, and refers to the need to eventually develop measures for assessing competence. The "basic" requirements in the training guidelines include the following:

- Interview with the medical patient. Knowledge of the basic psychosomatics theory. Communication with the patients who are severely ill or terminal. Communication with the patient's relatives. Liaison with other professionals and health teams.
- Assessment and dealing with psychiatric and psychological disorders in medical patients. Psychopharmacology and interventions in crisis, and psychotherapeutic interventions in medical patients (including their family). Coordination of care in a complex medical patient.

The “advanced” requirements in the training guidelines include the following:

- Specific attitude and identity of the liaison psychiatrist, with knowledge and skills in issues regarding special psychosomatic issues and specialized psychotherapy adapted to medical patients and the intervention during crisis.
- To be able to achieve adequate advanced technical level of liaison with health teams and to be able to advise in situations of ethical dilemmas.
- Specific training through interdisciplinary clinical sessions, with participating medical staff and both internal and external supervision by staff with experience in liaison psychiatry. Journal clubs and study of the specific topics of CL references. Competence measurements must be developed.

In fact, early in the 60's attempts were reported in Spain to guide the training of psychiatrists in this field in Madrid hospitals (University Clinic and La Paz hospital). In the late 70's and early 80's, together with the relevance given to research, several publications from Zaragoza (Lobo and Seva 1980) and Santander (Vázquez Barquero et al. 1985) emphasized the relevance of training medical students and residents in PLPUs, but no specific guidelines were described.

In 2000 M. Lozano et al., on behalf of the Spanish Psychosomatic Society (SEMP), reviewed the teaching bases for C-L Psychiatry. The main training schemes in PLPUs were outlined, taking into consideration the four main perspectives, clinical, teaching, research and management activities. Furthermore, a core curriculum (34 topics) for teaching, the main features of the training schemes and the specific training aims were recommended, showing that acquiring knowledge, craft and art are the ultimate teaching objectives for residents in psychosomatic and liaison psychiatry. In this report, “knowledge” is considered to include the subjects to apply in clinical practice; “craft” is the coping experience in assessing patient's psychopathological problems; and “art” refers to the position adopted by the physician in relation to the transference accompanying the patients and the families throughout their suffering, as well as the transference with the medical-surgical team (Lozano et al. 2000).

In 2014 a group of CL Psychiatrists, from Zaragoza and Galicia, on the bases of accumulated experience in Spain, and the review of the latest European and international guidelines, summarized a realistic set of norms and directions for training in PLP in residency programmes, and proposed a set of more specific competencies to achieve, the appropriate methods to reach the objectives and some evaluation mechanisms (Gómez-Reino et al. 2014).

In relation to teaching, the PLP Workgroup in the Sociedad Española de Psiquiatría (SEP) has also contributed to the international effort in establishing microcomputer literature database, with selected Spanish references in the main PLP topics (Strain et al. 1999). Moreover, it has proclaimed the importance of building up fellowship programs for advanced training; and has published in the *Psychiatry Resident Textbook* the state of the art for presenting clinical ward rounds in psychiatry and PLP (Villas et al. 2009).

13.5.2 Training in Other Medical Specialties

Medical specialties in Spain are divided into four groups: medical (twenty-four), surgical (eight), combined medical-surgical (such as Dermatology, six) and laboratory (nine). In total there are forty seven specialties, if we dismiss laboratory and psychiatry, remain thirty seven medical specialties that could have some kind of training in psychiatry. After reviewing all training programs in Spain, twenty of them point out the need for learning about psychiatry for their residents. In several (Neurology, Geriatrics, Occupational Medicine and Family Medicine), a rotation in psychiatry is mandatory. Only two use the “psychosomatic” term specifically in their programs (Neurology and Occupational Medicine). Neurology requires a two-month training in Psychiatry, specifying the need to acquire skill in diagnosis and treatment knowledge in the most frequent psychiatric and psychosomatic conditions. Occupational Medicine indicates the need for knowledge of psychosomatic patients in the working environment. Both Geriatrics and Family Medicine target a wide range of Mental Health competencies, many of which have a direct relationship with psychosomatic psychiatry, such as dementia, behaviour disorders or chronic somatization. In other specialties, reference is made to different clinical aspects, such as psychodermatology, biopsychosocial component of inflammatory bowel disease, psychiatric comorbidity with pregnancy or psychological aspects of pain, but without a mandatory rotation in psychiatry.

13.5.3 Training in Medical Schools

Psychiatry is a crucial discipline in the standard teaching of psychological medicine for general physicians. In Spain, medical graduates, in a 6-year curriculum, have formal teaching in their second and third year of their Medical School on Psychological Medicine and Psychiatry as separated subjects with some (but still few) lectures devoted to “Psychosomatic Psychiatry”. Under the recent European Union guidelines for advanced university training (“Bolonia plan”), some Departments have undertaken innovative teaching methods, emphasizing the discussion of clinical cases, bed-side clinical teaching, and the discussion of a clinical case in the final examination (Lobo et al. 2012).

The increasing demand for improved skills by medical graduates in the psychosocial aspects of medical care is acknowledged and for example, the Medical School of the University of Zaragoza approved the year 2000 a new optional 6-Credit (European Credit Transfer System, ECTS subject for fifth year medical students, called “Psychosomatic and Liaison Psychiatry”. In contrast with previous experiences coming from German-speaking countries with a long tradition in this type of teaching, this is a unique experience in our national Medical Schools. The philosophy is based on both medical humanism and evidence-based knowledge. Emphasis is placed on the discussion of clinical cases, bed-side clinical teaching, and a research-oriented part. An “Innovative Teaching Plan” was implemented, with special training of student-leaders to stimulate student-student interaction and participation in small groups. Trainee performance was assessed by the marks in the final examination, and a reliable and valid tool, the Medical Teaching Quality Questionnaire was used to document trainee’s satisfaction. Good performance and high satisfaction of medical students have been reported, suggesting that lessons may be drawn to inform about efficient and effective ways of teaching and learning this subject (Lobo et al. 2012). In the last decade, there is a mandatory Clinical Assessment of Skills and Competences Evaluation in Spanish Medical Schools. Zaragoza has pioneered a Consultation-Liaison mock station for exam practice, with outstanding satisfaction among last-year medical students.

13.5.4 Other Training Initiatives

In terms of postgraduate training, there is an official proposal from the Spanish Ministry of Health and Education to create an Advanced Certification in Psychosomatic and Liaison Psychiatry, to give credit to those professionals with at least 5 years of specific psychiatric training and experience in the field. The Spanish Psychosomatic Medicine Society (SEMP) with members from different medical disciplines including Psychiatry, is active promoting several continuing professional developments thorough website, annual meetings, courses, on-line activities and increasing affiliations with other Medical Associations (specially with Family and Community Medicine, Internal Medicine, Family Therapy, Private Psychiatrists Society, Spanish Psychodermatology Group of the Spanish Dermatology Academy and European Association for Dermatology and Psychiatry) as well as with Colleges of General Physicians and Medical Surgical Academies of the different Autonomous Communities. There are active Associations in several Autonomous Communities, with different types of teaching activities. It is also noteworthy the educational influence of the PLP Workgroup of the Spanish Psychiatry Society (SEP), with active debates on different organizational schemes (liaison with general practitioners, medical-surgical units, integrated care, etc.), and educational proposals especially for early career psychiatrists.

13.6 Current Prominent Research in the Field

13.6.1 Working Groups and Research Networks

Research activities in Psychosomatic and Liaison Psychiatry Units (PLPU's), have also improved considerably and have certainly been a priority in the strategies of the Associations of liaison psychiatrists in this country. It was in this context that the first national work- group appeared, but a crucial turning-point was the birth of the ECLW for General Hospital Psychiatry and Psychosomatics (Huyse et al. 1996). The stimulus provided by the ECLW was seminal in European countries, and Spanish psychiatrists participated from the first stages. Under this umbrella, a new Workgroup was supported and partially funded in 1997 by the Fondo de Investigación Sanitaria (FIS), an agency of the National Institute of Health Carlos III (ISCIII). The Spanish researchers have participated in important multicenter, national, and European studies of the ECLW workgroup, including the development of the ARSI/COMPRI/ INTERMED system for the early detection of complex medical patients (Huyse et al. 2001b) and the development and implementation of a quality-assurance system (QA), originating in consultation-liaison psychiatry (Herzog et al. 2000).

The background, structure, and experience of the FIS Workgroup proved to be decisive and the main PLPU's in the country were invited to participate in the new venture of what was called REPEP (which stands for the Spanish Research Network in Liaison Psychiatry and Psychosomatics) (Lobo et al. 2007a). Figure 13.3 shows the geographic distribution of nodes in the network: a coordinating center in Zaragoza; three hospitals in Madrid; three in Barcelona; and the Universities of Elche and Cadiz, in the Southern part of the country.

The general objectives of the network were to coordinate research in hospitals throughout the country in such a way that complementarity and synergies in different centers would be promoted. Ideally, powerful scientific plans might be developed and implemented; transfer of research results to the National Health System (NHS) might be facilitated, having an impact in preventive and clinical medicine; and, certainly, the potential for training of new researchers would be strengthened. Since our discipline should be progressively more grounded in empirical research, we felt that this perspective might help to enlarge what is presently a small specialty. Specific strategies were developed to fulfill the objectives, and plans to train researchers and for eventual transfer and dissemination of research results were likewise considered to be important in the network.

The initial results of this strategy have been reported (Lobo et al. 2007a). The structure of the Network was consolidated and a total of 139 researchers eventually participated, with important interdisciplinary links. The quality of the process was judged to be adequate according to the programmed QA system (Herzog et al. 2000) and a crucial point, following and initial study in the coordinating hospital, was the successful implementation of a multicenter project on co- morbid depression in medical patients at the time of hospital discharge and a follow-up period in primary care (Lobo et al. 2005).



Fig. 13.3 Psychosomatic and Liaison Psychiatry Units participating in the Spanish Research Network in Liaison Psychiatry and Psychosomatics (REPEP)

This common study strengthened the links and the coordination of the Network, and was the starting-point for subsequent, coordinated studies. Furthermore, new doctoral courses were organized in eight different nodes; the improvement of *Cuadernos*, the official journal of the SEMP was proposed by members of the Network; and advances in dissemination of research were documented.

Among the lessons learned from the exciting experience of organizing a research network in PLPU's., two crucial events occurred in our particular case that may explain the relative success achieved. The first one was the invitation by the ECLW referred to above, to participate in the ambitious, European research venture. Although preparatory work and previous experience was necessary, such an opportunity could not be wasted, no matter how inconvenient it might initially seem. The ECLW experience taught us, among other things, how to organize and run a large, multidisciplinary research group; it facilitated the incorporation of methods applicable in national and transnational multicenter research groups and studies and the development and implementation of documentation instruments that have increased the armamentarium of Spanish groups. The influence of the ECLW in NHS hospitals has, in many ways, facilitated the new enterprise, and the European research network has always been a supporting as well as a critical observer of our efforts. Around this group, as has been the case in countries such as Italy, (Rigatelli et al. 2002) the Spanish workgroup started a new "generation" of activities, with a highly productive interchange with European colleagues.

The final lesson learned in the Network relates to the importance of leadership, organization, and camaraderie, which, at least in part, are also learned from previous experience. We believe that those in our Network were all united. Interpersonal,

working relationships were excellent, and the organizational structure, built on previous workgroups, was reasonably solid. Furthermore, the knowledge of being involved in a project with public-health implications greatly facilitated the commitment and persistence in the effort demanded by an ambitious project such as the one we describe here.

The second opportunity, obviously, was the national call of the ISCIII, with unprecedented funding, to develop biomedical research networks. Following that experience, members of the network have participated in a more ambitious enterprise and successfully applied to be involved in the new initiative called CIBERSAM (which stands for Centers for Network Biomedical Research in Mental Health). This was a new network for “excellent” research groups in the field of mental health, which was launched in 2008. One of the six research programs that constitute CIBERSAM is devoted to psychosomatics, jointly with a broad concept of anxiety disorders, stress and behavioral disorders. This has allowed a fruitful collaborative research that has led to foster ongoing research projects in the field of psychosomatic medicine, stress, and neuropsychiatric disorders. The scope of the studies has been quite broad, such as neurobiology of anxiety underlying chronic pain (Romero-Grimaldi et al. 2015), eating disorders (Villarejo et al. 2012), management of depression in primary care (Aragonés et al. 2017), multimorbidity (Olaya et al. 2017) or patterns of evolution and outcome of mild cognitive impairment (Marcos et al. 2016). Therefore, the CIBERSAM network has significantly fostered the neurobiological, clinical and epidemiological research on psychosomatics in Spain.

We definitely believe that this kind of organization is in a good position to help in the development of Psychosomatic and Liaison Psychiatry.

13.6.2 Epidemiological Research

Epidemiological research related to psychosomatics has produced abundant papers and good quality research, and this includes relevant Spanish contributions. In an article published in 1997, the potential input of epidemiology to psychosomatic medicine was emphasized (Lobo and Campos 1997) and a review of the state of the art was presented in the last meeting of the European Association of Psychosomatic Medicine (Lobo 2017). Following the outline put forward by a pioneer in epidemiological psychiatry (Shepherd 1978), contributions from the following perspectives have been reported in the international literature. In relation to what Shepherd called “the completion of the spectrum of disease”, early relevant contributions in primary care were reported, such as those related to somatization (García-Campayo et al. 1996); or the reasons for consulting the primary care physician (Vazquez-Barquero et al. 1992). General population studies have been completed, including those by the Cantabria group (Vazquez-Barquero et al. 1997). There was more recent documentation related to the “clustering phenomenon”, the coincidence of somatic and psychiatric morbidity in a sector of the general population, reported for the first time in a predominantly elderly population (Lobo-Escolar et al. 2008) and contributions in a subject of increasing interest, such as the multimorbidity (Olaya et al. 2017). In

relation to the more ambitious task of “the establishment of outcome”, which requires longitudinal studies, some examples include the documentation of the increased mortality in elderly depressed patients (Saz and Dewey 2001).

Of particular epidemiological and public health interest is “the actuarial assessment of morbid risk”, where a relevant contribution deserving an editorial comment in the American Journal of Psychiatry documented that depression in the adult and elderly individuals increases by 65% the risk of type II diabetes mellitus, the ‘population attributable fraction’ being 7% (Campayo et al. 2011). M. Shepherd also underlined the potential of psychiatric epidemiology to contribute to “the evaluation of the efficacy of treatment”, and some relevant studies document in this country the potential of this methodology in the study design (Justicia et al. 2017), including the design of randomized treatment studies (Ortiz Collado et al. 2014). Finally, the British expert also underlined the potential of epidemiological studies for “the conceptual construction of diagnosis and classification”, where some relevant studies have similarly been conducted by Spanish psychiatrists (García-Campayo et al. 1996). In addition to this, other Spanish groups contributing with epidemiological type of studies (Dueñas et al. 2016) have reported on the biological bases of psychopathologies such as pain (Borges et al. 2017), even in experimental, animal studies (Romero-Grimaldi et al. 2015).

13.6.3 Research on Multimorbidity and on “Complex Patients”

In relation to the issue of **multimorbidity**, which receives increasing interest in the international literature (Sartorius et al. 2015) and attracts the attention of psychosomatic related research groups (Olaya et al. 2017), relevant work on **“complex patients”** has similarly been completed in Spain. Internationally, there is an interest in better addressing the health care needs of complex patients. Previous studies suggest that a third to a half of health costs on a year-by-year basis is due to the top 2% and 5% of patients, presumably those with high health complexity (Kathol et al. 2010). To date, it has been difficult to disentangle clinical and non-clinical barriers to improvement, whether biological or non-biological, which would allow systematic corrective action that advances health and function in chronically ill medical patients with health complexity which includes “case complexity” and “care complexity” items (de Jonge et al. 2006).

On the basis of clinician input and empirical testing over the last twenty years by the INTERMED multi-national European consortia (Huysse and Stiefel 2006), the INTERMED complexity assessment tool was initially developed under the umbrella of the ECLW consortium, as a way to address this problem. INTERMED is the first empirically based instrument to link case and care complexity with outcomes for patients who suffer from primary medical illnesses, primary psychiatric illnesses, or a combination of the two and connect identified complexity barriers to prioritized patient-centered assistance. It is a more integrated approach in which medical and psychological, clinical and non-clinical factors receive attention as part of the

	HISTORY	CURRENT STATE	PROGNOSES
BIOLOGICAL	● ●	● ●	●
PSYCHOLOGICAL	● ●	● ●	●
SOCIAL	● ●	● ●	●
HEALTH CARE	● ●	● ●	●



Fig. 13.4 Description of a typical “complex patient” assessed by the INTERMED method in Spain

assessment, intervention, and patient-centered assistance process. The INTERMED has been extensively studied and refined (de Jonge et al. 2006; Stiefel et al. 2008). It is based on the assumption that return to health is dependent on altering factors in four risk domains: biological, psychological, social, and health system (Fig. 13.4). Individuals scoring above the “standard,” threshold have been considered to have worse clinical outcomes (Luthi et al. 2011). The Spanish version has been previously validated by the authors of this chapter, and used in different medical populations in this country (Lobo et al. 2007c).

The new, integrated model of case management inspired by INTERMED, which systematically assesses biopsychosocial and health system case management without the need for case manager handoffs, is increasingly being used as an adjunct to standard clinic and hospital-based care. However, limited detail related to the complexity profile for internal medicine (IM) inpatients has been previously reported. It was in this background that a recent study was conducted on the internal medicine units of two Spanish University and NHS hospitals covering official health regions. The prevalence of health complexity was quite considerable (one fourth of patients). Perhaps the more important finding in this report was that, by using the INTERMED, it was possible to identify differential non-biological actionable health risks and needs associated with clinically meaningful health complexity that should be considered for greater attention in patients admitted to general medical units. However, only a minority of patients with health complexity had a psychiatric referral during their hospitalization. This study concluded that, in IM inpatients, INTERMED identified health complexity could lead to improved patient outcomes through the initiation of corrective action for specific psychological, social, and health system factors that prior studies demonstrate contribute to persistent illness, illness complications, and high health-related cost (Lobo et al. 2015).

Other contributions in the international literature related to Psychosomatic Psychiatry include specific chapters written by Spanish authors in the textbooks of Wise and Rundell (2002); Levenson (2011); Lloyd and Guthrie (2007). And the organization of important international meetings, such as the ones under the auspices of the European Association for Consultation-Liaison Psychiatry (EACLPP), held two different times in Zaragoza, and the 2017 meeting of the European Association of Psychosomatic Medicine held in Barcelona.

13.6.4 Studies in Medical Ethics

One of the most significant changes that have taken place in medicine in recent years has been the change in the clinical relationship, from the so-called medical paternalism to respect for the autonomy of the patient in making decisions about their health (Gracia 2001). The bioethical principle of autonomy is divided into two separate requirements: that of recognizing the freedom to make autonomous persons' decisions, while not harming others, and protecting those who have their autonomy impaired. In Spain, as in some other countries, both in clinical practice and in research it is currently required by law and ethics to obtain the patient's informed consent. The assessment of the patients' mental capacity, included in the general theory of informed consent, is considered to be a very relevant issue in present day PLP, because physicians often ignore a patient's inability to make decisions. The notable frequency of impaired mental capacity to make health decisions has been documented both in medical and in psychiatric patients. Specifically, at least 40% of patients admitted to internal medicine wards have mental disability, although physicians tend not to recognize it (Raymont et al. 2004).

There has been a growing interest in recent years in developing tools for assessing the capacity for decision-making in the field of health (Appelbaum 2007). Among the various tools available to assess mental capacity, the MacCAT T (MacArthur Competence Assessment Tool for Treatment) and MacCAT-CR (MacArthur Competence Assessment Tool for Clinical Research) are considered to have obvious advantages and greater empirical support, being the most frequently used at the international level (Dunn et al. 2006; Banner 2012). Both have stirred considerable interest in Spanish PLP and, in this background, important efforts to validate the international instruments have been done. Thus, Spanish versions of both the MacCAT-T (Alvarez-Marrodán et al. 2014) and the MacCAT-CR (Baón-Pérez et al. 2017) have been validated. According to this model, capacity consists of at least one of the four following dimensions: understanding of the information provided, appreciation of its impact on the person, use of logical reasoning in the process of decision making, and expression of choice. It has been argued that the assessment of the patients' mental capacity contributes to a better quality of care and compliance with the law and ethics in obtaining valid informed consent (Ventura et al. 2014). In this way, it is possible to achieve an adequate balance between respect for the freedom of patients who are capable of make informed decisions and to protect people with impaired mental capacity.

13.7 Special Programs

Among relevant Programs related to PLP, we could certainly refer to initiatives in **Primary Care (PC)**. Our Spanish CL workgroup had strong links with international health services researchers on PC mental health (MH) (Van der Feltz-Cornelis et al. 1997; Creed and Marks 1989). Furthermore, the Zaragoza two-stage epidemiological PC study was carried out in 1993 (Lobo et al. 1996b). The substantial prevalence of hidden psychiatric morbidity was confirmed, the physical and psychiatric comorbidity being more prevalent than expected (Lobo et al. 2007b). In relation to immediate clinical needs and following an international paradigm shift of managed care (Hamilton et al. 1996), an active liaison model between hospital-based PLP teams and PC was established. The Zaragoza model was implemented, with special emphasis on medically ill patients who are reluctant to be referred to a MH outpatient practice (Lobo and Campos 1996). After 20 years, we stand for this model to be more extensively developed by PLP teams and to a lesser extent also by MH teams in the community. Outpatient PLP is still a promise, although some previous initiatives had been recently discontinued because of the economy crisis.

Apart from the shadows, there is some light in relation to outpatient liaison service provision, as suggested by some cost-effective, specialist multidisciplinary clinics. In the Autonomous Community of Aragon some pioneering work has been done in **Psycho-Dermatology**, thanks to Lucia Tomas. She is the current president of the European Society of Dermatology and Psychiatry and is also leading a National Workgroup, which is involved in teaching and research (Dalgard et al. 2015; Marron et al. 2016).

Medical Sexology has a relevant background in Spain, and strong associations with Psychosomatics have been apparent. It is considered to be a multidisciplinary subject, where psychiatrists have interacted with psychologists, urologists and gynecologists. Pioneers in the discipline, such as Krafft – Ebing, Masters and Johnson, Kinsey, Money, Kaplan or Lo Piccolo have been influential; similarly, knowledge and theories coming from different backgrounds, and specifically psychosomatic and psychophysiological theories, factorial personality studies such as those from Eysenck, and behavioral and cognitive theories have proved to be nuclear in the development of sexual dysfunction theories as well as in the bases of cognitive-behavior and pharmacological therapy in this field. Massana, in his *Unit of Psychophysiology and Behavioral Therapy*, Department of Psychiatry of the University Hospital Clinic in Barcelona developed in 1972 the first sexology team in a public institution in this country, collaborating with psychologists and following models based on Eysenck and Marks at the Maudsley Hospital in London. A number of collaborators in this Unit, and particularly JM Farré were crucial to the development of the field in this country. Massana founded in 1969 the first association in Barcelona, the “Societat Catalana de Sexologia “and the first epidemiological contributions were presented at the 1978 meeting of the SEMP.

Clinical activities have persisted since then in several cities, particularly in the Barcelona area, as well as teaching activities and a number of research studies. The main international textbooks have been translated into Spanish, and some into

Catalán, by initiative of and prologue by the pioneers in the discipline. The first international sexology meeting was organized in 1979 by Farré, Maideu and Valdés, in collaboration of the SEMP and its president, V. Salvatierra, from Granada, the main contributions being collected in the first scientific sexology book published in this country. All these activities have importantly influenced the development of the discipline, and specific clinical and research groups, usually multidisciplinary. Farré moved to the Dexeus University Hospital of Barcelona in 1987, to lead the Psychiatric and Psychosomatic Service, where he has been quite active in the development of clinical, teaching and research programs. Amongst the sexology research, they have approached studies related to personality factors associated with sexual dysfunctions; and epidemiological studies.

Relevant contributions in this field include publications such as the “*Enciclopedia de la Sexualidad*”, with 6 volumes; “*La mujer. Su cuerpo y su mente*” (Farré 1998); a book studying women psychosomatic and gynecological problems, including the sexual ones (Dexeus and Farré 1994); original, influential books on the origins of sexual desire (Fuentes 1995); articles on antidepressant induced sexual dysfunction (Montejo et al. 1997); a chapter on sexual dysfunction in a Primary Care textbook (Farré and Lasheras 1998); a 5-year, follow-up study on erectile dysfunction (Farré et al. 2002); or the monograph on sexuality and mental health (Montejo 2003). The SEMP also publishes systematically a *Vademecum* related to psychopharmaca of interest in relation to sexual dysfunction (Hurtado and Dominguez 2017).

In relation to **Psycho-Oncology**, international trends are likewise observed in this country. The role of PLP in cancer patients has been traditional and relevant, as shown by advances in this discipline, and has raised considerable interest (Lobo and Tres 1988). In this chapter, only some relevant topics of current interest among Spanish psychiatrists are highlighted.

1. “Delirium” in cancer patients, a “medical” issue presenting with “psychiatric” symptoms. Some authors in our country refer to it as a “confusional syndrome”, which is considered to be frequent in oncology, the expected prevalence varying from 5% to 30% on the bases of well-documented studies, but in different patient populations.
2. Cognitive impairment that may occur as a result of chemotherapy in cancer patients, affecting their central nervous system (Campos and Lobo 2005). According to the current literature, complaints from patients or relatives can reach 40% of patients, but PLP consultants consider that objectionable difficulties are confirmed in only 20% of patients approximately. While recent studies document that this cognitive impairment is reversible in the medium term, this is a subject of increasing clinical and research interest, as shown by some ongoing studies, predominantly in University hospitals.
3. The role of new psychotherapies. Spanish C-L psychiatrists play an important role in new psychotherapies for cancer patients and their families, and have been influenced by some international guidelines. Specifically, they have adopted the view that emotional distress (“unpleasant emotional experience affecting cognitive, behavioral, social, spiritual”), may be the sixth vital sign in medicine (along

with blood pressure, pulse, temperature, breathing, and pain). Among the three most commonly used models of psychotherapy for cancer patients (cognitive-behavioral psychotherapy, counselling and support psychotherapy, and meaning centered psychotherapy (Watson and Kissane 2011), the latter has recently been quite influential. The relevance of the “Meaning Centered Psychotherapy” (MCP) developed by W. Breitbart at the Memorial Sloan Kettering Cancer Center (MSKCC) has been highlighted and assimilated in Spain by T. Ventura, in the Zaragoza University Hospital, because it is considered to enhance sense, peace and purpose in the patients’ lives, even as the end of their life approaches; and because its usefulness in reducing symptoms of hopelessness and distress and providing spiritual well-being, hope and quality of life have been convincingly supported in specific studies (Breitbart et al. 2012). There are currently ongoing efforts to adapt the different MCP formats to the Spanish environment.

4. A Southern European Psycho-oncology Workgroup was developed by Prof. Grassi, from Ferrara University and current president of Psycho-oncology Section of the WPA, with Spanish participation (F. Gil, Catalan Oncology Institute; and R. Campos, Zaragoza University Hospital), to improve the detection of psychosocial distress in cancer patients. The existing US training models were adapted for Southern Europe (Italy, Spain and Portugal), the oncologists documenting the feasibility of and satisfaction with the program (Grassi et al. 2005). As part of the Psychooncology liaison program in Zaragoza, a 3-year longitudinal study was conducted to explore the psychological adjustment in women survivors of breast cancer (Esparza et al. 2015). This study suggested that post-traumatic growth is not just an illusion, since a correlation with quality of life was documented, the improvement remaining stable at follow-up. It also highlighted the importance of having further intervention studies for the increasing population of cancer survivors.

13.8 Summary and Conclusions

This chapter reviews the important historical background of what we call in Spain Psychosomatic Psychiatry (PP), or Psychosomatic and Liaison Psychiatry (PLP). It has previously been argued that both medical humanism, which has a long tradition and historical roots in this country; and empirical, or evidence based science are crucial philosophical ingredients in present day developments. Different theories born in other countries are also apparent. Aside from theories well known in Anglo-Saxon countries, we review the influence of the so called “anthropological” medicine, the existential philosophy or the “cortico-visceral” medical models. Among the current dominant trends, the influence of the American, consultation-liaison model has been crucial, as observed in the first specific PLP Units generated following this model in the late 70’s. However, the decisive implant of psychiatric services in all general hospitals of the National Health Service stimulated the common clinical sense of psychiatrists, that were increasingly consulted by colleagues from

non-psychiatric services. Some early movements in Psychosomatic Psychiatry research are also reviewed, and important inputs were apparent in the late 70's. International, external observers considered that the main clinical research those years occupied a philosophic orientation midway between the "ultra-Western" (very biological) and "non-Western" (very psycho-social) traditions, meaning that they were positioned midway in the dimension biological-behavioral-psychological-social. Models different from the strict "medical model", and specifically the Johns Hopkins "perspectives" are prominent, and the foundation of *Cuadernos de Medicina Psicosomática y Psiquiatría de Enlace* in 1987 was an important event. The *Sociedad Española de Medicina Psicosomática (SEMP)*, and its PLP Section have been quite active in the last decades, and a specialized Workgroup has also been organized in the *Sociedad Española de Psiquiatría (SEP)*. A notable development of the discipline is documented in a recent national enquiry, showing that among more than 100 hospitals providing data, close to 60% have a PLPU. While the staff is still insufficient, some PLPUs are very active, and most have specific liaison programs. Current education in PLP includes remarkable activities, the crucial one being the mandatory rotation in PLPU's in the official, national 4-year training program in Psychiatry; and the psychiatric teaching directed to general physicians in Medical Schools (MS) is also vigorous. Important research initiatives are similarly apparent, including the organization of National Networks such as the CIBERSAM, which has recruited the most advanced research groups throughout the country, all of them publishing systematically in international high impact journals. Among the prominent research, epidemiological type studies have already an important tradition, and now include studies in subjects such as multi-morbidity or "complexity of care"; in the last years the connection with advanced biological studies and translational type of research is also prominent. Specific areas of PLP interest are related to Primary Care, Medical Ethics, Psycho-oncology and Medical Sexology, all of them with quite qualified representatives.

The general view of the discipline, which aims at an eventual, official sub-specialization in Psychiatry, is quite positive in view of the recent development. Vigorous, individual initiatives have been observed in Spain in the last decades, and might persist in the future. However, it has been argued that the future will depend fundamentally on the vision and compromise of the psychiatric services; on the commitment and leadership of the psychiatrists; and, certainly, on the advances in research and innovation.

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Questionnaire Response

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry

Please return this as an attachment to your email

Country on which you are reporting: Spain

Your Name: Antonio Lobo

Institution: University Zaragoza

City & Country (e.g. London, UK): Zaragoza, Spain

Name(s) and Country of Others who provided information: All authors, from Spain

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?

Yes (X) No () In some sense ()

- a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes (X) No ()
- b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes () No (X)

2. Is there a Department (or equivalent) of Psychosomatic Medicine in institutions in the country?

Yes () No (X)

Is teaching of psychosomatic medicine in medical schools required by law or health care system in the country? YES (X) No ()

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in the institution or other institutions in the country?

Yes (X) No ()

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in the country? Yes () No (X)

- a. If YES, which?

Psychosomatic Medicine () Consultation-Liaison Psychiatry ()

- b. If YES, the status of such certification is:

- i. Independent Medical Specialty ()
- ii. Subspecialty of Internal Medicine ()
- iii. Subspecialty of Psychiatry ()
- iv. An independent non-medical discipline, as Psychology, Social Work

()

v. Other (Specify):[]

5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in the country? Yes (X) No ()

If YES, please list names of the organizations and the websites if available:

-Sociedad Española de Medicina Psicosomática

-Sociedad Española de Psiquiatría, Sección de Psiquiatría Psicosomática y de Enlace

6. Please list the names of professional journals published, if any, in the country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:
-*Cuadernos de Medicina Psicosomática y Psiquiatría de Enlace*, now with a new denomination, *Psicosomática y Psiquiatría*.
7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in the country? Yes () No ()
 - a. If YES, where does it occur? Check all that apply:
 - b. Medical School () Residency () Fellowship ()
8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in the country? Yes () No ()
9. Concerning traditional/folk/indigenous practice of healing in the country (please check all that apply)
 - a. It is insignificant ()
 - b. Some subgroups (e.g. ethnic, religious) practice it ()
 - c. A significant part of the general population practice it ()
 - d. Is the most prevalent healing method used ()
 - e. It is often used in combination with Western medicine ()
 - f. More widely used methods are as follows (Please list, e.g., spiritual healing, meditation, herbal, etc):
10. Please add any comments to your response here:

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Chapter 14

Psychosomatic Medicine in Modern Greece



George Moussas, Athanasios Karkanias, and George N. Christodoulou

14.1 Introduction

Psychosomatic medicine dates back to the distant past, providing us to this day with the simple but innovative idea of an integrated (holistic) approach and consequent integrated provision of services to our patients.

This perception of Psychosomatic disease that arises from the teachings of ancient Greek philosophers and physicians (Christodoulou 1987) keeps influencing the practice of modern medicine to this day and is based on two basic principles:

1. The principle of psychogenesis
2. The principle of holism

The first principle refers to the importance of psychological factors in the pathogenesis of any illness and the second one, arising basically from the teachings of Socrates and Plato (Charmidis 1975) maintains that the part (the organ) cannot be restored if the whole (the body) is not treated (Christodoulou and Associates 2000).

The basic psychosomatic principles (psychogenesis and holism) are prevalent in the perception of illness and health in Modern Greece. People believe that life events play a major role in the development of both physical and mental illness and this is depicted in traditional songs, cinema, films, theater and the Mass Media. To what extent this is the result of transgenerational impact of the teachings of Socrates,

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Plato, and Aristotle or of the evidence arising from observation or experience remains subject to speculation.

As refers to clinical practice, most physicians do take into account psychosocial factors although this position is not subject to adherence to guidelines or systematic teaching and is consequently individualized.

The establishment of psychiatric departments in general hospitals has been a major breakthrough for the dissemination and implementation of psychosomatic principles.

The correlation of vulnerability of a body system or an organ to develop a specific disease, has been postulated long ago (Alexander and Coleman 1934). Vulnerability is associated with life events able to mobilize primary stresses as well as to break established mental defenses functioning successfully up to a point in time (Fava and Sonino 2010). The vulnerable organ can be any single one. For example, some people may have a sensitive digestive system, while others may appear to have a weaker cardiovascular system or certain skin sensitivities etc. (Holmes and Rahe 1967; Holmes and Masuda 1974).

The principles of psychosomatic medicine, its philosophy, the skills associated with it and the experience obtained from its practice have introduced the holistic approach in clinical practice, especially with reference to chronic illnesses. This is particularly important, because with the exception of infections, the most important cause of death globally are chronic illnesses (Engel 1977; Bauer et al. 2010)

Psychosomatic medicine views health and illness under a holistic bio-psychosocial vista, as opposed to the traditional medical model, which understands the disease as a result of only physiological mechanisms (Christodoulou 1987; Novack et al. 2007; WHO 2009; Patel and Prince 2010)

Since 2003, the American Board of Medical Specialties (ABMS) has established the subspecialty of Psychosomatic Medicine within the specialty of psychiatry. This is a clear recognition of the importance of Psychosomatic Medicine (Gitlin 2005).

Lipsitt (2003) has stated that Consultation Liaison (C-L) Psychiatry and Psychosomatics have common roots. These two fields actually overlap. The seed of psychosomatics is dispersed over a wide scientific area. According to Mentzos (2008), psychoanalysis in psychiatry originated mainly from the Psychosomatics approach.

Christodoulou (1987) characterized the psychosomatic approach as an ideology that infiltrates all aspects of not only disease but also health. In his view it is “a comprehensive way of looking at health and disease that contributes to avoidance of over-simplifications, scientific dogmatisms and easy solutions to complex problems”. C-L Psychiatry is one of the implementation arms of the psychosomatic approach (Christodoulou 1987)

According to Fava et al. (2005) Psychosomatic Medicine may be defined as a comprehensive interdisciplinary framework for the following:

1. Assessment of psychosocial factors affecting individual vulnerability, course, and outcome of any type of disease.
2. Holistic consideration of patient care in clinical practice

3. Integration of psychological therapies in the prevention, treatment, and rehabilitation of medical disease.

Lipowski (1986) postulated that C-L Psychiatry is a subspecialty of psychiatry mediating between Psychiatry and Medicine.

14.2 Psychosomatic Medicine in Modern Greece

In Greece, the establishment of psychiatric departments in general hospitals, within the National Health Service (NHS) in 1984 as part of the “Psychiatric Reform” gave C-L Psychiatry a great opportunity to play an important role in the holistic function of general hospitals. Psychosomatic Medicine and C-L Psychiatry influenced physicians, nurses and administrators in a variety of positive and negative ways and in spite of many difficulties arising from divergent perception of priorities (on the part of psychiatrists) and resistances (on the part of physicians) the outcome was as a whole positive and keeps improving.

At the initial phase of the reform, the integration of psychiatric units in general hospitals primarily focused on addressing purely psychiatric patients on multiple structural and operational levels, (clinical departments, emergency services, out-patients’ clinics, etc.). C-L Psychiatry was a function that was difficult to organize and implement because of the lack of trained staff, especially during the first decade. Of course, there have been, and still are to this day, a number of exceptions, but even in the best case scenarios, the situation is far from ideal.

There are, unfortunately, serious deficiencies in primary care provision, made worse by the current financial crisis (Christodoulou et al. 2012; Christodoulou and Christodoulou 2013; Christodoulou 2016). The weight is transferred to the hospitals, especially the public ones. So, inevitably, psychiatric departments of these hospitals have to deal primarily with more urgent priorities (psychiatric cases) rather than C-L cases.

In spite of these drawbacks, however, C-L Psychiatry has advanced the holistic approach in theory and in practice and to some extent has bridged the gap between Psychiatry and the other medical specialties.

There is a rather limited number of Departments offering fully developed psychosomatic services, although therapeutic and research initiatives in a number of psychiatric departments of general hospitals incorporating the principles of Psychosomatic Medicine do exist.

More specifically, in Attica, the region in Greece that includes Athens, there are currently nine psychiatric departments in General Hospitals, two University Psychiatric Departments as well as a Children’s Psychiatric Department. In Thessaly, Macedonia and Thrace, the majority of hospitals have psychiatric departments but these are not yet fully organized towards the direction of developing a fully functioning C-L service.

In Thessaloniki there are three hospitals that have developed C-L services with an approved organization chart and a Psychosomatics Unit. In Epirus there is a functioning service at the University Hospital as well as in the “Hatzikosta” General Hospital. In Crete, the General Hospital and the University Hospital have also developed C-L services.

Nationwide a total of 95 hospitals that have Psychiatric and Children’s Psychiatric Departments have developed C-L services but these do not operate in the same way, as a result of their differences in degree of service development.

On secondary and tertiary care levels C-L Psychiatry constitutes an important sector of the Psychiatric Departments in several hospitals nationwide.

C-L Psychiatry offers:

- (a) Care of patients
- (b) Training of professionals
- (c) Research
- (d) Interaction and cross-talk of C-L psychiatrists with somatic physicians.

This activity has by and large proved beneficial for both parties. Psychiatrists have learned to assess and respect priorities, to avoid the use of psychiatric jargon and to respect the time and effort of other professionals. Somatic physicians have learned to broaden their vista and thus be able to value the therapeutic importance of interaction with the patient and to become more sensitive to their psychological needs, not for reasons of good social behavior but because of the contribution of this approach to a more effective management of somatic pathology.

The Hellenic Psychiatric Association (HPA) since 5 years ago (2011) has set up an active C-L Psychiatry scientific section. The section has developed a number of notable scientific and educational activities.

So far, Psychosomatics and C-L Psychiatry have not been recognized as psychiatric subspecialties in Greece.

14.3 Patient Care

All parameters considered, the current state of the provided psychiatric services in General Hospitals in Greece is an obvious improvement compared to the past. Further progress is presently difficult to achieve due to financial constraints, bureaucracy and inadequate training of physicians and nurses in psychosomatic medicine and the person-centered approach which is a crucial component in the practice of psychosomatic medicine.

C-L Psychiatry can be exercised in a wide spectrum of organizational and service models:

1. The classical model in which a C-L team is called upon by the examining physician to offer a psychiatric consultation/evaluation.

2. The participatory model in which the consulting psychiatrist participates in the activities of general clinics on a regular basis.
3. The specialized model in which the staff of the C-L unit participates in special units such as the Special Infections Unit, Artificial Kidney Unit, etc. (Moussas 2006).

In Greece, it is the classical model that is mainly practiced.

Approximately 20–40% of patients admitted to a General Hospital appear to suffer from mental health problems, yet studies mention that only a small percentage of these patients are seen and are provided with psychological support and care. Only 7–10% of them are forwarded to C-L Services. This percentage appears to be lower in Greece, varying between 3% and 4% (Lykouras et al. 1989; Moussas et al. 2008). As previously mentioned, patients in General Hospitals are seen on the basis of the classical model. In this case, the attending physician requests consultation in writing for a patient evaluation. The evaluation is usually carried out in the presence of the attending physician.

Routine calls are related to situations such as depression, suicidal behaviour, anxiety manifestations, delirium, substance abuse, behavioral disorders, pre-existing mental disease, chronic pain, capacity assessment, legal transactions etc. (Jackson et al. 2004; Kaupp et al. 2005; Andersen et al. 2008; Abbass et al. 2009).

The clinical work conducted by C-L Psychiatrists is summarized in (Table 14.1).

Holmes (1978) has enriched the field of psychosomatics by identifying a group of Life Events that contribute to the development of illness. The life situations presented in the Holmes & Rahe Life Events Scale and their relative importance are of course subject to the influence of cultural factors. For example, in southern European countries loss of a child would be expected to have a greater emotional charge than death of spouse or divorce. This, of course, must be verified by research.

Table 14.1 Clinical work conducted by C-L psychiatrists in a general hospital

<i>Mental disorders:</i>
due to somatic causes
as a reaction to physical illness (medical or surgical)
due to somatization disorder or somatoform disorder
due to psychosomatic disorder
due to co-existing somatic ailments
<i>Psycho-social problems:</i>
Tendency to commit or attempt to commit suicide
Prolonged period of healing without justification (hospital dependency)
Lack of cooperation, non-compliance to treatment or to a recommended course of treatment
Problems with patients treated in Special Care Units (e.g. patients with chronic renal failure, portable peritoneal dialysis devices, oncology patients, Increased Care and Rehabilitation Unit patients, etc.)
Dying patients
Patients facing serious socio-economic problems

Ierodiakonou and Iakovidis (1997), modified

The Interdisciplinary team of C-L Psychiatry in Greek general hospitals should consist of at least a specialist psychiatrist in the leading position, a resident psychiatrist and a psychologist.

The standard patient evaluation procedure is the following:

14.3.1 Procedure for the Assessment of Patients in C-L Psychiatry

1. Referral by the attending physician
2. Provision of information by the attending physician about the nature of the somatic illness causing the patient's hospital admission.
3. Diagnostic Psychiatric and Psychosomatic interview and evaluation of the patient as well as request for information about the patient's history from his/her family
4. Communication with the attending physician, presentation and discussion of the findings
5. Presentation and discussion of the patient's case with the interdisciplinary group
6. Written report
7. Regular monitoring during the period of hospitalization.
8. Suggestions for the management of the patient following discharge, e.g. referral to outpatient department or to community facilities, specialized treatments (individual treatment, group therapy, family therapy, etc.)

Even by its mere existence, the interdisciplinary C-L team promotes the holistic approach in the management of the patient. The team mediates between the patient, the family, the nursing staff, the attending physician and other players. This action helps in reducing the stigma attached to mental illness by actively intervening in matters arising from differences in educational level, training, sexual orientation, culture and attitude between the various partners of the complex interaction that may arise. The participating partners in this complex interaction are psychiatrists, psychologists, social workers, priests, administrative staff, other patients, treating physicians, nursing staff and of course the patient him (her) self whose position is central in this interaction.

Many psychiatrists working in Greek general hospitals have had training in Psychoanalytic Psychotherapy, the Systemic approach, Group-Family therapy, and Cognitive-Behavioral therapy and this is certainly an asset.

The usefulness of the C-L Psychiatry team has been shown to be considerable in the case of patients who refuse treatment and insist on leaving the hospital against doctors' advice. In such cases, the members of the C-L team assess the dynamics between the partners, especially the physician, the patient and the family. Cases of refusal of treatment refer mainly to young patients, drug users, or people who have sustained injury (Albert and Kornfeld 1973; Holden et al. 1989; Milloy et al. 2015). In Greek general hospitals this phenomenon appears quite frequently in patients

with substance abuse and patients suffering from serious somatic illnesses, particularly cancer (personal observations).

On the whole, in Greece, C-L Psychiatry provides services in three basic areas.

1. Cooperation with the attending physician to exchange information and ideas on the psychological, psychosocial and somatic problems of the patient
2. Mediation/ advocacy aiming at establishment of a therapeutic alliance of the attending physician with the staff on the one hand and with the patient and the family on the other
3. Provision of mainly supportive psychotherapeutic interventions aiming at the enhancement of the patients' ability to cope with the stress arising from their illness and mediation on family issues to resolve conflicts or provide psychological support, reassurance and consolation, according to the case.

The management of "Transference and Counter Transference" situations in the therapeutic relationship is a useful tool in the hands of the physician. By applying the principles of non-interpretative intervention and using the Watzlawick principles (1967) of "interactional view", doctors are taught a new approach towards patients and their families. The Paul Watzlawick five axioms refer to communication that takes place during interaction and can be applied in the doctor-patient relationship. Emphasis is placed on the satisfaction of the spiritual needs of the patient, whenever these needs are expressed. This is an important aspect of treatment for some patients.

C-L Psychiatry, as part of a complex and multidimensional hospital system, could play an important role in improving the patients' quality of life, reducing the days of hospitalization and promoting a holistic model of treatment. Unfortunately, the current financial crisis in Greece (Christodoulou and Christodoulou 2013) combined with bureaucratic difficulties, as well as the failure on administrative and political levels to realize its importance, act as obstacles to the further development and utilization of this special service.

To summarize, we could argue that the C-L team actually catalyzes the process of understanding the conscious and unconscious dynamics characterizing the relationship between patients and their families, physicians and the hospital staff, the C-L Psychiatry team and all the other players in this complex interaction. This process lies at the epicenter of any therapeutic attempt and facilitates or hinders treatment and the duration and quality of the patients' hospital stay.

14.4 Training

Training in the field of C-L Psychiatry refers to the training of residents, psychiatrists, mental health professionals and non-psychiatric physicians.

In Greece, the period of training in C-L Psychiatry as part of the requirements for the psychiatric residency lasts 6 months. Training is carried out in general hospitals with Psychiatric Departments in the framework of a rotation system. Apart from the

requirements for training in psychiatry, psychiatric trainees are required to have a good level of knowledge and skills in general medicine.

Every new trainee is supervised by a qualified psychiatrist. The entire team of trainees takes part in the ward rounds and in special meetings to resolve difficult clinical problems. They also receive training and supervision in psychopharmacology psychotherapeutic interventions and communication techniques.

The team of C-L Psychiatry participates in the training programme of the Psychiatric Department in the general hospital. There are no universal training protocols pertaining to C-L Psychiatry but in most departments training is individualized (person-centered) as “a person-centered psychiatric practice requires a person-centered psychiatric education” (Ramalho et al. 2016).

In recent years, an intense activity has been noted regarding scientific publications and books where specific chapters on C-L Psychiatry and Psychosomatic Medicine appear. Additionally, a master’s programme in C-L Psychiatry addressed to psychiatrists and other mental health professionals by the second Athens University Psychiatric Department has been available to interested candidates over the past 5 years.

The training of trainee psychologists in Psychosomatic Medicine is conducted in the public sector (NHS and Universities) or in the private sector through training in the principles of psychosomatics and psychotherapeutic approaches such as psychoanalytic, behavioral, cognitive and systemic. The role of psychologists in the general hospital is exercised through participation in the C-L therapeutic team. They work under the supervision of psychiatrists.

An important point in the training of trainees is the management of complex psychological problems and “difficult patients” like suicidal patients, patients with substance abuse comorbidity, mentally ill patients with somatic pathology, cancer patients, patients with delirium, patients coming from a different linguistic and cultural environment, patients who suffer from PTSD (as is the case with many refugees who are hosted in Greece in the last years).

14.5 Research

Greek Psychiatrists have always been interested in psychosomatics and have carried out research on relevant topics (e.g. Christodoulou et al. 1977, 1983; Lyketos et al. 1982) but in recent years research has become more vigorous.

Research in the area of Psychosomatics and especially in C-L Psychiatry has undoubtedly contributed to bridging the gap between mental health professionals and somatic physicians. The involvement of mental health professionals in various research protocols has brought recognition on the part of somatic doctors and changed their attitude, which until recently was derogatory and skeptical as regards the scientific competence or general composure of mental health professionals as a whole.

Following the foundation of Psychiatric Departments in general hospitals in 1984 hundreds of presentations and round table discussions have been presented in local and International scientific congresses covering a wide spectrum of topics such as psychological problems of patients with various somatic illnesses, cognitive disorders linked with somatic illnesses, the Intensive Care Unit syndrome, hospitalized self-destructive patients, substance abusers, patients with disorders related to food intake, problems of patients in artificial kidney units, problems of patients with Ca, patients with co-existing mental and somatic illnesses, stress and depression, burn-out syndrome, problems arising from patients' relationship with family members etc.

The participation of Health Care workers in various specialized care facilities, such as Psycho-oncology clinics, Pain Management clinics, Asthma clinics, Chronic Refractory Breathlessness clinics, Sleep Disorder clinics, Rehabilitation clinics, Stop-smoking clinics, Obesity clinics etc. has opened new communication channels with doctors focusing on these issues, thus initiating new scientific protocols for research.

The advances in Informatics and new technologies have offered the opportunity to extend C-L Psychiatry in the primary care field. For example, telepsychiatry, although still at its early stages, is a promising field for Greece, in view of the geographical distribution of the population (remote, isolated areas, including many islands).

In recent years, there has been considerable interest in psychosocial issues concerning cancer patients. Psycho-oncology deals with the psychosocial, behavioral, spiritual, and existential dimensions of cancer, with the reactions of the patients and their families and with the ways to support patients in coping with their illness. It has been recognized in many countries as a subspecialty of oncology (formally established around the mid-1970s in the United States). In Greece, it is the team of C-L Psychiatry that deals with the psychosocial aspects of cancer prevention, the management of psychological and psychiatric problems of cancer patients and their families and the provision of comfort and care to those who need it. The team also tries to raise the awareness of the somatic doctors concerning the distress of the patients and their families.

The importance attached to Psycho-oncology becomes manifest by the fact that the Hellenic Psychiatric Association has established a special psycho-oncology section and within this framework congresses, workshops and research have been carried out.

14.6 Publications

A number of distinguished Greek physicians and mental health workers have published dissertations, books and papers on Psychosomatic Medicine.

Among them, Marinos Geroulanos (1867–1960), Professor of Surgery at the University of Athens and Academician was one of the first physicians who fully

adopted the psychosomatics theory. Professor George Lyketsos (1916–2011), Director of Dromokaition Hospital, has published a great number of papers on psychosomatics (dermatological illnesses, hypertension, peptic ulcer, bronchial asthma), psychologist Anna Potamianou has dealt with psychosomatics under a psychoanalytical view-point, Dr. Nikos Rasidakis published on psychosomatics, mainly in Greek, Professor Haralambos Ierodiakonou from the University of Thessaloniki has published mainly from a historical and psychoanalytic perspective and Dr. Gerasimos Rigatos, an oncologist and medical historian has greatly contributed to Greek and international psychosomatics literature (e.g. Rigatos and Kappou-Rigatou 1987). Peter Sifneos, a psychoanalytically oriented psychiatrist of Greek origin introduced the term “alexithymia” and extensively studied this “no words for emotions” phenomenon.

A research group of the Department of Psychiatry of Athens University at Eginition Hospital led by Prof. George Christodoulou (Christodoulou, Alevizos, Rabavilas, Kontaxakis, Trikkas and others) published extensively on psychosomatic medicine. This group produced papers on alexithymia, peptic ulcer in adults and children, the Irritable Bowel Syndrome and its connection with depression, glosodynia, diabetes mellitus etc. (e.g. Trikkas et al. 1987a, b; Christodoulou and Alevizos 1987).

A book entitled “Psychosomatic Medicine: Past and Future” Plenum Press, New York was edited in 1987 by George Christodoulou, past President of the International College of Psychosomatic Medicine who has also organized two International Congresses in Athens, the 16th European Conference on Psychosomatic Research, 6–11 September 1986 and the 15th World Congress of Psychosomatic Medicine, 16–20 April 1999.

Currently, the establishment of psychiatric units in general hospitals has provided the basis for advancement of research in Psychosomatics and C-L Psychiatry with the subsequent production of publications. Physicians from non-psychiatric specialties have also contributed to psychosomatics literature (e.g. Kosmadaki and Antoniou 2011; Karaiskos et al. 2011). Publishers have also taken the initiative to promote translations of foreign books on psychosomatics into Greek and a quick review has recorded as many as 30 such titles in the last 10 years.

Information about the practice of Psychiatry and the structure of psychiatric services in Greece can be found in a number of publications (Anagnostopoulos et al. 2009, 2016; Christodoulou et al. 2010, 2012).

14.7 The Future of Psychosomatic Medicine

The future of Psychosomatic Medicine in Greece depends, to a large extent, on recognition and acceptance of Psychosomatic Medicine and its implementation arm, C-L Psychiatry by professionals, decision-makers and the public. Psychosomatic Medicine must provide proof of its usefulness and this can be achieved by well-organized and reliable research that reveals its effectiveness and efficiency. It also

depends on the extent to which the holistic approach acquires universal acceptance and (as a consequence of this) is integrated in the everyday practice of medicine, both in hospitals and in the community. It must be pointed out that the practice of C-L Psychiatry should not be restricted to the hospital but should be expanded to incorporate the community as well. Advocacy of psychosomatically oriented physicians addressed to decision-makers and the public is necessary in order to achieve the above goals.

14.8 Conclusion

Psychosomatic Medicine in Modern Greece is based on the principles of psychogenesis and holism introduced to western medicine by ancient Greek physicians and philosophers. The establishment of psychiatric departments in general hospitals in 1984 has been a major breakthrough for the implementation and dissemination of psychosomatic principles. Nationwide a total of 95 public hospitals in Greece have developed psychiatric and children's psychiatric departments with Consultation-Liaison (C-L) services but these services operate on widely varying levels of development, efficiency and effectiveness. In this chapter, patient care, training of residents and other professionals, research and publications on psychosomatics and C-L Psychiatry are discussed as well as the achievements and drawbacks in the practice of psychosomatic medicine. It is concluded that the future of psychosomatic medicine in Greece depends to a large extent on recognition and acceptance of psychosomatic medicine and its implementation arm, C-L Psychiatry, by professionals, decision-makers and the public.

Questionnaire Response

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry in your (or your chapter's) Country.

Please return this as an attachment to your email

Country on which you are reporting: *GREECE*

Your Name: *GEORGE CHRISTODOULOU*

Institution: *I*

City & Country (e.g. London, UK): *ATHENS, GREECE*

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?
 Yes (**X**) No () In some sense ()
 - a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes (**X**) No ()
 - b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes () No (**X**)

2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?
 Yes (**X**) No ()

Is teaching of psychosomatic medicine in medical schools required by law or health care system in your country? YES () No (**X**)

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?
 Yes (**X**) No ()

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No (**X**)
 - a. If YES, which?
 Psychosomatic Medicine () Consultation-Liaison Psychiatry ()
 - b. If YES, the status of such certification is:
 - i. Independent Medical Specialty ()
 - ii. Subspecialty of Internal Medicine ()

- iii. Subspecialty of Psychiatry ()
- iv. An independent non-medical discipline, as Psychology, Social Work ()
- v. Other (Specify):[]
5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes (**X**) No ()
- If YES, please list names of the organizations and the websites if available:
- *Section of Consultation-Liaison Psychiatry and Psychosomatics of the Hellenic Psychiatric Association (E-mail: psych@psych.gr, www.psych.gr)*
 - *Hellenic Psychosomatic Society (www.psychosomatic-society.gr)*
6. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:
7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in your country? Yes (**X**) No ()
- a. If YES, where does it occur? Check all that apply:
- b. Medical School (**X**) Residency (**X**) Fellowship ()
8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes () No (**X**)
9. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)
- a. It is insignificant (**X**)
- b. Some subgroups (e.g. ethnic, religious) practice it ()
- c. A significant part of the general population practice it ()
- d. Is the most prevalent healing method used ()
- e. It is often used in combination with Western medicine ()
- f. More widely used methods are as follows (Please list,e.g., spiritual healing, meditation, herbal, etc):
- Homeopathic Medicine and acupuncture are mainly practiced.***

10. Please add any comments to your response here:

We perceive Psychosomatic Medicine as the theoretical basis and consultation – liaison Psychiatry as the main practical arm of it.

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Chapter 15

Psychosomatic Medicine in Poland



Bohdan Wasilewski

15.1 History

15.1.1 Historical Background and Introduction to the History of Medicine: Sources of Tradition of Psychosomatic Disorders Treatment in Poland

Over the course of more than thousand years of history Poland was a multinational and a multicultural country. It is only after the World War II our country has become homogenous in terms of nationality and culture as a result of murders on the Jewish population, mass relocation of the German population, of the Ukrainians and Poles. In terms of geopolitics Poland is located in the place where Eastern and Western cultures intermingle. The division of Poland during a period of over hundred years of partitions kept its Western and Southern part under a dominating influence of the civilization of the West and the Eastern part – under the domination of the East. In the poorer Eastern and partially – Southern parts of Poland the institutional medicine limited its activity to cities and gentry manors. The majority of inhabitants used services of folk therapists – folk healers, midwives and women who specialized in herbs. It was a continuation of the culture of the ancient Slavs where the medical function was attributed to wizards, shamans and witches who had a privileged social position. One of the most frequent remedies was to say prayers to worshipped gods because it was believed that diseases are caused by the sins or by evil spirits who haunt people. In such cases making sacrifices or using sacred herbs was considered effective. In order to reach their goal – obtain health from a god – the people sought intermediation of pious and virtuous individuals, whose requests would be heard. That is why indigenous priests cultivated the art of healing as those being more

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educated and knowing nature better. This tradition was continued in the period when Christianity was introduced and popularized. Christianity contributed to the decline of medical sciences, as the priests started to despise the natural remedies and insights gained by men many centuries earlier from observation of nature. They turned to the treatment in which liturgical procedures were used to refer to the Lord's grace to free people from evil spirits. The church undertook a combat against competitive activity of rural healers and herbalists who were accused of magic and cooperation with the Devil. The practice of folk medicine was based on magical and religious interpretation of the world, so was the understanding of diseases. Inhabitants of a traditional village were convinced that a disease might come from God as a punishment for their sins. It would touch those who had committed some sin, were guilty and the disease was their penance. It was believed that, if God wants to keep somebody alive, doctor's help is not needed for this to be done. Also the God's opponent – the Devil could cause diseases. Epilepsy, somnambulism and mental diseases were considered devilish. Poland being a country of tolerance did not experience the cataclysm of the inquisition although spontaneous trials for cooperation with the Devil were held and judgements were executed. This nevertheless created conditions for a specific coexistence of the folk medicine and the academic medicine taught in Polish universities since the fourteenth century and practiced mainly by priests and monks.

It should be acknowledged that Catholicism reached Poland with a 1000-year delay with regard to the Western Europe, in a majority of the Polish territory enslavement of peasants was waived as late as in the second half of the nineteenth century. In the second half of the twentieth century the peasants were covered by the universal health care. Illiteracy was common in rural areas. Church schools were the only place to get some basics of education which was mainly limited to religious topics. The activity of shaman healers and herbalists has continued to this day, although its scope is more limited than 50 or 100 years ago. At the same time the Catholic and Orthodox churches actively used psychosomatic methods. Trekking to the holy places has been systematically organized. Pilgrims massively participate in these events with an intention that God saves their health or the health of their beloved ones. In many cases the set-up of the pilgrimage, the very process and the experienced interactions close to religious ecstasy have a significant therapeutic effect. The Roman Catholic Church in Poland also used healers until present time, who carried out their activity in churches, for example Clive Harris for whom the church organized a tour of healing sessions throughout the country with over 9 million attendees.

The activity of priests as exorcists in Poland has a similarly wide range. To my knowledge, Poland has the only training centre for systematic training of exorcists. Priest exorcists undertake to heal people who are 'haunted by the Devil' by expelling it from the body with special prayers and procedures. Spectacular expelling of the Devil that caused confusion of the person's mind is at the same time an ideological lesson for the participants or witnesses. The haunted, held by strong assistants, is writhing in paroxysms and speaks a bass voice of the Devil. The Devil gives in under the influence of prayers, incantations and the image of the cross. The expelling procedures are sometimes repeated or take several days. In the second half of the

twentieth century when a basic structure of public health care was established in rural areas, interventions were made only when unpredictable actions of traditional or religious healers openly put the health of patients at danger. A home treatment using traditional methods was promoted to deal with common diseases while, at the same time the remaining health-related superstitions were criticized. The phenomenon of 'plica polonica' was one of them. There was a conviction that cutting out some tangled hair which had hardened from dirt and sweat and had not been washed or cut for years would lead to the child's disability – a hump and twisted limbs. I quote a story by Czesława Mitrus, born in 1928 in Kozłówka (*Etnografia Lubelszczyzny* 2015). It describes a procedure of removing the plica in a 6 years old boy using the only way that was considered safe: 'only when they baked bread the mother took the bread out, the child stood above ... this bread and only with these little coals they burned these plicas out. And nothing happened. The child was healthy.' In Polish folk medicine, the treatment addressed mainly the symptoms. The ailments such as pains, eczemas, ulcers, etc. were treated. It was not known however how to treat the source of the symptoms. It was the disease that was treated not the sick person. The methods involving all unpleasant means were particularly useful to chase the disease away – disgusting, bitter things e.g.: dung, bitter, cleaning agents, emetics, decoctions of thorny plants. This method was used together with the opposing one – that of 'pleasing the disease' by avoiding everything that could annoy it. It was believed that the disease would calm down at least for some time and often – that it will 'completely leave the sick.' Mineral waters were traditionally used and often their treating features were 'objectively' confirmed. In Eastern Poland a traditional Russian method was used, i.e. basking in the sauna known as the 'banya' combined with whipping the patient with birch twigs to stimulate their blood circulation. In Poland a tradition of hydrotherapy was very strong and used by both traditional folk medicine and medicine based on guild tradition and academic knowledge. The first reports about Polish health resorts refer to Cieplice Śląskie and date back to 1137. Information referring to Łądek date from around 1241. The first treaty on the hydrotherapy was written in Latin by Marcin from Miechów and published in 1522. In 1555 Dr. Józef Struś published his anatomical work. In 1575 the court physician of Stefan Batory – Wojciech published in Krakow a work entitled 'Cieplice' in which he gave the first indications and counter indications to use healing resort treatment. For this reason he is considered the Father of Polish balneologists. One of the first written information about the resorts in Poland was a notice that the Mongols robbed and destroyed bathing devices in Łądek Zdrój around 1241. In 1678 during the ground works a buried source was found at the location of the present source 'Wojciech'. The uncovered items included stone basin for 'sitz baths', a tank carved in a rock, wooden vats, buckets and other items indicating that this source was used for medicinal purposes in very distant times. In 1498 a bathing facility was built in Łądek Zdrój and 'Stare' source was erected. Next, bathrooms, guest rooms and a chapel were built. In 1625 doc Schilling from Nysa provided a description of Łądek Zdrój and in 1677 doc Jerzy Wolter from Kłodzko re-examined and published the chemical composition of water from 'Jerzy' source and listed diseases that could be cured with it: gout, kidney and gall stones, infertility and intestinal diseases (Kochański 2002).

15.1.2 Introduction of Western Concepts of Psychosomatic Medicine, Leading to the Present

In the nineteenth century when the bases of the contemporary psychosomatic medicine were formed Poland was partitioned by three occupants: Russia, Germany and Austria. Parts of Poland remained integral parts of these countries and participated in the process of the development of medical sciences respectively. Academic medicine reached Polish territory mainly in the nineteenth century, deriving mainly from German sources both directly and indirectly through the countries occupying Poland. Thanks to the model of German medicine that formed the basis psychosomatic medicine she has reached Polish territory as an integral part of academic medicine.

The development of academic sciences and medicine was most disturbed in the Russian part where Polish universities and medical academies were closed as a consequence of up-risings organized by the Poles and a policy of russification and national oppression was enforced. Therefore the works of Johann Christian Heinroth (1818) and M. Jakobi (1822) reached the occupied territories in 1795–1915 much more through Germans and Austrians than through Russians. Worth mentioning is a tradition of incorporating the psychosomatic approach in the academic medicine which was initiated by Heinroth and practiced in the University of Leipzig. Wilhelm Wundt (1832–1920) contributed to its popularization. In Leipzig in 1879 he created the first laboratory of psychophysiology which was oriented at examining the influences between the mind and the body. W. Wundt was a tutor of 186 doctoral dissertations, including those of three Polish doctoral students (Wundt 2016).

Aleksander Świątochowski (1849–1938) from the Russian partition gained his doctor's degree under the professor Wundt as his tutor. Due to unfavorable situation in that part of Poland he was not able to continue the research and academic activity (Gaertner 2015b). Leopold Ochorowicz (1850–1917) from Austrian Partition was in a more advantageous situation. He studied at the University of Leipzig and obtained his doctor's degree for the dissertation on 'On Conditions of Consciousness' under the tutelage of Wilhelm Wundt. In 1881–1882 Ochorowicz was a doctor then an assistant professor at the faculty of psychology and philosophy of nature in Lvov University and continued his work relating to the psychophysiology of emotional states in Lvov and Wisła. Władysław Witwicki (1878–1948) was also among the lucky ones – he studied at the Leipzig in a later period and obtained his doctor's degree under the tutelage of Wilhelm Wundt. In the interwar period Witwicki was the head of psychology at the University of Warsaw, his lectures were very popular and wielded significant influence. The period of the 20 years of independence of Poland between 1918 and 1939 was the time of continued fight for unification of the country which had been functioning as separate parts integrated into other countries for over 120 years. It was also the time to protect Polish independence in the war against the Soviet Union in 1920 and in the 1930s the preparation to confront Russia and Germany, which ended in the Russian and German invasion in 1939 and subsequent 6 years of occupation of Poland (Molotov-Ribbentrop Pact) during WW II.

Despite the obstacles related to the tormented history of the country, the development of medical sciences and the academic activities continued in universities. In the interwar period the interest in psychosomatic issues was reflected in the fact that the topic of mental disorders in allergic conditions was chosen as one of three main topics of the fifth General Meeting of the Polish Psychiatric Association (Polskie Towarzystwo Psychiatryczne – PTP) (Płock, Gostynin; 8–10. 06.1935). In the interwar period research centres and academic centres important for psychosomatics were located in Lvov and Krakow (the former Austrian part), Vilnius and Warsaw (the former Russian part) where Polish scientists from Petersburg and Kiev and Poznań (the former German part) worked.

While discussing the contribution of the particular regions of Poland to the development of psychosomatic medicine in Poland I would like to provide a wider discussion about the Krakow school. The beginning of psychology as a separate science at the Jagiellonian University in Krakow was inseparably linked to Władysław Heinrich (1869–1957). This Krakow-born psychologist and philosopher, member of the Polish Academy of Skills (Polska Akademia Umiejętności-PAU), studied mathematics and natural sciences in the University of Technology in Zurich and philosophy and psychology Munich (Heinrich W. 2016). In 1894 he obtained his doctor's degree under the mentorship of Richard Avenarius for his dissertation: 'Bemerkungen zur neueren physiologischen Psychologie in Deutschland mit besonderer Berücksichtigung der Aufmerksamkeit' (Remarks on the recent physiological psychology in Germany with particular regard to attention). He subsequently engaged himself with the Jagiellonian University where he was an assistant professor in the department of experimental physics in 1897–1900. Władysław Heinrich was the first in Poland to conduct experiments relating to emotional sensations. He completed his training in the area of experimental psychology and natural sciences methodology in 1900. He taught psychology and psychophysics. He also studied in Paris. On his initiative the first Laboratory of the Experimental Physics was created in 1903 in Jagiellonian University. Following this example a Psychological Laboratory was set up at the faculty of Philosophy at the University of Jan Kazimierz in Lvov in 1905–1906 and was equipped at an advanced European level. It was destroyed during the World War I and recreated in the post-war period. Its development was influenced by Heinrich's visits in similar centres in Great Britain and in the USA. In 1903–1939 Heinrich lectured psychology, philosophy and methodology of sciences. Therefore it can be stated without exaggeration that Władysław Heinrich was a 'Polish Wundt' in some respects. Inspired by an example of W. Heinrich, another outstanding Polish philosopher Kazimierz Twardowski (1866–1938) did the same in 1907 at the University of Lviv. At the University of Warsaw, Edward Abramowski (1868–1918) opened the third Psychological Laboratory in Poland in 1915 and in the same year he set up the first Faculty of Psychology at the University of Warsaw and later in 1919, the faculty was changed into the Experimental Psychology Unit and chaired by Wundt's disciple – Władysław Witwicki. Another person of extraordinary merit in the Krakow-based psychology group was Stefan Szuman (1899–1972), a medical doctor, psychologist, specialist in theory of arts, painter,

co-creator of the Polish developmental school, creator of the concept of joy of life and the theory of aesthetic education and a precursor of psycholinguistic research.

In 1905 the Department of Psychiatry and Neuropathology was established at the Jagiellonian University and chaired by professor Jan Piltz (1870–1930) and continued by distinguished professors, great personalities who influenced the overall shape of Polish medicine: Eugeniusz Brzezicki, Antoni Kępiński and Adam Szymusik. Jan Piltz – as many other Polish psychiatrists – was influenced by the Russian-Polish Petersburg school where he worked in the Neurology and Psychiatry Clinic of the Medical Surgical Academy in Saint Petersburg for 1 year and obtained his doctoral degree under the academic supervision of Vladimir Mikhailovich Bekhterev. His experience was enriched by the cooperation with Eugen Bleuler in Zurich and work in the neurological clinic at Salpêtrière. After being nominated to the position of professor of the University of Warsaw and the Head of the Neurological and Psychiatric Chair at the Jagiellonian University in 1905 he developed the clinic over the period of 20 years following the example of the psychiatric clinic in Munich – it encompassed three large buildings and several research laboratories, including the neurophysiological one.

In 1948 the worst period in the post war history of the university began – the Stalinist period. Implementation of the comprehensive therapeutic approach promoted by psychosomatic medicine was hindered by the activities of the communist authorities which made it impossible for some known scientists to continue their work. Stalinism affected the philosopher Roman Ingarden, historian Władysław Konopczyński and economist Adam Krzyżanowski and interpreted psychotherapy and clinical psychology as a form of Western indoctrination. In the following decades the political turmoil disturbed the progress at the Jagiellonian University. After Stalin's death in 1953, formerly removed professors started coming back beginning 1956. In 1968 and 1981 waves of student anti-government demonstrations swept through universities. In 1968 the communist authorities initiated activities against Polish citizens of Jewish origin. They were removed from their positions and often forced to emigrate, like many important representatives of psychosomatic medicine, humanities-oriented psychology and psychiatry. One of them was an excellent internist general practitioner professor Julian Aleksandrowicz (1908–1988) the head of the Haematology Clinic of the Medical Academy in Krakow, a clinician, philosopher and philanthropist. Aleksandrowicz paid attention to anthropological and psychological factors predisposing development of diseases already back in the 1950s and popularized working on the psychological aspects as an indispensable part of therapy. He introduced services of psychologists in his clinic and promoted a personal and a more profound contact of the doctor with the patient (Gaertner 2015a). Polish Psychosomatic Association granted professor Aleksandrowicz with an honorary membership and promoted his scientific heritage. Doctors, psychologists and psychotherapists from Krakow also contributed largely to the development of Polish psychosomatics along with internal medicine. In 1950 Dr. Mieczysław Chojnowski and Dr. (later professor) Antoni Kępiński organised a Psychological Laboratory together. It was the first such laboratory in Poland and its task consisted in developing and adapting psychological tests and

carrying out research with psychiatrists. It is worth emphasising that clinical psychology was not lectured in universities in Poland at that time, therefore the activity of this team was truly of a pioneering nature. In 1956 the laboratory initiated scientific cooperation with foreign centres: doctor Choynowski and prof. Zenomona Plużek had additional training in the USA where they completed their studies in clinical psychology. A ward specialised in Eating Disorders Treatment was opened in Krakow in 2002 where both anorectic and bulimic types were treated and which was the only place in Poland where severely ill patients are admitted. In the Krakow centre comprehensive treatment of psychiatric disorders combines both biological therapy (pharmacotherapy and ECT) and psychotherapy including individual, family, and couples therapy, as well as rehabilitation activities. It has a national range and is continued to date. Important psychologists and psychotherapists from Krakow contributed significantly to the introduction of comprehensive therapeutic approach that addressed the psychological component of disease. They were in particular: Maria Susułowska (1915–1998), Jerzy Aleksandrowicz and Maria Orwid, (1930–2009).

It is worth mentioning that since 1992 a Krakow-based Association of Psychosomatic Education has been actively involved in psychosomatic topics related to sociology, philosophy, alternative medicine and psychology. It also publishes scientific articles in a quarterly journal, 'Art of Healing' [pl. *Sztuka leczenia*]. Articles come from yearly symposia on somatotherapy which were organised mainly in Krakow with a cooperation of somatotherapy centers from Western Europe.

At the University of Lvov Wilhelm Wundt's disciple – Leopold Ochorowicz (1850–1917) continued academic activity in the area of the psychiatry and neurology in the interwar period under the lead of professor Henryk Halban, originally Henryk Blumenstok (1870–1933), who was professor of the University of Lvov, and then by his disciple Adrian Demianowski (1887–1959), who was a Polish psychiatrist and professor of psychiatry of the University of Lvov. When Lvov was detached from Poland to become a part of Ukraine after WWII, he moved to work in the Medical Academy in Wrocław (Breslau). His heritage is maintained and continued by Bohdan Wasilewski who draws from the experience passed on by Demianowski's follower – Lucjan Korzeniowski and his follower Stanisław Pużyński. After Poland regained independence in 1918, the University of Vilnius was reorganized with a considerable participation of Stanisław Karol Władyczko (1878–1936). He was a Polish neurologist and psychiatrist, professor of the Psychoneurological Institute in Petersburg and the University of Stefan Batory in Vilnius. He was a follower of Bekhterev – creator of reflexology and a member of the French Academy of Sciences, honorary member of Royal College of Psychiatrists. His disciples included professor Antoni Feliks Mikulski (1872–1925) and subsequently after 1925 – professor Rafał Radziwiłłowicz (1860–1929). The activity of the Vilnius school brought a neurophysiological understanding of functional symptoms to the newly recreated Poland. This approach was inspired by the work of Pavlov and Bekhterev as well as a multi-level approach to understanding of the diseases and treatment.

A separate chapter of the history of Polish psychosomatics owes to a person of a versatile education – Kazimierz Dąbrowski (1902–1980) who established the Institute of Mental Hygiene in Warsaw in 1936 with a support of the Rockefeller Foundation. K. Dąbrowski was a leader of a dynamic development of academic activity and counselling activity related to psychosomatic and neurotic disorders until 1939. During the war and shortly after it, he continued his clinical activity and underground education of psychotherapists (1939–1950). His work was finally closed down in 1950 by the Communist government (Dąbrowski 1964).

During the Second World War the supervision over hospitals was taken over by the German authorities. The Nazi ideology assumed elimination of the weak and disabled -therefore a systemic action of elimination of patients, ‘Aktion T4,’ was carried out. As a result approximately 25,000 patients of psychiatric institutions were murdered in the occupied Poland between 1940 and 1942. In many cases the medical care givers were killed together with the patients (Gliński et al. 1989). Institutions of secondary education and universities were closed; libraries were out of service and robbed. Both the German and the Soviet occupiers physically eliminated Polish intelligentsia in a systemic way. It is estimated that over 850 professors and academic teachers were killed. Many important physicians were murdered under an order issued by Stalin in 1940 to kill 17,000 Polish officers. Many were relocated to Siberia or left Poland for various countries. During the war, Polish Medical Faculty worked at the University of Edinburgh where Polish refugee scientists were stationed.

Both domestic and international political situation influenced considerably the development of psychosomatics in Poland in the post-World War II period. In 1945–47 the pre-war psychosomatic medicine slowly recreated – this was a period when two Polish governments acted independently – one in Warsaw and one in London. Poland experienced a civil war against the Warsaw Government which cooperated with Russia but the iron curtain on the Elbe river had not come down yet to divide the East from the West. The Polish National Institute of Mental Hygiene was under the leadership of Kazimierz Dąbrowski who had dynamically increased the scope of activities. Wards were established, outpatient clinics in several cities opened and the post-diploma education continued academic involvement in the higher education at the Higher School of Mental Hygiene in Warsaw. Numerous researchers undertook again their research in psychosomatics, psychotherapy, including psychoanalysis, that had previously been interrupted by the war. The development of psychosomatics was stopped for ideological reasons when the communists took power in Poland fully in 1947, and the period of the Cold War that divided Europe started. Gradually by 1950 all forms of activity initiated by Kazimierz Dąbrowski were eliminated and he himself – forced to emigrate to Canada – the country which (like Sweden) accepted the victims of ideology based cleansing in Poland until 1968. Between 1947 and 1953 Stalin’s system was implemented in Poland which eliminated all influences of Western ideology and planted the heritage of the soviet science, which led to replacement of psychosomatics, psychoanalysis and clinical psychotherapy with a ‘science’ based on the work by Trofim Denisovich Lysenko (1898–1976). The combat to implement ideologically- correct dogmas by Lysenko involved dismissal from positions, arrests and murders of several outstanding representatives of the sciences in

the Soviet Union. In 1950, compliant to a resolution adopted by the Polish Council of Ministers, the organization and the curricula of all medical academies in Poland were unified in line with the compulsory system of the Soviet Union. Subjects 'infected' with the ideology of the Western imperialism, such as psychology, were eliminated. They were replaced by subjects which were to serve the ideological and political propaganda. Selection of academic staff was also carried out according to ideological criteria. It was obligatory to teach theories by Trofim Lysenko, the leading soviet scientist who denied the existence of genes and promoted pseudo-scientific theories (lysenkoism). In the later period this theory was withdrawn from academic curricula. A special commission chaired by professor Andrei Vladimirovich Snezhnevsky (1904–1987) came to Warsaw from Moscow to support implementation of lysenkoism in 'ideologically resistant' environments of Polish psychiatry and psychology. As a result of the commission's activity radical personal changes were made and influential psychiatrists and psychologists were removed from their positions or transferred to provinces. It was forbidden to teach or research areas that were not based on Soviet sciences, including psychosomatics, clinical psychology and psychotherapy. Stalin's death in 1953, the workers manifestations in Poznań and the political change in 1956 (the Polish October or Polish thaw) ended the era of Stalin's ideology. Nonetheless its organisational and ideological effects were only gradually reduced until the political overturn in 1968 because many important psychiatrists, psychologists and sociologists of Jewish origin had left Poland.

In the new political period (1970–1980) Edward Gierek, who had spent 22 years in Belgium and France, was the leader who opened Poland to the West and considerably liberalized political oppression. Polish psychologists and sociologists made direct contacts with institutions and representatives of medicine and psychology from Western Europe and the USA. In their publications they addressed the need to take into account the problems of the psyche in medicine and introduced the notion of 'psychosomatic medicine' to our country. In the late 1970s these tendencies gained strong popularity.

15.2 Education and Research

Gradual erosion of the communist system and the social movement of the 'Solidarity' (pl. *Solidarność*) initiated a process of a socio-political transformation in Poland that started with a memorable year of 1989 when democratisation of the country started. In a referendum conducted in 2003 the Polish people voted for the accession to the European Union. The country, which chose a pro-European path at the turn of the first and the second millenniums made a consistent choice also in the area of the health care model. The model of the public health care system was mainly based on German example and innovative medical techniques were transferred primarily from the USA. Thanks to the policy of opening to the West, many important colleagues from foreign countries tried to change attitudes of Polish physicians in the 1980s providing documentation of the importance of psychosomatic aspects in medicine. Some of them included R. Kielhorn, A. Krakowski, T. von

Uexküll, W. Jacob, J.J. Groen, A.E. Meyer, H. Moliński, W. Schüffel and several others. The help of foreign colleagues consisted in providing psychosomatic literature, facilitating research trips and giving lectures in Poland for those physicians who were interested in psychosomatics. Success of these efforts was manifested when scientific publications and handbooks of psychiatry and other clinical disciplines were published in Polish literature relating to psychiatry (Łazowski 1979; Leder 1979; Cwynar and Mazurowa 1968) both. The needs visible in the every-day clinical practice and patients' expectations were the main driving force of the psychosomatic medicine in Poland. The scientists who participated in internships on various clinical specialisations in clinics in Western Europe transferred the experience of comprehensive therapy and prevention that addressed psychological and social aspects of diseases. The leading Polish university clinics that propagated comprehensive psychosomatic understanding of therapy and rehabilitation included: Institute of Cardiology of the Warsaw Medical Academy led by prof. Z. Askanas, the Haematology Clinic of the Warsaw Medical Academy in Krakow, led by prof. J. Aleksandrowicz, Neurosis Clinic of the Psycho-Neurologic Institute in Warsaw led by prof. S. Leder, the Unit of Psychosomatics and Sexology of the post-diploma Medical University in Warsaw led by prof. B. Wasilewski and Paediatric Clinic of the University in Lublin led by prof. L. Szewczyk. Obviously the listed centres do not provide a complete range of units and clinics which significantly contributed to creation and development of Polish psychosomatic medicine. The following contributors represent military medicine: prof. J. Łazowski, prof. W. Gruszczyński and prof. Rydzyński, social medicine: prof. Sieniawska, psychology: prof. J. Tylka and prof. K. Wrzesniewski, sociology: Dr. Z. Słowska. New psychosomatic centres were opened both in public healthcare like a Psychosomatic Team in Children's Hospital at Niekańska St. in Warsaw and non-public facilities like Psychosomatic Institute with two clinics in Warsaw and filial clinics in Poznań and Bydgoszcz. Conservative attitude of main medical societies, including the Polish Psychiatric Association impeded recognition of psychosomatics as a medical discipline. A milestone decision was made in 1984 by Polish Medical Association (the largest doctors' association active since 1820) on the initiative of a member of the then presidium of the Polish Medical Association, Dr. Bohdan Wasilewski (later on the head of the Unit of the Psychosomatics and Psychotherapy of the Post Diploma Medical University in Warsaw). The resolution of the presidium established the Section of Psychosomatic Medicine a national autonomous scientific section of the Polish Medical Association. The act of establishing an autonomous psychosomatic association under the patronage of the largest scientific medical association which has a scientific heritage of high reputation enabled many important representatives of internal medicine, cardiology, psychiatry, paediatrics, psychology and sociology and have common debates in Kołobrzeg which resulted in the first publication in 1987 – the first book was published thanks to the Section of the Psychosomatic Medicine of the Polish Medical Association. Consolidation of the psychosomatic movement took place in 1984 when the Section of the Psychosomatic Medicine was created under the auspices of the Polish Medical Association. Its 'Godparents' were among others: B. Wasilewski, K. Czubalski, J. Kuch, J. Tylka, K. Dropowa, J. Łazowski, Z. Słowska and K. Wrzesniewski.

Development of consultation-liaison psychiatry in Poland was derived from the opening of Poland to the Western medicine as a result of somewhat more liberal policy of the government than in other countries of the Eastern Block. It allowed a working cooperation of scientific societies and institutions with their Western counterparts. The first scientific reports falling into the scope of the consultation-liaison psychiatry appeared in the 1960s and 1970s (Hese et al. 1988; Cwynar and Mazurowa 1968) continued by Leder and Brykczyńska (1999a, b); Rymaszewska and Dudek (2009). The 32nd Meeting of the Polish Psychiatric Association in 1976 was dedicated to the aspects of consultation-liaison psychiatry, psychosomatic medicine and the role of psychiatrists in the system of primary health care. In the following years some psychosomatic societies were created: Section of the Psychosomatic Medicine of the Polish Medical Association (1984), Polish psychoncological Society (1992), Commission for Psychiatry in General Medicine under the Polish Psychiatric Association (1993) and the Section of Psychodermatology under the Polish Dermatological Association (2008). This proves the link between the development of the consultation-liaison psychiatry with the development of the psychosomatic medicine. It is illustrated by creation of section specialized both in consultation-liaison psychiatry and psychosomatics under both the general medical associations and specialized ones.

Initiated 1976 at the General Meeting of the Polish Psychiatric Association (1976) the topics of consultation-liaison psychiatry and psychosomatics were maintained during the subsequent general meetings (1989, 2007). Consultation-liaison psychiatry is not currently considered a separate subspecialty. It only constitutes an element of training in the specialty of psychiatry. At the third year of the psychiatry specialization course it is required to undergo a 2 months internship of consultation-liaison psychiatry at a psychiatric ward of a general hospital and to acquire consultation skills. In our country there are few separate units of consultation-liaison psychiatry in university psychiatric clinics and the psychiatrists who deal with the consultation-liaison psychiatry primarily are also few. In general hospitals psychiatric consultations are usually given by psychiatrists employed full time in a mental health clinic or working in a general or psychiatric hospital. Recently, the Polish Psychiatric Association has established the Section of Consulting Psychiatry.

Poland is bordering with Germany – a country where speciality of psychosomatics is strong. Thus in 1970s Poland had to decide what direction of development to follow. The choice was between focusing on the effort to create and develop specialisation of clinical psychosomatics or attempt to increase psychosomatic competences in physicians, general practitioners and representatives of many other basic specialities. Discussions held in the Polish Psychosomatic Association was very emotional yet focused on contents. The proponents of specialisation were grouped around professor K. Czubalski and supporters of the wide training action and withdrawal from further atomisation of medicine were grouped around Dr. B. Wasilewski (later professor) (Wasilewski 2006). A contents-based and democratically moderated discussion led to the adoption of a position that the main direction of the association's activity would be to try to

implant psychosomatics in the largest possible number of medical and psychological specialised associations .

The Section of the Psychosomatic Medicine of the Polish Medical Association was the main driving force of the development of the Polish psychosomatics. Every year it organised Polish psychosomatic symposia, initially in Kołobrzeg, later in other cities of Poland (until now 23 symposia took place). Quarterly organised, scientific training meetings were organised in Warsaw as well as international meetings, e.g. a satellite symposium – European Conference on Psychosomatic Research (ECPR) (in 1988 in Marburg and in 1990 in Helsinki). The Section of the Psychosomatic Medicine published materials from several meetings in a form of a book which included work by (Wasilewski et al. 1987; Tyłka 2000; Ogińska-Bulik and Juczyński 2008; Basińska and Ratajska 2010; Gruszczyński 2010; Wrześniewski 2002; Zalewska-Janowska 2011; Wasilewski 2013a, b; Pilawska & Siemińska 1998). The articles most often addressed psychosomatic problems in cardiological and paediatric diseases as well as rehabilitation, stress-induced neurotic and psychosomatic disorders. Additionally, articles about the theory of comprehensive medical training, health promotion and pharmacotherapy of functional disorders were published. The Section of Psychosomatic Medicine supported publication of both domestic psychosomatic publications (Łazowski and Dolińska-Zygmunt 1997) and the translations of essential foreign work covering the psychosomatic issues (Luban-Plozza et al. 1995). As a result of participation of members of SMP PTL in conferences organised by associations specialised in gynaecology (Klimek et al. 1993), family medicine (Kokoszka 2004), laryngology or oncology... (De Walden-Gałuszko 2011). Five volumes of articles related to psychosomatics with a slight emphasis on ethics or philosophy are the result of the yearly SMP PTL symposia (Wasilewski et al. 1987; Łazowski and Dolińska 1997; Pilawska & Siemińska 1998). During the period 34 years of SMP PTL's activity the interest in psychosomatics has not diminished in Poland despite a temporary period when the authorities of some specialised medical associations were reserved towards psychosomatic medicine. The profile of attendees of conferences show an increasing share of psychologists and pedagogues (as a result of introduction of sanitation and hygiene education in schools). The share of medical doctors decreased to 30% which is certainly too little. The causes will be further explained in the text. In 1987 as a result of negotiations of the SPS PTL with the Ministry of Health and deans of Medical Universities the need to educate students on the psychosomatic approach and a psychological knowledge were acknowledged. Unfortunately, the appeal was misunderstood as an attempt of the psychiatrists to proportionally widen the range of psychiatric education and on that basis, it was rejected by most academic teachers many of whom fought for their respective domains to be taught more irrespectively of the need for an integrated education. In some cities (Warsaw and Krakow) psychosomatic education was successfully included in the curriculum of medical studies as an integral part of studies of internal medicine and cardiology.

In the 1990s the Polish Psychosomatic Association engaged in a local psychosomatic movement, the Baltic Sea Society in Psychosomatica and Psychotherapy

(founded by German psychosomatic specialists H. Speidel and C. Bahne-Bahnson from Kiel, Germany). Psychosomatic specialists from Germany and other Baltic regions (T. Sivik and A.-B. Falaide) personally supported contacts with Polish counterparts. Our latest large common project was the Baltic Psychosomatic Conference in Szczecin in June 1998 in which 250 participants took part. Another important achievement of the last two decades was the inauguration of the Polish Balint Society under the leadership of prof. Bohdan Wasilewski with involvement of prof. S. Leder, J. Łazowski, I. Kaflik and many others. A group of over 50 Balint group leaders emerged with the support of our colleagues from Great Britain – J. Norrel, Germany – R. Kielhorn, M. Stubbe and others, Switzerland – B. Luban-Plozza who also activated Polish students to support this movement. The original outcomes of Polish Balint movement resulted in publication of a few highly valued methodological handbooks relating to this method (Wasilewski and Engel 2011 – Polish edition; Wasilewski and Engel 2015 – English edition; Wasilewski and Engel 2015 – Ukrainian edition; Wasilewski and Engel 2018 – Russian edition). With the support of Polish Balint Society and the SMP PTL the Ukrainian Balint movement was created and elements of psychosomatic medicine were included in the studies of medicine in Ukraine (Bukowiński Medical University in Chernivtsi, Medical University of Lviv). Polish psychosomatics saw development of an original concepts by Bohdan Wasilewski inspired by ethno-anthropology. It conceived most cases of depression which accompany somatic diseases as an adaptation reaction which signals the disease in a similar way as the pain and causes the individual to exclude himself or herself from social functions in order to gain energy to fight the disease and trigger social support indispensable for the healing processes. In Wasilewski's concept the depression fulfils initially a function of a physiological defensive reaction (Wasilewski 2008; Egan et al. 2014). When it lasts for a longer time it becomes a pathogenic factor and another component of the disease. Prolonged states of depression met with negative signals from people who create the patient's environment lead to a phenomenon of thanatosis (Wasilewski 2014a, b, c). In B. Wasilewski's concept it is an analogical process to apoptosis on the cellular level, i.e. auto-elimination of the cells. It is an unconsciously activated process of a programmable death of the human being. Erosion of social bonds is crucial for the thanatosis to be triggered as a continuation of a depressive reaction. In the author's view the phenomenon of occurrence of depressive states currently observed in Western countries is predominantly the result of a civilizational breakthrough which is taking place while abusing the social bonds and patterns of understanding the world and peoples' conduct (Wasilewski 2018).

15.3 Summary

Being located in an area of mutual influences of the Latin culture of the West and the Euro-Asian culture of the East, Poland was a clashing point for interactions between the Anglo-Saxon medical tradition and the Euro-Asian medical heritage

of Russia in the field of development of psychosomatic medicine. Eclectic model of understanding of the psychosomatic medicine dominates in Poland. It draws insights from various directions, including a psychoanalytical, behavioural or a holistic-ecological ones. An openness to new directions and specializations facilitated the integration of psychosomatics into different medical and psychological aspects but to serve as an obstacle to develop psychosomatics as a separate clinical specialty.

Questionnaire Response

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison

Psychiatry in your (or your chapter's) Country.

Please return this as an attachment to your email

Country on which you are reporting:

Your Name: Bohdan Wasilewski

Institution: Psychosomatic Institute, Warsaw, Poland

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?

Yes (X) No () In some sense ()

a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes (X) No ()

b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes (X) No ()

2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?

Yes (X) No ()

Is teaching of psychosomatic medicine in medical schools required by law or health care system in your country? YES () No (X)

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?

Yes (X) No () few in the country

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No (X)

a. If YES, which?

Psychosomatic Medicine () Consultation-Liaison Psychiatry ()

- b. If YES, the status of such certification is:
- i. Independent Medical Specialty ()
 - ii. Subspecialty of Internal Medicine ()
 - iii. Subspecialty of Psychiatry ()
 - iv. An independent non-medical discipline, as Psychology, Social Work ()
 - v. Other (Specify):[]
5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No (X)
- If YES, please list names of the organizations and the websites if available:
6. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:
- Sztuka Leczenia/ Art of Healing
7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in your country? Yes () No (X)
- a. If YES, where does it occur? Check all that apply:.
 - b. Medical School () Residency () Fellowship ()
8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes () No (X)
9. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)
- a. It is insignificant ()
 - b. Some subgroups (e.g. ethnic, religious) practice it (X)
 - c. A significant part of the general population practice it ()
 - d. Is the most prevalent healing method used ()

- e. It is often used in combination with Western medicine (X)
- f. More widely used methods are as follows (Please list, e.g., spiritual healing, meditation, herbal, etc):

10. Please add any comments to your response here:

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Chapter 16

Psychosomatic Medicine in the Baltic States, Soviet Union, and the Russian Federation



Gunta Ancāne, Artūrs Utināns, Artūrs Ancāns, and Artūrs Miksons

16.1 The Development of Psychosomatics in Latvia

16.1.1 *Healing in the Baltics During the Ancient Times and Middle Ages*

In Latvia, a psychosomatic approach to disease can be traced as far back as the Paleolithic era, though from today's perspective, the approach may be seen to be geared to the placebo effect. The Baltic tribes practiced magical healing and incantations. A witchdoctor or healer mainly based his technique on animism or animistic magic as shown by numerous idolatry figurines and other forms of art that were presumably used for these kinds of purposes (Derums 1988). In the bronze and iron ages special abilities were recognized as being supernatural human abilities – being able to contact with the supernatural world, in order to heal diseases. In the Latvian territory these people were called fortune tellers, witch doctors, wizards, prophets, witches (in a positive sense), enchantresses, quacks, medicasters etc. (Adamovics 1995). For Latvians the “positive witch” or good goddess is quite peculiar, compared to Western European traditions, because she is a human being with god-like gifts or powers (Laime 2013, in reference to Biezais 1955). Another good goddess for the Baltic tribes was Mara, whose one of many functions was to be a part of the childbirth process, which usually took place in a bathhouse for ancient Latvians.

In the Baltic healing beliefs various objects like spring water, plants, sacrificial stones and tombstones had an important role, because magical powers were bestowed upon them. For example, the sick were fully undressed and laid down on the ground naked, sprinkled with “magical” water, while their clothes were left by

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the “magical water” source, so that “all the pains and ailments stayed there”. Braids taken from tombstones were used to treat various diseases (Straubergs 1995).

Tribes of the Baltic territory are considered the last pagans of Europe. Christianity entered the Latvia and Estonia territories only in the thirteenth century. In the Middle Ages the Livonian order monks that practiced religion therapy tried to get rid of folk healers. The Livonian Chronicle of Henry mentions a monk by the name of Teodorih, who tried to convert Latvian peasants to faith healing – without herbal and plant remedies which were used by the folk healers. In the following centuries folk healer beliefs interblended with the Christian beliefs.

16.1.2 An Independent Latvia in the Beginning of the Twentieth Century

The development of Psychosomatics in Latvia went closely with the development of psychotherapy. At the beginning of the twentieth century, parallel to hypnosis, psychoanalytic ideas had entered Latvia. The works of Freud, Stekel and other psychoanalysts were translated and at the same time psychoanalysts worked in private practice. A professor in internal medicine Martins Sihle drew his attention towards ideas of psychosomatics in Latvia; he used the words psychosomatics, psychosomatic disorders and invited to practice psychotherapy and psychoanalysis, as well as analyzed the work of S. Freud, A. Adler and C.G. Jung. M. Sihle proposed a direction he named “Synthetic medicine”. In 1930 the first international conference in “Synthetic medicine” was led by Martins Sihle in Riga, capital of Latvia.

Professor M. Zile wrote: “Synthesis shows us the way to the human psychosomatic phenomenon as a new interpretation principle.” In his synthetic medicine concept he included biopsychosocial and mental factors in the etiology of diseases and used the terms “psychosomatics”, “organ neurosis”, “functional disease”, “locus minoris resistentiae”, “the purpose of disease”, “hygiogenesis (a analog term for salutogenesis)” as well as the huge role of psychotherapy in treating psychosomatic disorders. Professor M. Zile examined “spiritual” factors, that act parallel to mental and social factors, which included “the soul”, “the world ether”, “the spirit” and religions role in the treatment process of psychosomatic disorders. M. Zile’s synthetic medicine concept corresponds to present day approach of “holistic medicine”.

16.1.3 Psychosomatics in Latvia in USSR Before and After WWII

The fruitful development of Latvia as an independent state was interrupted in 1940 by Russian/soviet invasion. The same occupation happened to the other two Baltic States – Estonia and Lithuania. This was a tremendous trauma for a highly educated,

business and responsibility oriented, diligent society. The unacceptable values of another civilization (Samuel P. Huntington's concept) (Huntington 1996) were violently introduced. The relativism of moral standards, huge amounts of lies in official and public space, the murders, including public executions, and disappearances, the deportation of thousands of the most educated, prosperous people (together with their families, including little children and babies) to Russian Siberia had the long lasting effect on the mental health of society – an overwhelming fear was created.

A development of “Psychosomatics” or “Psychosomatic medicine” could not happen in the Soviet Union, because concepts of personality, the unconscious, etc. could not exist in an enslaved state and such topics were excluded from everyday life and the medical curriculum.

The living conditions in the Soviet occupational system themselves were psychotic in the sense that reality was denied. It was not allowed to see the poverty, dirtiness, hypocrisy all around. Occupation as a fact was denied and called “brothers help”. The life without freedom, a slave's life was especially hard to endure for the intelligent, artists, scholars, etc. Those whose activities demanded to be in contact with reality, as, for example, a doctor's work, was harder still.

As a rule, soviet men “building up communism were happy”. The few persons (dissidents) who openly pronounced a critical view to the soviet regime and were not happy about the reality were proclaimed “psychotic” and imprisoned for psychiatric “treatment”.

There were two kinds of hospitals. In general psychiatric hospitals, patients were mostly treated with psychotropic drugs and then “special” psychiatric hospitals in which “dangerous” patients were treated sometimes with such therapies as electroconvulsive therapy. Sometimes dissidents were placed in these “specialized” hospitals. The most frequent diagnoses were “sluggish schizophrenia”, bipolar disorder (manic and hypomanic phase) or personality disorder (in the last years of USSR they were named as psychopathies, for example, schizoid or psychoastenic psychopathy). The treatment of choice were neuroleptic drugs.

The tremendous fear and desperation in Latvia's people manifested not verbally but in high levels of alcoholism and somatization, less in crime. The life without self-respect and lack of respect of others who were all seen to be hypocritical liars and losers in the communication with conquerors and among themselves, created a lot of personality disorders. Life was hard for those who tried to be in contact with reality and even more for those, who tried to escape the awareness of the reality of captivity. The loss of self-esteem and self-value was one of the consequences. One of the most necessary characteristics for mental health was taken away.

Such specialties as narcology, (term is similar to “addiction psychiatry”), sexology and psychotherapy were formed as subspecialties of psychiatry. They were not popular. Some books with the title “Psychotherapy” were published. But they were not appreciated. More appreciated were books with hidden psychosomatic content. One of them was Dr. Natan Elstein (Elstein N. (Эльштейн Н.) 1983) in Estonia. He was an internal medicine specialist and wrote in his books how important it is to diagnose patient's feelings, because every emotion always goes together with the vegetative reactions inside the body.

There were a lot of psychosomatic disturbances in somatic hospitals. The attempts to ask psychiatrists for help in these situations were not successful because patients were often afraid of being registered as psychiatric patients. The patients much more willingly spoke about their emotional issues with those internal medicine doctors who had a wish to speak with them about emotional matters and feelings.

For general practitioners and internists helpful were the books of Latvian professor in psychiatry Imants Eglitis (Eglitis 1974, 1979, 1982; Eglitis et al. 1985) written on neurosis and psychosomatic disorders that were labeled in the Soviet Union as “small” psychiatry. These books were very much approved by general practitioners, and disregarded by psychiatrists, who in Latvia were very much biologically oriented and strongly against the “psychologizing the patients” and against psychodynamic understanding. The majority of psychiatrists worked in the field of “big” psychiatry – schizophrenia and bipolar disorders – and were denying every idea about the importance of psychosomatics.

Psychiatrists acquired their education in general medicine (6 years) and then specialized in psychiatry (1 year internship in internal medicine and 1 year in psychiatry). During the internship in psychiatry the young specialists were introduced to the concepts of masked and somatic depression that were understood as endogenous depression with somatic manifestations. Psychiatrists also learned about vegetative disorders caused by anxiety that were diagnosed as “neurocirculatory distonia” or “vasovegetative distonia”. Although these anxiety disorders were treated by general practice doctors (in the Soviet Union there was no separate specialty as family doctor), while psychiatrists treated masked or somatic depressions with anti-depressants.

The emotional etiopathogenetic factors in the occupied society were relevant. And the primary and the secondary gain of illness played its role. The psychosomatic disorders and illnesses existed. At the same time the psychoanalytical thinking about the role of the unconscious and the role of repressed emotions in the etiopathogenesis was forbidden. Still the medical practice needed some theory to understand the phenomenon of a somatization. Soviet authorities tried to fill this knowledge gap with the theory of two Russian scientists Konstantin Bikov and Igor Kurzin (Bikov and Kurzin (Быков К.М., Курцин И.Т.) 1952) called cortico-visceral theory. It emphasized the connections between the brain and all inner organ systems and their mutual influence. The main problem of it was that this theory looked at the person as an inhuman automatic machine, with cortex, with reflexes, but without emotions and without a personality. Still, this theory was appreciated very much by Soviet authorities as a counterbalance to western psychoanalysis and was imposed on the medical profession. In the 1950s of the twentieth century every research paper (dissertation) had to begin not only with a reference to the last communist party congress conclusions, but also with a summary of the impact/relevance of the cortico-visceral theory to the particular field, even traumatology and orthopedics. The vast majority of doctors felt only frustration for this theory.

Some 20 years later, in the 1970s, Eastern –bloc countries introduced the ideas of the civilization illnesses. They put an accent on the social factors, such as the

impact on health of environmental contamination, stress, urbanization etc. They were accepted by medical doctors, but ignored by authorities. The Soviet medicine remained single-mindedly biologically oriented.

Recommended treatment options for treating symptoms, which we currently call psychosomatic, were psychopharmacology, physiotherapy, psychotherapy. Methods of choice in the Soviet Union in psychotherapy were hypnosis, autogenic training, suggestion and self-suggestion, so called rational psychotherapy. Collective psychotherapy was used in large group work. The basic theoretical model that was used in psychotherapy to treat psychosomatic disorders was P.K. Anohin's biological theory of emotions (Simonov 1986; Topolansky and Strukovskaya (Тополянский В.Д., Струковская) 1986; Makarenko and Sudakov (Макаренко, Судаков) 1976), but the value of psychoanalytic theories was denied.

During the time of the USSR a small amount of doctors from Latvia had additional training in the mentioned psychotherapy methods and/or sexology in Behterv Institut (a 2 month course led by prof. Sergej Libih) in Leningrad. This additional training was promoted by the lead psychiatrist of Latvia at the time – Dr. Zuzanna Socneva. Prof. Sergej Libih and his assistants were successful in giving some knowledge in psychoanalytical way of thinking.

Despite the fact that a fair amount of Latvian doctors were deported in 1941 and 1949 to Russian Siberia or had emigrated to the West after WWII, Latvian medicine managed to save a few traditions from the time of the First independence which were psychosomatically oriented. Psychosomatically oriented here is meant to be more human, paying attention and respect to the emotions of patient. Mainly it concerned the doctor-patient relationship.

Pauls Stradins multidisciplinary hospital became especially famous. Pauls Stradiņš himself was a talented surgeon, who had worked in this hospital in the 1920s to 1950s, absolutely devoting his life to his patients.

Some patients wanted to be hospitalized in this particular hospital believing it a precondition to get healthy again. This raised a wish among medical students and young doctors to study and work in this hospital.

In this way the tradition of the doctor-patient therapeutic relationship was passed on – the understanding of the importance for the patients' health of a trustful and respectful emotional relationship between the doctor and the patient.

In a situation in which such a notion as “psychosomatics” did not exist, the doctors learned about the crucial meaning of emotions in etiopathogenesis and convalescence and tried to explain it to the patients. Patients felt relief after these conversations with doctors due to their feelings being understood. It was a kind of cognitive behavioral approach with some psychodynamic elements. Still it was never called “psychotherapy”, because no forms of psychotherapy officially existed.

One of the departments in Pauls Stradins hospital – Gastroenterology department – was successfully lead by an “old school” doctor Professor Dr. med. Nikolajs Skuja. This department was bursting with activity in treatment, education of students and doctors and research. This was the place where many doctors used to have every-day practice with patients in psychosomatic approach without calling it so. The patients who received treatment here were greatly satisfied with their treatment.

In 1981 researcher doctor Gunta Ancāne received the following research topic – how to decrease the relapse rate of duodenal ulcer. The dissertation “The prevention of ulcus duodeni relapses using psychotropic drugs” was written and presented in two specialties – in internal medicine (supervisor prof. Nikolajs Skuja) and psychiatry (supervisor prof. Imants Eglitis) and presented in 1986.

The main conclusions were that patients with ulcus duodeni always had some mental (emotional) disturbances, like anxiety or depression. The more intensive the mental symptoms are, the more untypical the clinical picture of the ulcer was. For example, so called “mute ulcer” – endoscopically visible but without clinical symptoms – was strongly correlated with depression signs. The dissertation contained some innovative ideas in the USSR, for example, the reciprocity between depression symptoms and the amount of Enterochromaffin cells in duodenal mucosa (invention certification Nr. SU-1374472. Ancane G. (Анцане Г.) 1985).

After the presentation of the dissertation, Dr. Gunta Ancane developed a standing consultation service in psychosomatics/psychotherapy at the Pauls Stradins Hospital. The demand for the consultations was high and from almost all departments: internal medicine, cardiology, pulmonology, endocrinology, and rheumatology.

16.1.4 Psychosomatics in Latvia in the Second Independency Since 1991 Till Now

The collapse of the Soviet Union was a difficult time. “It was the greatest and perhaps the most awful event of recent times. For the Soviet Union was not a civilization that once was great. It was uniquely mean and mendacious even in its brief hour of triumph” (Davies 1996).

These words show the absence of ethical values in USSR and this had an impact on people’s mental state. The deep wish for freedom was not mature enough; there were some infantile aspects in people that made it hard to take responsibility for their own lives. There was a wish to complain that others have done us wrong. Many people did not have the strength and maturity to start with rebuilding themselves and the state responsibly.

People after the collapse were confused, without a clear understanding of what to do next, because everything had changed. These were people, who knew what they should do but without the knowledge how to create the new state. The people were not used to think and to take decisions on their own. Even nowadays the lack of self-esteem and self-confidence can still be found as a feature in many Latvians.

As the “Iron curtain” fell, in the 1990s, Western specialists began to come to Latvia to give lectures and seminars. This significantly broadened the horizons of Latvian physicians and introduced them to world practice. These people were exceedingly different. The biggest surprise for Latvian doctors was that they mostly were not medically educated at all. In Latvia “psychotherapy” was identified with

the certain way of treatment that automatically belongs to the field of medicine. A fair amount of people coming with these lectures were far from medicine. Still everybody tried to advertise this method as the main one for mental health issues. Freudians, Adlerians, Jungians, Gestalt therapy, psychodrama, children therapy, art-therapy, group therapy, positive therapy, family therapy, cognitive-behavioral therapy, and many others advertised themselves as the most crucial psychotherapy forms for treating patients. At that time there was a popular expression that psychotherapy has 400 technics. We feel proud that in this offered pudding we could find which methods would be most suitable for the medical practice, choosing two directions – psychoanalytical-psychodynamic and cognitive-behavioral psychotherapy in their different organizational forms – individual, group, family, and children's therapy.

In 1991 the Latvian Psychotherapists association was established as a part of Latvian Medical association, who is responsible for the certification and the level of professionalism.

In 1992 the Latvian Psychosomatic medicine and Psychotherapy association was established.

For one period there was an idea to develop psychosomatics and psychotherapy not as an independent specialty but in the frame of psychiatry. But the authorities of psychiatry were very much against new ideas about the role of emotions, mental health, psychosomatics, psychodynamic understanding. May be it was due to the fact, that in Latvia psychiatry was mainly biologically oriented, much more than in neighbors countries Estonia and Lithuania. In Latvia the Soviet/Russian psychiatry was much stronger. So called Sneznewsky's (Moscow leader of psychiatry) school, which was political and antihuman oriented, was quite strong in Latvia. In the circumstances where the psychosomatic approach was denied and despised, it was impossible to develop it within the framework of psychiatry. That is why Psychosomatic Medicine and Psychotherapy developed as an independent medical specialty separate from psychiatry. It is possible that other non-medical professionals could practice psychotherapy in the future, however under the conditions that their education and training systems are structured and regulations for their practice are defined.

For Latvians the German experience was very helpful. The independent specialty in "Psychosomatische Medizin und Psychotherapie" was established in 1992 as well.

A big influence on the development of psychosomatic medicine and psychotherapy was from the First Baltic Sea conference on Psychosomatics and psychotherapy in Kiel (Germany) 1992, that was organized by Prof. Dr. med. Hubert Speidel and Prof. Dr. med. Klaus Bahne Bahson. Many hundred post-soviet state doctors were given the possibility to visit the Western country and to get exclusively new experience and knowledge. For many it was the first time in a Western country or even abroad. It was possible due to the noble-minded financial support of the organizers and sponsors. Without financial support the attendance of the conference would not have been possible for many Latvians due to the fact that a doctor's salary in Latvia, at the time, was about 200 dollars a month.

The new experience in Germany for many was shocking due to the unexpected humane approach and respect for people. More than ten doctors from Latvia were not only invited, but also the airplane tickets, the accommodation and the congress fee were paid in full by the organizers. Such a caring level of organization and attention to Eastern European countries gave many Latvian doctors an opportunity to get an extraordinary experience and new knowledge. This was a crucial point which not only gave knowledge but also gave insight into practical treatment aspects in psychosomatic medicine.

In 1993 another relevant event took place in Riga – excellent lectures in Psychosomatics were given by Professor Dr. Ulrich Malt from Norway. These lectures and seminars had a high attendance and the interest was outstanding. Hundreds of doctors from different specialties got unforgettable impressions.

In 1994 a great success was a lecture in Riga by Professor Dr. med. Hubert Speidel from Germany about the issue “Psychosomatics in surgery”.

The association of Psychosomatic Medicine and psychotherapy organized The Baltic Sea Conference on Treatment in Psychosomatics in Riga in September 1996: The Bio-Psycho-Social Approach. It was a significant contribution to education of all physician specialties in psychosomatic aspects of medicine. The speakers were world leaders in psychosomatics – prof. Ulrick Malt (Norway), prof. dr. med. Klaus Bahne-Bahnsen (Germany), prof. dr. med. Hubert Speidel (Germany), prof. Lennart Levi (Sweden), professor Charles V. Ford (USA), prof. Tatjana Sivik (Sweden). The interest generated by the congress was outstanding (Ancane 2011).

Psychoanalytic knowledge was an important factor that has promoted the development of psychosomatic medicine. From 1992 to 1995, 24 Latvian psychotherapists learned basic psychotherapy (mainly psychodynamics) in Eskilstuna, Sweden. From 1996 five Latvian psychotherapists were participants in a Norwegian analysis training group in Lithuania where they learned psychoanalytic theories and practice. From 1997 to 2000 twelve Latvian psychotherapists learned psychoanalytic psychotherapy in Sweden's Karolinska institutet. From 2000 eight Latvian psychotherapists have successfully completed various foreign programs to become psychoanalysts in accordance with the requirements set out by the International Psychoanalytical Association (IPA).

From 2005 to 2008, 18 Latvian psychotherapists took courses in child and teenage psychoanalytic psychotherapy lead by Finnish specialists.

The 3 month' study course in Psychosomatics and Psychotherapy for the doctors became so popular that the Faculty of Medicine wished to organize this as a course for the medical students. In 1994 at Riga Stradins University (the former Latvian Medicine academy (LMA)) a course in Psychosomatic medicine and psychotherapy was founded, which, in 1996, transformed into the Department of Psychosomatic medicine and Psychotherapy. In 2011 the department expanded and became the University Out-patient Clinic of Psychosomatic Medicine and Psychotherapy. The department provides education for undergraduate, postgraduate and doctoral studies, serves as a treatment and research center, as well as organizes psychoeducational and health promotional activities.

16.1.4.1 Education

The undergraduate study programs are developed for students for all health faculties – Medicine, Stomatology, Public health, Nurse Care, Rehabilitation.

The postgraduate study programs for residents are two kinds – for postgraduate studies 4 year long residency in Psychosomatics and psychotherapy and smaller programs for residents from other medical specialties, like surgery, gynecology, psychiatry, dermatology, pediatricians, family doctors, etc.

The main topics for students – doctor-patient relationship, personality theories, psychological defense mechanisms, bio-psycho-social model in medicine, psychosomatic theories (Freud, Schur, Alexander, Mitscherlich), alexitymia concept, primary and secondary gain of illness, stress and distress, the role of feelings and emotions, psychosomatic disorders and illnesses, introduction in psychotherapy issues – introduction in psychoanalytic/psychodynamic, cognitive behavioral, individual, group, family, children's therapy, supportive therapy, crisis intervention.

These study programs have changed during the years. From the beginning in the 90s, student and postgraduate student programs were rather similar because everybody started from zero.

Currently residents have already 111 academic hours of knowledge that is why new content is developed.

The 4 years postgraduate study in Psychosomatics and psychotherapy includes: (1) 540 hours of theoretical lectures and seminars, (2) 360 hours of supervisions and (3) 150 individual sessions in psychotherapy.

During studies the students are acquainted with different kinds of psychotherapy, but mainly they are trained in psychodynamic psychotherapy.

In spite of the substantial role of psychosomatics, this word does not appear in the specialty official title – MD with a specialty certification in psychosomatics and psychotherapy. The reason is illogical – in the mid-90s civil servants asked to shorten the title from “Psychosomatics and psychotherapy” to “Psychotherapy”. The doctors made a mistake and agreed. Now we are on way correct our past mistake and take the initial title back.

After the studies in residency a certification test follows that is organized by the Latvian Medical association, after which young specialists have the right to start an independent clinical job with the patients. A recertification is mandatory every 5 years.

Currently 76 doctors are certified in psychotherapy (and psychosomatics).

In 2012 in collaboration with the German and Austrian colleagues the Association of European Doctors for Psychosomatic medicine and psychotherapy (AEPM) was established.

In spring of 2013 the RSU Clinic of Psychosomatic medicine in collaboration with The Association of European Physicians for Psychosomatic Medicine (AEPM) organized an international seminar “Psychosomatic health – challenges and opportunities.” The three main speakers were:

Prof. Dr. med. Matiass Rose, who heads the Psychosomatic medicine Centre in Berlin Medical university clinic Charite, Prof. Dr. med. Thomas Löwe, who is the

head of the Psychosomatic clinic at Regensburg university and Dr. med. Bernhard Palmowski who works at the Berlin Psychosomatic medicine academy and is a board member of Berlin/Brandenburg German Psychosomatic medicine and psychotherapy association. In recent years there is a regular collaboration with dr. med. Bernhard Palmowski in particular.

In 2015 guest lectures and practical seminars were given by Marburg University Internal medicine center psychosomatic division Prof. Dr. med. Wolfram Schüffel from Germany.

The same year in Riga, a Spring workshop was organized: “Psychosomatic aspects in cardiology, gynecology, oncology, neurology and family practice”.

In April of 2016 in collaboration with CPME and Latvian physicians association Riga conference 2016 was organized on the topic of “The Doctor-patient relationship and migration crisis in clinical practice.”

The Department of RSU Psychosomatic medicine and psychotherapy functions as an opinion leader and develops the field not just in Latvia but also contributes to the world stage of psychosomatic medicine. There are students from all over the world at Riga Stradins University. Latvian educated specialists work in Germany, Great Britain, Switzerland and many others countries.

The main research topics – psychosomatics of chronic pain syndromes, especially low back pain, posttraumatic stress disorders, magical thinking versus critical-analytical by medical students, doctor-patient relationship etc.

Recently the Balint group movement has been established. Latvia is on the way to join the International Balint association.

16.2 The Development of Psychosomatics in Estonia and Lithuania

We sent a questionnaire about the situation in Psychosomatics to both of our neighbor countries – Lithuania and Estonia. The main topics included in the questionnaire were how did Psychosomatics develop starting from the first independence? Is there an independent doctor’s specialty in Psychosomatic medicine and psychotherapy? Can non-medical professions practice in Psychosomatic medicine? Are there professional doctor associations in Psychosomatic medicine? What are the main treatment methods in Psychosomatics? And information about conferences, congresses, research and education in the field of Psychosomatics in that country.

16.2.1 Estonia

The information about Estonia was provided by Prof. Dr. med. Andres Lehtmetts.

Psychosomatics has never been a separate specialty in Estonia. The elements of psychosomatic medicine have been included in the curriculum of psychiatry.

The trend has rather been to develop consultation – liaison psychiatry when it comes to shared responsibility with somatic medicine. There isn't an independent doctor's specialty in psychosomatic medicine and psychotherapy.

There are no specialists in the registry under psychosomatic medicine. Psychotherapy is not a medical specialty either, but the psychiatrists can receive a sub-specialization CME certificate when they undergo sub-specialization.

Psychologists have to be clinical psychologists to work in health care system. There are no further regulations for their practice.

There is no separate treatment system for psychosomatic disorders.

There was a seminar at the end of the 1980s organized by prof. Speidel from Germany and assistant prof. Mehilane from Estonia. Unfortunately there is no additional information on this topic. No specific research has been done in this area. There hasn't been any participation in international organizations.

Psychosomatic topics are integrated into the training curriculum of psychiatrists. At the moment the future track is in the direction of consultation – liaison psychiatry.

16.2.2 Lithuania

Regarding the situation in Lithuania, numerous invitations were sent to the Lithuanian Medical association as well as individual doctors in Lithuania; however there was no official reply on the matter.

16.3 Conclusion

We are convinced that Psychosomatic medicine is a very important future specialization for doctors.

The modern day life has come with many benefits. We have an ever-expanding knowledge base on treatment and management of somatic diseases. However the same modern life-style which is so heavily packed with information, opinions and facts, can put immense strain on our nervous system. It can become challenging to constantly keep up with the newest scientific discoveries, changing environment and having to adapt. This puts mental health in the spotlight. In order to adapt fast enough one must be emotionally healthy and be in contact with reality.

This is one of the reasons why mental and psychosomatic illnesses are on the rise. It means that doctors have to take back in their care the mental/emotional wellbeing of patients not just the somatic one. A clinically orientated doctor cannot ignore the emotional wellbeing of a patient, for as we know, from physiology, emotional suffering always leads to some kind of somatic suffering as well (e.g. symptoms).

The rise of psychosomatic symptoms in patients demands a physiological understanding of the whole body, emotional processes included. The patient's emotional state is certainly a biochemical one. This is a research field for doctors and neuroscientists. However when it comes to diagnosis and treatment it should be the responsibility of a doctor. We think Edward Weiss summed this up lovely in 1943, by writing that the crucial point in psychosomatics is “not to study the soma less; only to study the psyche more”.

The cooperation between doctor and patient always has to be on two levels – intellectual and emotional. If the patient will feel understood and gain a sense of trust and understanding – and thus emotional relief – somatic relief soon follows.

It is quite easy to diagnose a variety of unpleasant feelings that a patient might be experiencing on the conscious or subconscious level – fear, shame, guilt, resentment, helplessness, hopelessness, grief, sadness, bitterness, disappointment, anger, hatred, indignation. The value of being aware of these feelings in patients is the understanding that the biochemical processes of emotional experiences significantly affect the functioning of the whole human organism. Emotions and feelings are an essential component of the body's physiology.

For some doctors understanding the patient's feelings is a natural ability. Those are the colleagues who are competent in their own feelings. For others this ability comes with clinical practice and in the process of personality maturation.

At the moment only two emotional conditions prevail (both in clinical practice and medical literature of mental health care) – anxiety and depression. In case of overwhelming emotions, it is also mentioned that the patient is “emotionally unstable” – this doesn't bring any clarity to the clinical practice. It looks as if doctors have lost the ability to diagnose and differentiate emotions – one of the most fundamental components of human health. We would like to quote the Swedish doctor's Axel Munthe's reply to his colleague doctor Nordström, who asks for the reasons of Munthe's successes and his own possible reasons of failure: “I am sure that you know the ill human body as much as the healthy one better than I do, but it is possible that I am better at understanding the human soul.” (“The Story of San Michele”).

We propose to substitute the word “Soul” in medicine as feelings and emotions.

16.4 Psychosomatic Medicine in Soviet Union and The Russian Federation

In the territory which is now the Russian Federation the Old Slavonic and Slavonian tribes practiced magical healing before the incoming of Christianity. In the Ancient times as well as the Middle Ages the main notions about the ethiology of diseases were mostly “injury”, “evil eye”, “curse” and “bewitchment”. With the entering of Christianity in Russia, mental diseases were perceived as God's punishment or devil's reincarnation, thus mental disorders were mostly healed in monasteries

(Kannabih (Каннабих) 1994). Only in 1775 the mentally ill were hospitalized in specific wards in a general hospital or separate “yellow houses” (Kannabih (Каннабих) 1994). This kind of treatment was applied more frequently in cases of psychotic disorders and conversion disorders. Psychosomatic ideas and scientific psychotherapeutic treatment was not developed yet.

Ivan Sechenov could be considered the founder of psychosomatic ideas in Russia, who published a paper in 1886 with the title “Cerebral reflexes”, where he proposed a theory to explain human emotions (for example, love), drives and social processes (Sechenov (Сеченов) 2007). Sechenov’s paper reached its peak in 1904, in the teachings of Nobel prize winner physiologist Ivan Pavlov on conditional and non-conditional reflexes, on which the psychosomatic ideas were based in the USSR and Russia.

The development of hypnosis in the research of psychosomatic effects in Russia started in 1878. At the Harkov Medical Society a report was presented by a Russian doctor Vasilij Danilevski on the topic of animal hypnosis. Indications for the use of hypnosis in treatment of humans, which should be used in medicine in parallel to drugs, surgery and physical therapy, were worked out by Arnold Tokarski, who reported on this in 1887 to the Moscow Society of Psychologists (Rozhnova and Rozhnov (Рожнова, Рожнов) 1965). The teaching of hypnosis in Russia was also developed by a psychiatrist Vladimir Behterev, who defended his doctoral thesis in 1881 on “The experience of investigating body temperature in the cases of various mental diseases” (Nikiforov (Никифоров) 1986). Although the term “psychosomatics” was not used at the time, a psychosomatic mechanism is described in the thesis mentioned previously. Behterev described this clinical phenomenon physiologically by pointing out that thermoregulatory and psychomotor centers in the brain are next to each other and are connected by blood circulation. In his publications in 1905, 1908 and 1911 Behterev described the effects of hypnosis on the skin, physical pain and sexual feelings, and proposed that on these phenomena be used in medical diagnostics, labor pain alleviation and treatment (Behterev (Бехтрев) 2000). However in 1901 in a mental disease classification published by the famous Russian psychiatrist Sergej Korsakov there is not a single mention of psychosomatic disorders or diseases (Kannabih (Каннабих) 1994; Korsakov (Корсаков) 1954). Although in Korsakov’s book “Questions in clinical psychiatry” there is a chapter “Hypochondria and hypochondric psychoses”, where the author describes hypochondria as excessive fear about one’s physical health, but adds this disorder to craving disorders essentially because of neurasthenia (mental fatigue) and mental degeneration. In his work Korsakov distinguishes various forms of hypochondria: mild and severe hypochondria, melancholic hypochondria (*melancholia hypochondriaca*) and delusional or paranoid hypochondria (*paranoia hypochondriaca*). For the etiology of hypochondria Korsakov acknowledges upbringing factors and the use of mental treatment methods. In the use mental treatment methods a correct doctor-patient relationship must be established (Korsakov (Корсаков) 1954).

A separate medical specialty by the name of “psychosomatics” or “psychosomatic medicine” did not exist in the Soviet Union, because during medical studies such terms as psychoanalysis, subconscious, personality etc. were not accepted.

There were various books published for doctors with the title “Psychotherapy” The content mainly consisted of various types of hypnosis. A separate specialty of Narcology (addiction psychiatry) was created, as well as specialties like psychotherapy and sexology as sub-specialties of psychiatry. The first textbook for doctors with the title “Psychosomatic disorders” was published in Moscow in the publishing house “Медицина” (Medicine) in 1986 (Topolanski and Strukovskaya (Тополянский В.Д., Струковская М.В.) 1986). But a separate specialty by the name of “Psychosomatics” or “Psychosomatic medicine” was not created neither in the Soviet Union, nor in the present-day Russian Federation.

During the collapse of the Soviet Union a lot of psychotherapy schools flourished in the Russian Federation, including numerous psychoanalytic and Jungian analysis associations. There was a widespread development of a so called “wild psychoanalysis” – people from random professions called themselves psychoanalysts after attending a few months of training in Western Europe or the United States. At the same time there are legitimate educational programs in psychoanalysis in the Russian Federation that compete with each other, for example, Moscow’s psychoanalytic school and Saint-Petersburg’s psychanalytic school, as well as psychotherapy and psychoanalysis schools from other cities within the Russian Federation. Some of these schools are acknowledged by international associations, others or not. The hypnotic approach has not lost its position as well. Especially popular is Erikson’s non-directive hypnosis and NLP (neuro-linguistic programming) rather than the traditional directive hypnosis. Psychotherapy can be practiced by members of various professions, mostly psychiatrists and psychologists, but also those trained in social and humanitarian sciences.

Numerous books are being published on psychosomatic disorders. Eleven international congress have been organized in the Russian Federation on the topics of psychosomatic disorders and problems within psychosomatic medicine. The most recent was the XI International Congress “Psychosomatic medicine 2016”, that took place on June 2–3 in Saint-Petersburg. In 2013 in Rostov-on-Don a organisation called “Eastern Europe’s Psychosomatic Society” (Восточно-Европейское Психосоматическое Общество) was founded. This society organises conferences in psychosomatics, publishes papers and from 2015 started publishing a journal “Psychosomatics and self-regulation” (Психосоматика и саморегуляция).

Questionnaire Response

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry in your (or your chapter's) Country.

Please return this as an attachment to your email

Country on which you are reporting:

Your Name: Gunta Ancane

Institution: Rīga Stradiņš University

City & Country (e.g. London, UK): Riga, Latvia

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?
Yes (X) No () In some sense ()
 - a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes (X) No ()
 - b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes () No (X)

2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?
Yes (X) No ()

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?
Yes () No (X)

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes (X) No ()
 - a. If YES, which?
Psychosomatic Medicine (X) Consultation-Liaison Psychiatry ()
 - b. If YES, the status of such certification is:
 - i. Independent Medical Specialty (X)
 - ii. Subspecialty of Internal Medicine ()

iii Subspecialty of Psychiatry ()

iv. An independent non-medical discipline, as Psychology, Social Work ()

v. Other (Specify):[]

5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes (X) No ()

If YES, please list names of the organizations and the websites if available:

- 1) Latvian Association of Psychosomatic medicine and psychotherapy
- 2) Latvian Balint Group Association

6. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry: No one.

7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in your country? Yes (X) No ()

a. If YES, where does it occur? Check all that apply:

Medical School (X) Residency () Fellowship ()

8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes (X) No ()

9. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)

a. It is insignificant ()

b. Some subgroups (e.g. ethnic, religious) practice it (X)

c. A significant part of the general population practice it (X)

d. Is the most prevalent healing method used ()

e. It is often used in combination with Western medicine (X)

f. More widely used methods are as follows (Please list,e.g., spiritual healing, meditation, herbal, etc):

10. Please add any comments to your response here:

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Part III
Contemporary Psychosomatic Medicine
and Consultation-Liaison Psychiatry in
Asia: Development, Research, Education,
and Practice

Chapter 17

The Burgeoning Chinese Psychosomatic Medicine



Zhao Peng and Zhao Zhifu

Psychosomatic medicine has a distant source and a long stream in China, which can be traced back more than two millenia with the earliest record in the Inner Cannon of Huangdi (Tan et al. 2013). Psychosomatic medicine not only inherited the excellent traditional theory, but also recently saw new development. More and more people have become interested in psychosomatic medicine, and a series of monographs have been recently published concerning the disease spectrum and medical model (Yu 1990; Zhao and Liu 1994; Yao et al. 1995; Ji and Shi 1997; Zhao and Jiang 2000), which testifies to the burgeoning of psychosomatic medicine in China.

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17.1 Psychosomatic Medicine, Along with Profound Culture Soil, Has a Distant Source and a Long Stream in China

Inner Cannon of Huangdi is one of the earliest Medical Books kept to this day. The book was written approximately during the Spring and Autumn and the Warring States Period (770–221 BC), which includes many discussions regarding psychosomatic issues, unity of body and spirit, emotions as cause diseases. Inner Cannon of Huangdi pointed out that “people who, understanding natural rules, have balanced diet and regular daily life, can unite the body and spirit and die a natural death after 100 years’ age”. Body means viscera and spirit means psychological activities, so people can have a long and healthy life with the harmony of spirit and body. “Drinking much alcohol, living an abnormal life, dissipating genuine Qi and vital essence, living an irregular life can lead to decline after 50 years of age.” Without control of life behavior and desire will shorten their life.

Excessive joy and anger will injure viscera, people who suffer change from rich to poor also are likely to acquire mental diseases and death according to Inner Cannon of Huangdi. The change of social status and economic condition may harm the energy and organs, which cause diseases.

Inner Cannon of Huangdi has been passed on for more than 2000 years, people still make annotation and improvement to this book, raise new theory and doctrines according to different diseases in different time, however holism has always been the basic guiding ideology. For instance, Daxi Zhu, one of the four eminent physicians in Jin and Yuan period (1115–1368 AD), has left abundant heritage to the later generation. He believes that “Emotional fire motivates ministerial fire and causes excessive ministerial fire”. This type of disease is called psychosomatic disease.

Confucius is the founder of the Confucian cultural tradition. “The humane people live long lives” is the classic sayings in the Analects of Confucius, which is the incisive exposition and generalization of family harmony, social civilization and long life. The first Chinese Dictionary-Shuo Wen Jie Zi (about 100–121 AD) has the explanations that virtuous persons do not only benefit others, but also themselves, which means dealing well with the relationship among people is not only good to themselves but also to others. People with kind mind can have a health mind and body. Another famous Chinese folk saying is that all diseases are from anger.

In, Chinese medical education from the handing-down teaching method to present formal education, the teaching of Chinese traditional theory has been compulsory, although the holism of Chinese medicine was neglected under the effect of the biomedical model in the recent years. Traditional Chinese Medicine (TCM) was subjected to destruction due to the separation of mind and body, and increasing subspecialization. However, the medical thought in the TCM quickly awakened with the advent of the biopsychosocial medical model, and turned to new dawn of development.

17.2 Bio-psycho-social Model Promotes the Development of Modern Psychosomatic Medicine

The reappraisal of biomedical model started after China Reform and Opening-up during last century, which was initially discussed utilizing the dialectical method. In 1979, a large-scale medicine dialectic symposium was held in Guangzhou, and then *Journal of Medicine and Philosophy* was published in Dalian. The first academic annual conference of medical psychology was held in Xi'an and established a psychosomatic medicine research group in 1980. Workshops based on psychosomatic medicine for mental health was held twice by China Ministry of Health and WHO in 1981 and 1982. The lecture was given by psychosomatic medicine specialist Professor Ishikawa from Japan, and Professor Wang Xiaodao, Liu Tao and Sun Boyuan were the key initiators. The research group held a special session in Beijing in 1984, focused on discussing the relations between personality and coronary heart disease. Psychosomatic Medicine Professions Commission was set up and the first annual conference and study session was held in Dalian in 1986. Psychosomatic Medicine Branch of the Chinese Medical Association was established in 1993. The two earliest monographs, *Modern Psychosomatic Medicine*, and *Practical Psychosomatic Medicine*, were compiled by Ji Mingtang in 1988 and Liu Tao in 1989 respectively. The early development of Chinese modern psychosomatic medicine mainly introduced the history of western psychosomatic medicine and theory viewpoints. The thought of Chinese Psychosomatic medicine has a long history, but there is no such word as "psychosomatic medicine". It is thanks to the development of modern world psychosomatic medicine, that China acquired a clear modern language for it.

Nowadays, Chinese and Western medical specialists and scholars have joined together under the banner of psychosomatic medicine, promoting psychosomatic medicine to develop in breadth, depth and localization.

17.2.1 Psycho-Cardiology Development

The investigation led by Professor Hu Dayi on consecutive patients from the department of cardiovascular clinic in ten hospitals in 2005 shows that the incidences of anxiety and depression are 42.5% and 7.1% respectively among 3260 patients. The incidences of depression is 9.2% in coronary heart disease and 4.9% in high blood pressure respectively, and of anxiety is 45.8% in coronary heart disease and 47.2% in high blood pressure in the cardiovascular department (Wu and Yuan 2015). Although patients with cardiovascular diseases have a high incidence of emotional disorder, cardiovascular doctors in the general hospital have a low recognition rate of the depression and anxiety, which is 15.9% in the Shanghai survey in the 1990s. Professor Hu Dayi actively advocated "Psycho-Cardiology" in the 1990s, he first set up psycho-cardiology clinics and ward rounds, then gradually developed visits and

ward rounds by cardiologist and psychiatrist together. Eventually, clinicians equipped with knowledge of both cardiology and mental health emerged, giving the patient with cardiovascular disease and psychological problems early recognition, diagnoses and necessary treatment based on the whole perspective of diseases (Wu and Yuan 2015). Chinese Expert Consensus on Psychological Prescription of the Patients in the Cardiovascular Department published in the Chinese Cardiovascular Journal, which was led by Professor Hu Dayi in 2014, aims to make psychocardiology as the most important part in the whole treatment system of cardiovascular disease, and states that the cardiologist should give priority to the diagnosis of psychological disorders, and if the symptoms are emotional in origin, avoid treating the patient as heart disease patient, which can cause a double hit to their body and economy, and waste medical resources (Wu and Yuan 2015).

Professor Mao Jialiang from Shanghai created a Somatic Self-rating Scale according to characteristics of psychological disorders in the general hospital with who present with somatization symptom. It achieved good reliability and validity after improvement for many years, and was easily mastered by the cardiologists, and accepted by the patients with psychological problem. This scale happened to coincide with the new diagnosis of somatic symptom disorder in the Fifth Edition of the American of Diagnostic and Statistical Manual of Mental Disorders, the forms of psychological disorder are various somatization symptoms, which provide great help for the doctor to recognize the psychological problem, drug selection and clinical observation. Psycho-cardiology obtained universal recognition after great efforts for many years, and more psychologists were invited to hold consultations.

17.2.2 Establishment of Digestion Psychosomatic Disease Cooperative Group

The purpose of 50–70% of patients who go to physicians for relief of digestive symptoms have functional gastrointestinal disorder, and traditional somatic therapy based solely on the biomedical model is less than effective. For such patients, our scholars combine psychiatric and psychological treatment with traditional gastroenterology treatment with good results.

The Second Gansu Hospital is a general hospital, mental health center, and hospital of traditional Chinese and Western medicine. A diagnostic model used here is the “3-3-3” model, which indicates a wrap-around three-combination diagnosis during three stages of the disease development in three different places (Lv 2016). Three combinations: Western Medicine + Traditional Chinese Medicine + Psychology; three stages: pre-disease, having disease, recovery; three places: health checkup, clinics, ward. The Digestion Internal Medicine Department has set up three combination diagnosis center and digestive psychosomatic clinics, we use above ways to check disease by Western Medicine, check patients by Traditional Chinese Medicine, and check mental disorder by Psychology.

Professor Chen Yulong is the expert who promotes the concept of digestion psychology disease, publishing *Research and Clinical of Digestive System Psychosomatic Disease* in 2007. Chinese Medical Association Digestology Branch established the Digestive Psychosomatic Disease Cooperative Group based on Functional Gastrointestinal Disorder, and compiled a book named *China Digestive Psychosomatic Disorder-Theory and Practice*, as well introducing digestive psychosomatic disease into university courses.

Professor Chen Shengliang acts as the Chair of Cooperative Group of Digestive Psychosomatic Disease. He believed that oriental people have different stresses compared to westerners due to different life styles (Chen 2009). Higher and higher morbidity of functional gastrointestinal disorder may be affected by many factors including social development, faster pace of social behavior, more psychological stress, environment change, change in diet habit and structure. However, oriental people may have different clinical statuses and symptoms from westerners. Additionally, religious cultures and differences in health knowledge levels may predispose some individuals to misinterpret or misattribute symptoms. So there are some differences of symptom spectrum between them. But if talking about the whole functional gastrointestinal morbidity, they are nearly the same. Nowadays, the morbidity of irritable bowel syndrome has increased. We have nearly the same proportion of gastroesophageal reflux disease with westerners in some Chinese developed regions. Functional gastrointestinal morbidity is related to psychological stress and life style, not specially with race.

17.3 Research and Cooperation Between Psychiatry and Psychology

Psychiatry and psychology developed very quickly in China. Special mental health institutions were established by law. The Act of Psychology Health and Psychiatry Health also established Counseling Psychology and Psychiatry departments in general hospitals,

which provide help to psychosomatic medicine, and establish alliance among researchers. For instance, many members from Digestology Psychosomatic Medicine Cooperation Group China, not only work in China Medicine Association, but also join in China Medicine Association Psychiatry and Chinese Psychology Health Association.

17.4 Creation and Development of Traditional Chinese Medicine on Psychosomatic Medicine

We all know that there are two medical systems in China: one is the introduction and absorption of western medicine that is based on modern medicine. The other is Traditional Chinese Medicine (TCM) including herbs and acupuncture. Bio-psycho-social medicine model, after being imported into China, has aroused great interests in the medical fields, especially in TCM, because the bio-psycho-social model is in line with the TCM regarding the theory of the unity of nature and the human, integration of form and spirit. Comparisons were made between the two models. Professor Ou Yangqi, Dong Jianhua, Ma Pengren, and Lu Guangxin began to pay attention to this field. Practical Traditional Chinese Medical Psychology compiled by Professor Dong Jianhua and Ma Pengren from Beijing University of Chinese Medicine was published.

The national psychosomatic medicine symposium was held in Tai'an in 1988, during which the Traditional Chinese Medicine on Psychosomatic Medicine Group was set up. Professor Zhao Zhifu acted as the group leader.

The 4th national psychosomatic medicine symposium, with many representatives from TCM field attending, was held in 1992, during which the Traditional Chinese Medicine on Psychosomatic Medicine Group was upgraded to a formal committee. The world psychosomatic medicine should seek wisdom from Traditional Chinese Medicine, said WHO experts, which greatly encouraged TCM members. The symposium had set the goals of finding ideas, absorbing technology and methods from modern medicine, creating the system of TCM on psychosomatic medicine, and also decided to hold the first TCM on psychosomatic medicine symposium in 1994. The first Department of TCM on psychosomatic medicine in China was launched in Guang'anmen hospital as the China Academy of Chinese Medicine in 2000. Professor Zhao Zhifu was appointed as the first director.

The concept of TCM on psychosomatic medicine has been widely accepted. The Psychosomatic Medicine Branch of China Association of Chinese Medicine was set up in Beijing in 2015. Specialty Committee of Psychosomatic Medicine of World Federation of Chinese Medicine Societies was set up in Chang Sha, Hu Nan Province in 2016. The 14th Asian Congress on Psychosomatic Medicine was held in Beijing in 2010. The 24th World Congress on Psychosomatic Medicine will be held in 2017.

The establishment and development of TCM on psychosomatic medicine have achieved great support from world psychosomatic medicine and famous experts, including the Director of Japanese Society of Psychosomatic Medicine – Professor Ikemi; former President of International College of Psychosomatic Medicine, President of Asian College of Psychosomatic Medicine, President of Kyushu University- Professor Kubo; the WHO expert on psychosomatic medicine-Professor Singh. They have come to China, attended the meetings and gave many speeches and established a good relationship with TCM on Psychosomatic Medicine through communication and cooperation.

TCM on psychosomatic medicine is a clinical discipline that promotes psychosomatic health by prevention and treatment of psychosomatic diseases with TCM theory and methods, which is also the development and creation on the basis of TCM theory (Zhao 2006):

1. Inheriting the theory and methods of TCM, the holism of spirit and body is the basis of TCM on psychosomatic medicine

Physiological basis: The heart, likened to the monarch in the body, controls mental activities, cited in the Inner Cannon of Huangdi. That means heart governs the spirit, spirit plays a leading role in all activities, and all the activities was carried out by the lead of spirit, maintaining the normal physiological function of human body.

Pathological mechanism: Sorrow hurts the heart, then hurts others organs; Rage impairing liver, fear impairing kidney, melancholy impairing lung, worry impairing spleen, overwhelming joy impairing heart; Rage driving Qi upward, overjoy slackening Qi, anxiety making Qi depressed, excessive sorrow consuming Qi, terror collapsing Qi; The excess of blood causing anger, while the lack of that expressing fright, cited Inner Cannon of Huangdi. Emotional morbidity leads to physical damages, said Sun Simiao, a famous doctor (581–682 AD). Mental activity plays a dominating role to the internal organs. Depression causes physical diseases, said Zhu Danxi, another famous doctor (1281–1358 AD). Excessive emotions stimulate the brain and harm the organs and viscera.

Diagnosis and treatment principle: Good doctors should treat patients' spirits firstly, and then their bodies, said Hua Tuo, a famous doctor (145–208 AD). Melancholy restricting rage, fear restricting overwhelming joy, rage restricting worry, overwhelming joy restricting melancholy, worry restricting fear, cited Inner Cannon of Huangdi that discussed five kinds of emotions restricts each other.

2. "Rigid and Gentle Differentiation" is the core of TCM on psychosomatic medicine

"Rigid and Gentle Differentiation" is Professor Zhao Zhifu's clinical experience summarization for decades, which is a theory and clinical system in order to guide diagnosis and treatment for psychosomatic diseases, also called "TCM Rigid and Gentle Psychosomatic Theory".

"TCM Rigid and Gentle Psychosomatic Theory" believes that: In psychosomatic diseases, liver is firstly hurt, so liver cannot control conveyance and dispersion properly, conveyance and dispersion are excessive or deficient, cause imbalance of Rigid and Gentle, and imbalance of Ying and Yang.

If conveyance and dispersion are excessive, Yang-hyperactivity and Yin-deficiency will happen, and cause syndrome of hyperactivity of liver, called Rigid. Otherwise, if conveyance and dispersion are deficient, stasis of liver will happen, called Gentle.

Moreover, according to characters and syndromes, the Rigid people usually suffer from symptoms like irritable, flushed face, obesity, yellow coated tough, ozostomia, edgy, impatient, high and fast voice, active, expressive; the Gentle people

usually suffer from easy to be tired, colorless, emaciated, white coated tongue, stench, temperate, patient, soft and slow voice, quite, inarticulate.

According to “TCM Rigid and Gentle Psychosomatic Theory”, the patients should be classified into 2 classes, 4 orders and 16 families: 2 classes mean Rigid and Gentle; 4 orders mean Rigid-excess, Rigid-deficiency, Gentle-excess, Gentle-deficiency; And each order has 4 families: (1) Rigid-excess: Up inverse of liver Qi, Excessive fire of liver, Excessive fire of liver and heart, Excessive fire of liver and heart with phlegm and blood stasis; (2) Rigid-deficiency: Insufficient Yin of liver and heart, Insufficient Yin of liver and kidney with inverse liver Yang, Insufficient Yin of liver and kidney with internal wind activity, Insufficient Yin results in insufficient Yang; (3) Gentle-excess: Stasis of liver Qi, Stasis of liver blood, Stasis of liver and spleen Qi, Stasis of liver Qi and phlegm stagnate in lung; (4) Stasis of liver and insufficient of spleen, Insufficient Qi of heart and liver, Insufficient Yang of spleen and kidney, Insufficient Yang results in insufficient Yin.

Professor Zhao Zhifu has been funded by National Natural Science Foundation of China, State Administration of Traditional Chinese Medicine and National Science and Technology Support Program. Rigid and Gentle Differentiation theory has been widely used and verified during the clinical diagnosis and treatment of psychosomatic diseases, and achieved a big success in herb treatment formula screening for cardiovascular neurosis, somatic disorder, cholecystitis, and climacteric melancholia.

17.5 Conclusion and Prospects

Psychosomatic Medicine has gone through a long history in China, which experienced more than two millenia from the era of the Inner Canon of Huangdi up to now. The theory and practice of Psychosomatic Medicine are becoming more and more developed. Although Psychosomatic Medicine has experienced ups and downs, its tenacious vitality continues to this day. Nowadays, psychosomatic medicine, with more and more people getting to know and accept, has achieved unprecedented popularity and is integrated into the trend of world medical development. Now, Chinese experts on psychosomatic medicine, including Traditional Chinese Medicine and Western Medicine, pay great attention to the interaction and cooperation with world medicine. They not only learn from tradition, but also follow the zeitgeist of modern times. Chinese experts made great efforts to work on basic research and clinical practice, which influenced the academic development to be more active and flourishing. We believe that psychosomatic medicine in China will lead the way in the transformation and promotion of human health .and, in turn, contribute to the development of human civilization.

Questionnaire Response

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry in your (or your chapter's) Country

Please return this as an attachment to your email

Country on which you are reporting: China

Your Name: Zhao Zhifu

Institution: Guang'anmen Hospital, China Academy of Chinese Medical Sciences

City & Country (e.g. London, UK): Beijing, China

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?

Yes (X) No () In some sense ()

 - a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes () No ()
 - b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes (X) No ()

2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?

Yes (X) No ()

Is teaching of psychosomatic medicine in medical schools required by law or health care system in your country? YES () No (X)

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?

Yes (X) No ()

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes (X) No ()
 - a. If YES, which?

Psychosomatic Medicine (X) Consultation-Liaison Psychiatry ()

 - b. If YES, the status of such certification is:
 - i. Independent Medical Specialty ()
 - ii. Subspecialty of Internal Medicine (X)
 - iii. Subspecialty of Psychiatry ()

iv. An independent non-medical discipline, as Psychology, Social Work ()

v. Other (Specify):[]

5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes (X) No ()

If YES, please list names of the organizations and the websites if available:

Branch of Psychosomatic Medicine, China Association of Chinese Medicine

Branch of Psychosomatic Medicine, Chinese Medical Association

6. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:

Journal of Clinical Psychosomatic Diseases

7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in your country? Yes (X) No ()

a. If YES, where does it occur? Check all that apply:.

b. Medical School (X) Residency () Fellowship ()

8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes (X) No ()

9. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)

a. It is insignificant ()

b. Some subgroups (e.g. ethnic, religious) practice it ()

c. A significant part of the general population practice it (X)

d. Is the most prevalent healing method used (X)

e. It is often used in combination with Western medicine (X)

f. More widely used methods are as follows (Please list,e.g., spiritual healing, meditation, herbal, etc): herb, acupuncture, massage

10. Please add any comments to your response here:

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Chapter 18

Psychosomatic Medicine in Japan



Chiharu Kubo

18.1 History of Psychosomatic Medicine in Japan

Psychosomatic medicine in Japan has a long history as an academic discipline, and the members of the Japanese Society of Psychosomatic Medicine provide medical service of the highest level with a wide variety of treatment options based on a blend of our historical and modern medical background.

Psychosomatic Medicine was introduced to Japan by Dr. Yujiro Ikemi (Kubo 2000), who went to the US in 1951 as a fellow of the Institute of Tuberculosis at the Mayo Clinic in Minnesota. Although it was there that he first had a chance to study psychosomatic medicine, he also studied at other American psychosomatic centers, such as the Menninger Foundation. After returning to Japan, he was appointed to the position of Associate Professor of the Department of Internal Medicine at Kyushu University. It was then that he decided to concentrate his efforts on pioneering work in the field of psychosomatic medicine. His first important work was a special lecture on the ‘Psychosomatic Aspects of the Gastrointestinal System’, which was presented at the Annual Congress of the Japanese Society of Gastroenterology in 1955. He and his co-workers collected experimental evidence of functional changes in the gastrointestinal system induced by strong emotional reactions to hypnotic suggestion. Eventually, his work convinced researchers who had been skeptical, and he was able to promote increased interest in psychosomatic medicine among physicians throughout Japan.

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In 1958 he presented the paper 'Experimental Studies on the Psychosomatic Disorders of the Digestive System' at the World Congress of Gastroenterology in Washington. This paper created tremendous interest among gastroenterologists in the US, including Professor Bockus, a leader in the field, who invited him to contribute his work to his textbook on gastroenterology.

In 1958, Professor E. Weiss, another pioneer of psychosomatic medicine, invited him to the Department of Comprehensive Medicine of Temple University Medical Center as an instructor. This association was the foundation for the creation of the Department of Psychosomatic Medicine at Kyushu University School of Medicine.

Upon returning to Japan in 1959, he visited Professor T. Miura, one of the most distinguished Japanese psychiatrists at that time and who was also interested in psychosomatic medicine. With the support and help of Professor Miura, Dr. Ikemi founded the Japanese Society of Psychosomatic Medicine as Nihon-Seishin-Shintai-Igakukai and organized its First Congress, which was held in Tokyo on November 30, 1960 under the presidency of Professor Miura. In 1961, with the support of the Japanese Minister of Education, Dr. Ikemi established the first Institute of Psychosomatic Medicine in Japan at Kyushu University and was appointed the first professor of the institute. In 1963, this institute was redesignated as the Department of Psychosomatic Medicine, and followed the model of the Department of Comprehensive Medicine of Temple University Medical Center.

Professor Ikemi coined the word "shinryounaika" as the Japanese term for psychosomatic medicine, and it was accepted by the Japanese government as a clinical entity.

The first congress of the Japanese Society of Psychosomatic Medicine was held in 1960, with fewer than 100 members. The society has grown tremendously since then, both in terms of scope and size. In 2015, we had 3300 members. They comprised 2361 (71.6%) medical doctors, including 708 (30%) internists, 647 (27.4%) psychiatrists, 484 (20.5%) specialists of psychosomatic internal medicine, 119 (5%) pediatricians, 67 (2.9%) obstetricians and gynecologists, 65 (2.8%) dentists, 40 (1.7%) dermatologists, and 231 (9.8%) others. Psychology and nursing staff accounted for nearly half of the 939 non-physician members.

In 2009, the 50th anniversary of the Society was celebrated on June 5th in Tokyo. Under its leadership, this groundbreaking event brought together four of our fellow societies: (1) The Japanese Society of Obstetrics and Gynecology, (2) The Japanese Society of Internal Medicine, (3) The Japanese Society of Psychosomatic Dentistry, and (4) The Japanese Society of Psychosomatic Pediatrics.

The Japanese Society of Psychosomatic Medicine has twice hosted the World Congress of Psychosomatic Medicine (WCPM). In 1977, the 4th Congress of the International College of Psychosomatic Medicine (ICPM) was held in Kyoto under the presidency of Dr. Ikemi. In 2005, I was privileged to be the co-president of the 18th congress of the WCPM in Kobe along with Prof. Tomifusa Kuboki (Kubo and Kuboki 2006). The theme of the congress was "Let's Get Together in Japan, a Country with a Long Tradition of Mind-Body Awareness, to Discuss Scientific Approaches to the Mind and Body!". It was a huge success, with more than 1100 participants from 30 countries. At that time, we were honored by the attendance of the Emperor and Empress and inspired by the Emperor's encouraging speech.

We currently have nine university hospitals with Psychosomatic Medicine departments: Kyushu University, Tokyo University, Tohoku University, Toho University, Kagoshima University, Kansai Medical University, Kinki University, Nihon University, and International University of Health and Welfare.

The Japanese Society of Psychosomatic Medicine has two journals, BioPsychoSocial Medicine and the Japanese Journal of Psychosomatic Medicine. The Journal of BioPsychoSocial Medicine is an international journal that has been published since 2007. The Japanese Journal of Psychosomatic Medicine “Shin Shin Igaku” has become a leading journal and has been published since 1961.

18.2 Development of Psychosomatic Medicine in Japan

The development of psychosomatic medicine can be divided into three main periods. In the first period (1930s–1940s), research was conducted in the area of the psychosomatic relationship in neuroses, such as anxiety neuroses and conversion hysteria. Clinical examination and treatment as practiced at that time was based on that research. In the second period (1950s–1970s), psychosomatic disorders, such as peptic ulcer, bronchial asthma, muscle contraction and headache, were the focus of research and clinical investigation. The causes and processes of these disorders were found to be closely related to psychosocial factors. However, going back to the original aim of psychosomatic medicine, the opinion gradually gained strength that the goal should not be limited to diseases such as neuroses and psychosomatic disorders.

Psychosomatic medicine has moved into a third period (1980s–present) and is evolving toward an approach in which the generalities and totality of the pathogenesis of diseases is understood from a psychosomatic perspective and in which patients are treated physically and psychologically as a “whole person” with the cooperation of the various areas of clinical medicine. Psychosomatic in Japan has become a fundamental core of holistic medicine that integrates clinical practice, education, and research in numerous fields, including adolescent medicine, primary care, palliative care, geriatric care, rehabilitation, chronic pain, occupational stress, and the prevention of lifestyle-related diseases.

In 1985, Psychosomatic Medical Doctor certification program was started, and in 1990 health coverage for psychosomatic therapy such as counseling, autogenic training therapy, behavioral therapy, transactional analysis therapy, and others was approved by the Health and Welfare Ministry.

Together with the evolution of the concepts underlying the framework of psychosomatic medicine, fundamental beliefs concerning medicine and generally accepted medical models are changing. While traditional medicine and medical treatment have been based on biomedical models centered on specific diseases, it is now felt that the basis of medicine should be changed to a bio-psycho-social model, as advocated by G. E. Engel (1977), a model that attempts to focus on patients and to see them as somatic, psychological, and social beings.

Psychosomatic medicine has come to be recognized as an integral part of the Japanese medical community and was admitted to the Japanese Association of Medical Sciences in 1979. The Society also participates in the Science Council of Japan as a cooperating academic research organization.

Since approval was gained for the use of the term psychosomatic medicine in the advertisements of hospitals and clinics in 1996, the number of institutions with a “Department of Psychosomatic Medicine” has increased. This has contributed to an increase in the number of patients reporting in a timely manner to hospitals and clinics for the treatment of psychosomatic diseases such as irritable bowel syndrome, headache, unidentified clinical syndrome, depression, anxiety disorder, and others by providing them with better access to effective treatment. To train the specialists necessary to meet the increasing demand, we are promoting the establishment of Psychosomatic Medicine Departments at Japanese universities. Further discussion can be found in a paper recently published in *BioPsychoSocial Medicine* (Murakami and Nakai 2017).

The Japanese Society of Psychosomatic Medicine provides an extensive range of services that include academic activities, promotional and educational campaigns, and international activities, all related to psychosomatic medicine.

The members of our Society are determined to act sincerely in our role of enhancing public health by actively promoting a health care system that is responsive to the needs of Japanese society while constantly striving to improve our medical capability.

At present, Japanese psychosomaticists are world leaders in the management of psychosomatic disorders, and Japanese psychosomatic departments and hospitals are world leaders in education and research. The Japanese Psychosomatic Society is the largest Society in the world.

18.3 Asian College of Psychosomatic Medicine (Ishizu 2012)

The Asian chapter of the International College of Psychosomatic Medicine was established in Tokyo on April 12, 1982 with the intention of spreading and enhancing clinical, teaching, and research activities related to psychosomatic medicine throughout Asia. The first meeting of the Asian chapter was held in 1984 in Tokyo. After establishing a firm foundation and having meetings every 2 years, the name was changed in 1991 to the Asian College of Psychosomatic Medicine with a view to giving this organization independence and creating a strong, solid mandate to fulfill the need for knowledge, teaching, research, and clinical advancement of the Asian community. This is a tribute to the many years of leadership of the Japanese Society of Psychosomatic Medicine and fulfilled Professor Ikemi’s dream of Japan becoming a leading country in promoting psychosomatic medicine in the region. Professor Ikemi was also responsible for creating an atmosphere in which the needs of Asia could be fulfilled, such as by establishing the ACPM- World Health Organization (WHO) Professorship of

Psychosomatic Medicine and Psychopharmacology, with the help of the World Health Organization. The headquarters of the ACPM and the ACPM – WHO Professorship were established in Japan. After the sad passing of Professor Ikemi in 1999, the leadership of the society fell to me, and I have been privileged to have served as president of the ICPM, president of ACPM, and president of the Japanese Society of Psychosomatic Medicine.

18.4 Consultation-Liaison Psychiatry in Japan

Psychiatrists in the United States have in recent years begun to treat patients in the various clinical departments of general hospitals through what is now called consultation-liaison psychiatry, a supporting role that allows the realization of “whole person” medicine. This trend has gained momentum among psychiatrists in Japan and now plays an important role in general hospital psychiatry. “Consultation” implies both “consulting” and “advising”. Based on requests from clinical departments, psychiatrists are consulted in regard to a wide variety of psychiatric problems. “Liaison” is a term that refers to contact, connection, and relation. In this concept, psychiatrists are concerned with a variety of problems, such as those between a patient and the medical staff, patients and their family, or among the medical staff.

Among the various aspects of consultation-liaison psychiatry are the following: diagnostic evaluation regarding psychiatric problems from a bio-psychological point of view, treatment and advice as to the management of patients, settlement of conflicts within a medical group, and educating doctors and nurses in all clinical departments about the role of consultation-liaison psychiatry. The roles of consultation-liaison psychiatry can be found in the patient-problem-management approach of F.P. McKegney, which is characterized by positive involvement in the examination and treatment of patients in all clinical departments along with advice and guidance from the standpoint of “whole person medicine”.

18.5 Theoretical Aspects and Research into Psychosomatic Medicine

Dr. Ikemi’s lecture on ‘The Integration of Occidental and Oriental Psychosomatic Treatment’ was not only a masterpiece, but also the focus of the 4th ICPM congress (Fig. 18.1) (Ikemi 1996).

The Karger Publishing Company published a special issue of the Karger Gazette entitled ‘The Wisdom of the Body’, written by an editor of the Gazette based on Dr. Ikemi’s presidential address, with the intention of stimulating increased interest in “Oriental”, the term used at the time the paper was written, wisdom by the physicians of Europe and the Americas.

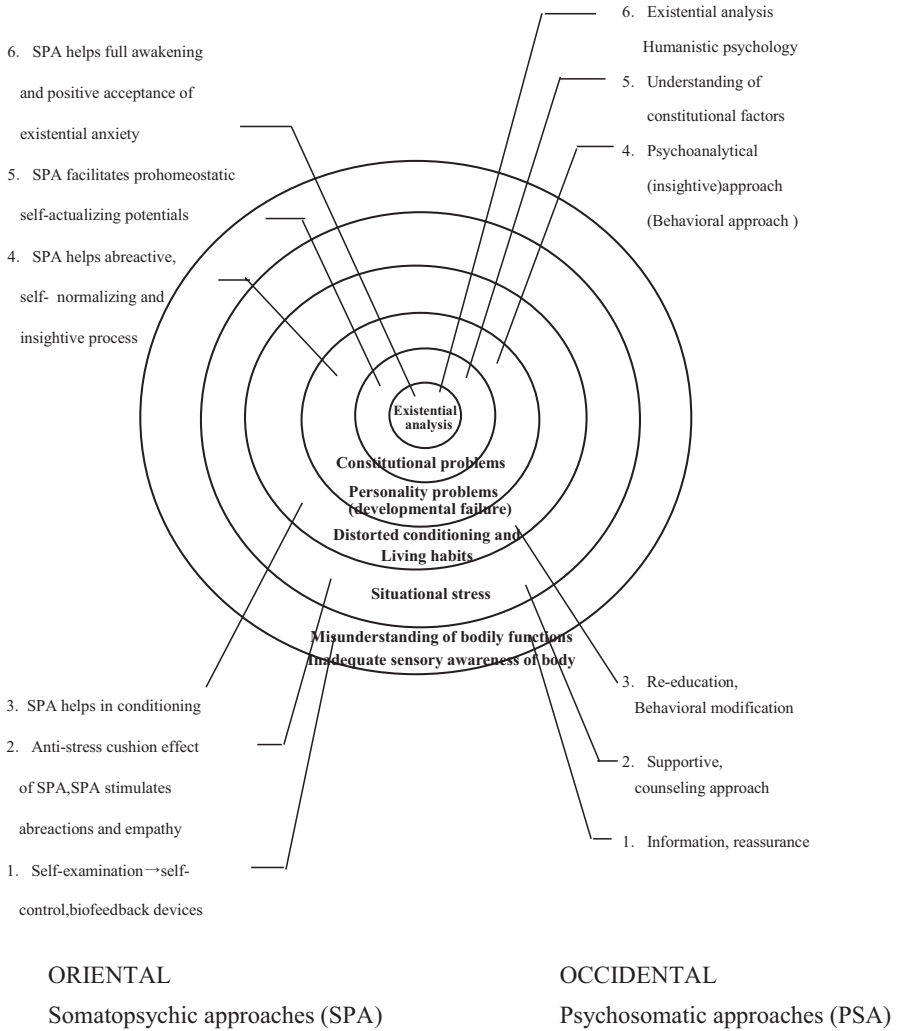


Fig. 18.1 Integration of the psychosomatic and somatopsychic approaches

Dr. Ikemi devoted his time and talent toward integrating Western medicine with “Oriental” somatopsychic and self-regulation methodologies, including Yoga, Qigong, Zen meditation, Japanese dance, and acupuncture. He defined a new concept of self-holistic approaches to medicine that he felt would be of benefit to mankind. His research and teaching facilitated an existential shift that allows people to lead more rewarding and successful lives.

In recent years, the pace and scope of the introduction of revolutionary medical techniques and technologies has been remarkable, including diagnosis by computed tomography and magnetic resonance imagining, organ transplantation,

extra-corporal fertilization, and the development of biotechnology. In addition, medically related topics such as quality of life, problems of terminal care, and the destruction of the natural environment are gaining increasing attention. This is leading to a bio-psycho-socio ethical (-ecological) approach that is ideal for the treatment of disease, with bioethics and ecological systems being taken into consideration (Ikemi 1996).

With the medical field moving toward a comprehensive model, peripheral movements, such as holistic medicine, medical behavioral science, and stressology, have become more active in recent years. Characteristic of today's psychosomatic medicine are its efforts towards basic bio-psycho-social research (the core of holistic or "whole person" medicine) and the development of systematic examination and treatment on the basis of psychosomatic relationships. With the introduction of new technologies and knowledge gained by our research, we have been able to shift our focus to the genetic basis of disease and the involvement of environmental factors. This has led to a change from simple mind/body relationships to a focus on psycho-neuro-immuno-endocrinology.

The Japanese Society of Psychosomatic Medicine has become a vehicle for bringing about the most advanced research activities, education techniques, and knowledge and has become a shining example for other psychosomatic societies. Our aims are to promote the study of psychosomatic medicine and to facilitate the introduction of cutting edge research into psychosomatic medicine and its related fields.

18.6 Current Practice of Psychosomatic Medicine

The focus of our society is stress-related diseases that have psychosomatic components and social factors that are closely related to a physical disease. Our approach is to treat not only the patient's physical conditions, but to treat illness holistically from its psychological, social, and environmental aspects. In broad terms the goal of psychosomatic medicine is holistic medical care, thus we constantly strive to develop mind-body correlation studies, diagnoses, treatments, and means of prevention that promote the progress of our field. Psychosomatic medicine is practiced with clinical psychologists, social workers, nurses, and medical doctors working together as a team, in cooperation with professionals in educational and industrial circles.

Because the initial complaints of patients suffering from psychosomatic disorders are somatic symptoms, thorough physical examination is needed first. Even though there is strong evidence of psychological factors in psychosomatic related diseases, if the diagnosis of a psychosomatic disorder is carelessly made without sufficient physical examination, there is the danger of overlooking serious physical conditions. Thus, it is important to perform the necessary examinations and to diagnose the nature and severity of physical conditions precisely before proceeding with medical and psychosomatic treatment regimens. It would be a mistake to

neglect psychological examination in cases where physical factors have been diagnosed, and vice versa.

In the medical treatment of psychosomatic disease, the skillful combination of both physical treatment for the somatic symptoms and psychological therapy are imperative. In the case of a disease that is suspected of being psychosomatic in nature because there is no response to general internal medical treatment, repeatedly encountered recurrence, chronicity, or that easily erupts when social stresses are observed, psychological examinations are necessary at the same time as the physical examination, or as soon as possible after. As a consequence of these examinations, if the possibility of a psychosomatic disorder is high, the doctor should inform the patient and help them understand that both somatic and psychological treatment will be necessary. However, in cases where the patients are convinced that they are suffering only from physical disease and thus resist the psychological approach, it is necessary to consider treatment from the physical aspect first, and then pursue the psychological approach at the right moment. Repeating physical examinations aimlessly and trying various kinds of treatment at random give patients the strong impression that their disease is only of a physical nature. At this stage, it is too late to treat them psychosomatically and to obtain their cooperation. In addition, the treatment environment while a patient is in a hospital is significant to patient care. Therefore, it is important that both the atmosphere in the wards and the attitude of the nursing staff are closely monitored to assist the patients to recover to the point they can re-enter society.

In order to improve the effectiveness of treatment, it is critical that a good relationship between the doctor and patient be created that includes the formation of rapport and motivation toward the treatment. Paying careful attention to the patient's complaints and worries, empathizing with their pain and grief, and approaching them warm-heartedly, faithfully, and with humanity are important in achieving the above-described prerequisite. In reality, the one who overcomes the disease is the patient him/herself. Therefore, to promote an inducement for the patients to accept the treatment, therapists need to explain that they will help the patient solve the problem and will be supportive at all times.

It should be noted that in the treatment of patients to merely remove the unsound parts and restore them, i.e. "the medical model approach," is insufficient and that it is important to understand and approach the patient in a way that promotes psychological growth, as in the "growth model".

18.7 Traditional Healing: History and Current Practice

For psychosomatic treatment, life guidance, drug therapy, various kinds of psychotherapies, and Japanese and Asian developed therapies are provided to our patients, in combination with physical treatment by internal and other clinical medicine

Table 18.1 Psychosomatic treatment

1. Physical therapy in internal medicine and other clinical fields
2. Life guidance
3. Psychotherapy by interview (Counseling)
4. Pharmacotherapy (psychotropic drugs, medicinal herbs)
5. Social casework
6. Psychotherapy: Autogenic training, self control, muscle relaxation, transactional analysis, behavioral therapy, cognitive therapy, family therapy
7. Oriental therapy: Morita therapy, Naikan Therapy, Yoga therapy, Qi-gong, Acupuncture and Moxa cautery

practitioners, according to the patient's condition (Table 18.1) (Japanese Society of Psychosomatic Medicine 1991).

From traditional Chinese herbal medicine, introduced in the fifth and sixth centuries, Japan developed a system it calls *Kampo*, after sixteenth century. There are a large number of medicinal herbs that contain crude drug components that exert anxiolytic and antidepressant effects. Many have unique mechanisms that act on the autonomic nervous system because of the complexity of the drug composition. Further, medicinal herbs and many of the formulations are characteristically effective on complaints such as being easily fatigued, hot flashes, chill, and other complaints aggravated by chilling. Their effectiveness has been shown in improving the somatic aspects of psychosomatic patients and for syndromes that are often considered intractable with the drug therapies of modern medicine. Thus, the medicinal herbs used in Japan have a unique position in drug therapy for psychosomatic patients rather than simply being a substitute for anxiolytic or antidepressant drugs.

Several Japanese or Asian developed therapies are also used in the treatment of psychosomatic diseases. Morita therapy is a psychotherapy for neurosis that was devised by Masatake Morita in 1924.

According to the Morita theory, a neurotic patient has a hypochondriacal character that is basically introverted, has a strong sense of perfectionism, and worries about trifles. The patients pay excessive attention the psychophysiological phenomena that they experience. As a result of the concentration of attention, their sense becomes sharp and attention is fixed more and more on the phenomenon (psychophysiological interaction). Furthermore, a person with such a character is overly demanding. They ignore reality and persist with unreasonable efforts to achieve their ideal. However, reality disappoints them and their symptoms become stronger.

The standard procedures of Morita therapy require admission and careful monitoring. The first stage is a period of reflection while lying in bed, other than when rising for toilet needs, for four to 7 days. The patient is isolated and prohibited from meeting or talking with anyone, smoking, or any other activity. The second stage is a period of slight work that lasts one to 2 weeks. The patient must get up and do light work on personal matters. Later in this stage, the patient voluntarily does a

little work outside the hospital. The patient must keep a diary that records the work done and feelings from the first day of the second stage. The therapist uses this material for guidance. The third stage is a period of hard work and lasts for one to 2 weeks. There is no work limit. The patient is permitted to read books and go out after three to 4 weeks from the start of Morita therapy. The fourth stage is a period of preparation for return to society. This can be as little as to several weeks. The patient lives a normal life, with permission given to meet family, return home if necessary, and to spend time with friends. Advice is given throughout these four stages on how to modify disadvantageous cognitions and criticisms about any aspect of social interaction. The basic principle is the spirit of "fact is truth". In other words, the patient is advised to look, think, and learn to view things from the standpoint of fact.

Naikan (insight) therapy is unique Japanese psychotherapy initiated by Ishin Yoshimoto in 1941. It is indicated for the treatment of neurosis, psychosomatic disorders, alcohol dependency and school refusal in 1965. For use in hospitals, the original therapy is slightly modified and the patient is restricted to a private room for 1 week to isolate them from all outside information. The patient sits on the bed or a chair facing the wall continuously from 6:00 AM to 9:00 PM and concentrates on systematically remembering the following kind of events related to the patients' relatives, year by year, from childhood to the present. (1) kind deeds they did for the patient. (2) what the patient did in return, (3) what the patient did to embarrass them. Normally, a patient starts with his or her mother, and moves on to father and siblings. The interviewer visits the patient every 2 hours determining cold facts about the patient. After exchanging a deep bow, the interviewer asks the patient "At this time, you were checking yourself around what age and about whom?" "What did you think about it?" and then listens to the response for about 5 minutes. The patient is required to remember substantial past behavior, not just vague recollections. On the other hand, the interviewer makes no judgment of the retold story but earnestly listens to what is described. Finally, they exchange a deep bow again to complete the interview.

The point of Naikan is not to discuss the present symptoms at all, but to recall relationships between the patient and relatives from the childhood of the patient. By doing so, alterations in the total personality are disclosed, not at a superficial level, resulting in the spontaneous disappearance of symptoms. It is a therapy which cannot be overlooked in understanding the multiple facets of psychosomatic disorders and neurosis.

Acupuncture and moxa cautery are also used for patients with psychosomatic disease. A physical condition of stiffness "Kori" occurs under various stressful circumstances. If this condition is of long duration, it triggers the onset of various complaints. However, local stiffness and muscle spasms are not always relieved by rest or muscle relaxation. Acupuncture is quickly effective for these conditions. Furthermore, acupuncture has analgesic, sedative, and regulatory actions on the autonomic nervous and immune systems. Therefore, acupuncture can be highly

useful for unstable pain, unsuitable sensations, psychosomatic hypertonia, and especially for complaints of muscle spasm. The autonomic nervous system becomes stable through the long-term performance of acupuncture. This therapy is effective for a wide range of patients. Moxa cautery is used in a similar way to acupuncture.

The purpose of yoga is to control the body, respiration, sensation, and mind (meditation), progressing gradually from easy to difficult stages of control. It has been shown to be useful in the case of complaints related to muscle tension, poor posture, irregular breathing, and alexthymia.

18.8 Conclusion

Japanese psychosomatic medicine has shifted from being on the periphery of medical practice to where it is now considered a core discipline of clinical medicine. We have been able to develop a harmony between evidence based and narrative based medicine. This shift has brought great benefits, but it has also brought about a number of problems that need to be resolved. These include educational, economic, and philosophical issues. In terms of education, we need to encourage all universities, not just the current nine, to include extensive teaching of psychosomatic medicine in their curriculums. The Japanese health insurance system must be updated to include provisions that allow the successful treatment of patients with psychosomatic diseases, many of which take more time for treatment than is currently funded. We need to continue our public education efforts to impress on the healthy population the importance of stress management, health promotion, and other forms of preventive medicine.

It is encouraging that we have been able to integrate our efforts to promote psychosomatic medicine with those of other members of the world community. The members of the Japanese Society of Psychosomatic Medicine have been impressively active in their participation in the World Congress of Psychosomatic Medicine and the Asian College of Psychosomatic Medicine, which has grown tremendously in recent years. Our interactions with the world community serve to broaden our perspectives and to promote the perspectives of the Japanese Society, build strong bonds with individual researchers and clinicians, and help us provide the best possible care to our patients.

Questionnaire Response

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry in your (or your chapter's) Country.

Please return this as an attachment to your email

Country on which you are reporting: Japan

Your Name: Chiharu Kubo

Institution: Kyushu University

City & Country (e.g. London, UK): Fukuoka, Japan

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?
 Yes () No () In some sense ()
 - a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes () No ()
 - b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes () No ()

2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?
 Yes () No ()

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?
 Yes () No ()

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No ()
 - a. If YES, which?
 Psychosomatic Medicine () Consultation-Liaison Psychiatry ()
 - b. If YES, the status of such certification is:
 - i. Independent Medical Specialty ()
 - ii. Subspecialty of Internal Medicine ()
 - iii. Subspecialty of Psychiatry ()
 - iv. An independent non-medical discipline, as Psychology, Social Work ()
 - v. Other (Specify):[]

5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No ()
 If YES, please list names of the organizations and the websites if available:
 Japanese Society of Psychosomatic Medicine

6. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:
 Journal of the Japanese Society of Psychosomatic Medicine
 BioPsychoSocial Medicine (online)
7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in your country? Yes () No ()
 a. If YES, where does it occur? Check all that apply:
 Medical School () Residency () Fellowship ()
8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes () No ()
9. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)
- It is insignificant ()
 - Some subgroups (e.g. ethnic, religious) practice it ()
 - A significant part of the general population practice it ()
 - Is the most prevalent healing method used ()
 - It is often used in combination with Western medicine ()
 - More widely used methods are as follows (Please list, e.g., spiritual healing, meditation, herbal, etc):
10. Please add any comments to your response here:

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Chapter 19

Psychosomatic Medicine in Korea



Kyung Bong Koh

19.1 Introduction

Psychosomatic medicine is a scientific discipline which deals with the biopsychosocial approach, that is, an integrative approach in the care of patients as well as research into interactions among biological, psychological, and social (environmental) determinants of health and diseases. This field encompasses consultation-liaison (C-L) activities (Lipowski 1968). C-L psychiatry refers to clinical application of psychosomatic approach to problems occurring at the interface of psychiatry and medicine (Lipowski 1985).

19.2 Brief History

19.2.1 *Traditional Korean Medicine and Psychosomatic Medicine*

From a traditional Korean medicine's perspective, mind and body have been regarded as interrelated from a long time ago. Separation of mind and body is seen as illness, and its extreme form as death. In other words, one-side dominance of either mind or body over another is regarded as illness or death. Therefore, health means incorporation of mind and body into oneness (Hong 1993).

Korea in this chapter refers to the Republic of Korea (South Korea) as very little information is available from North Korea

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Prior to the introduction of Western medicine, traditional medicine was predominant along with shamanism and folk medicine in Korea. Traditional Korean medicine was greatly influenced by traditional Chinese medicine for a long period of time. In the middle period of the Chosun era (early seventeenth Century), however, traditional Korean medicine began to develop independently of traditional Chinese medicine. Thus, in Korea, the name of “Chinese medicine” was legally changed to “Korean medicine” in 1986. Chinese medicine focuses on diseases and diagnoses, whereas Korean medicine focuses on a humanistic approach based on constitution and nature. In particular, Korean medicine emphasizes the importance of mind and emotion in the maintenance of health and recovery from illness (Association of Korean Medicine 2012). Korean medicine also uses therapeutic modalities such as herbology, therapeutic exercise, and stimulation therapies like those in Chinese medicine. Stimulation therapies include *chim* (acupuncture), *t dum* (moxibustion), *jiahp* (ischemic compression therapy, finger pressure therapy, *shiatsu*), and *buhang* (negative pressure therapy, cupping or tubing) (Chun 2013).

In traditional medicine based on traditional Chinese philosophies, the human body can be explained in physical terms of 5 cosmic elements such as fire, water, wood, metal, and earth. The body is also operated with cosmic positive or negative energy (*ki or Qi*), *um-yang* (yin-yang), of the 5 elements. In this medicine, emotions were also understood as energy, which is related to 5 major body organs such as liver, heart, stomach, spleen, and kidney. According to this theory, health can be maintained in a state of harmonious balance between the *kis* in these visceral organs. However, emotions may unbalance the *kis* and then disturb the function of the visceral organs. In particular, anger has been identified with the energy of fire (*hwa-ki*) and such emotion is supposed to negatively affect the visceral organs, mostly heart and liver, resulting in a disease such as *hwa-byung*, fire-disease (Min 2013).

Shamanism has provided people with an explanation of the world, life, and disease. Shamanism relates suffering or symptoms of any diseases with physical harming by evil spirits with unresolved anger and vengefulness because they died from unfairness (Rhi 1970).

Traditional medicine and shamanism has provided Koreans with concrete and physical explanation for nature, emotion, and human suffering (disease), whereas the traditional philosophy based on Confucianism has taught a way of life in which people suppress emotion not to jeopardize harmonious interpersonal relationships. In this culture, Koreans have learned to express their suppressed emotion in somatized form (e.g., *hwa-byung*) while saving their face (Min 2013).

19.2.2 Modern Psychosomatic Medicine in Korea

Western medicine was officially introduced to Korea by medical missionaries who played a leading role in establishing Chejungwon, the first Western hospital in Korea (the former name of Severance hospital) in 1885 and its medical school in 1886 with financial support from the government. At that time, they reported that

their patients included mental disorders such as hysteria, hypochondriasis, neurasthenia, depression and insomnia (Korean Neuropsychiatr Assoc 2009; Park and Yeo 1999). Medical students at Severance medical school began to take lectures on psychiatry and neurology in 1913, and participate in clinical clerkships after the department of psychiatry was established in 1917 (Korean Neuropsychiatr Assoc 2009).

From a Western medicine's perspective, psychosomatic medicine in Korea began to be introduced by some psychiatrists after 1960. Lee (1960), psychoanalyst, presented a case of psychotherapy for a patient with psychogenic headache. Min (1966) reviewed cases referred for psychiatric consultation at the outpatient clinics. Kim first used biofeedback treatment for patients with stress-related symptoms in 1978. Thereafter, some of articles and books on psychosomatic medicine and C-L psychiatry were published, and then more articles were presented and published after the Korean Psychosomatic Society was founded and the Korean Journal of Psychosomatic medicine was published (Koh 2011). In particular, research on stress considerably increased after both the Korean Psychosomatic Society and the Korean Society of Stress Medicine were founded.

From a historical perspective, modern psychosomatic medicine began from psychoanalysis and psychodynamic studies, followed by the development of experiment-centered psychophysiology (Lipowski 1986a, b; Fawzy et al. 1982) and then C-L psychiatry (Fawzy et al. 1982). In this respect, it is interesting to review the developmental history of a variety of academic societies in Korea. Academic societies related to psychotherapy and psychoanalysis including the Korean Academy of Psychotherapists were founded in 1970s, the Korean Society of Psychopharmacology, the Korean Society of Biological Psychiatry, and the Korean Association of Social Psychiatry in 1980s (Korean Neuropsychiatric Assoc 1991), and then the Korean Psychosomatic Society and the Korean Society of Stress Medicine in early 1990s. The subspecialization in Korean psychiatry started from psychoanalysis, then leading to the development of biological psychiatry, social psychiatry and lastly psychosomatic medicine (Koh 2011).

Primary physicians saw many patients with psychiatric problems but were inadequate in dealing with such patients, resulting in less than optimal outcomes. In the United States, this awareness of psychiatrists gave impetus for the federal government to support the development of C-L psychiatry (Eaton 1986). In Korea, however, C-L psychiatry was initiated and developed by individual psychiatrists' interest in and passion for this field without any support from the government.

Psychosomatic medicine, especially C-L psychiatry exerted a great influence on the status of psychiatry as well as therapeutic approach for patients. In other words, this field provided an impetus to the advancement of medicine and behavioral medicine by opening up psychiatry services in general hospitals, thus helping psychiatry overcome isolation from the community. Nowadays, psychiatry is no longer a department alienated from medicine, but has entered the mainstream of medicine. Psychosomatic medicine played a leading role in applying the biopsychosocial integration to medical education and care for patients with physical symptoms or diseases (Lipowski 1986a).

In modern medicine, molecular biology and gene therapy are popular, but the value of psychosomatic medicine is not diminished. On the contrary, this field is likely to be fueled by the development of other medical fields (Jeong 1993), as the range of interaction can be widened and a psychosocial or humanistic approach to emerging fields is required as well.

I here review psychosomatic medicine in Korea in terms of clinical practice, education, and research. In addition, physicians' and patients' attitudes toward psychiatry are reviewed along with sociocultural aspects of psychosomatic medicine in Korea.

19.3 Clinical Practice Relevant to Psychosomatic Medicine in Korea

The specialization of medicine and development of medical technology tended to make physicians work like technicians and foster dehumanization of medicine, as physicians could deal with patients as diseases rather than as persons. Consequently, patients' individual psychological needs were often neglected (Schwab 1989; Engel 1980; Koh 1990a). Therefore, C-L psychiatry which emphasizes a holistic approach was required to prevent dehumanization of medicine.

The rate of referral for psychiatric consultation in general hospitals in Korea during the period from 1976 to 1986 was reported to range from 1.4% to 2.7%, which was not lower than that in other countries except the United States (Seo 1983; Lee et al. 1981; Cho et al. 1984; Sheivitz et al. 1976; Taylor and Doody 1979; Zuo et al. 1985). Nonetheless, about a quarter of medical inpatients perceived their psychological problems and distress as serious. In addition, 71% of the medical inpatients were found to have psychosomatic disorders (psychological factors affecting physical conditions) (Koh 1988). However, the rate of referral for psychiatric consultation was less than 3% (Koh et al. 1988), which revealed that a considerable number of patients with stress-related physical symptoms and/or with both physical diseases and psychological problems did not receive proper psychiatric care.

Most psychiatrists in a majority of general hospitals participate in consultation activity. However, liaison activity is limited to psycho-oncology in some general hospitals, although psychiatric consultation for cancer patients has been done in 212 hospitals (NHIC 2006). The Korean Society of Psycho-oncology was founded in 2005 (Hahm et al. 2007). Among 84 training hospitals in Korea, 23% were found to have psychosomatic clinics (Seo 2012). Although treatment team is necessary for effective C-L activities (Lipowski 1974), only psychiatrists work as consultants without collaboration with nurses, psychologists, and social workers in most of Korean general hospitals (Byun 1988). In addition, there are limitations in consultation-liaison activities due to the lack of C-L specialists and insufficient payment system by the National Medical Insurance for C-L activities (Koh 2011).

Despite these shortcomings, the necessity for C-L activities was enhanced in Korea, as the number of big general hospitals increased along with patients' higher expectations for quality care in accordance with their improved socioeconomic status. Therefore, the importance of education for nonpsychiatric physicians as well as psychiatric care for medical patients was emphasized (Lipowski 1983). To this end, liaison activities needed to be activated to improve the quality of care for medical patients. In addition, C-L psychiatry has recently strived to focus on the prevention of diseases and rehabilitation rather than just the treatment of diseases (Pasnau 1988). From a psychiatric perspective, liaison activities of psychiatrists would help expand and invigorate psychiatry, because they would generate more interest in somatic symptoms and expand psychiatrists' roles into nonpsychiatric wards and clinics (Koh 2011).

Some significant changes were observed over a period of 10 years after the C-L service was established in a university hospital (Koh et al. 1988). The rate of referral for psychiatric consultation increased; especially among the age group over 60 years, there was nearly a three-fold increase in the rate of referral. Regarding reasons for requests of consultation, psychological symptoms increased, but suicidal attempt and bizarre behavior markedly decreased. The most frequent reason for consultation requests was for 'unexplained somatic symptoms' at the beginning, and for 'psychiatric evaluation' at the end of 10 years. About 72% constituted concurrent physical and psychiatric disorders. In the distribution of physical symptoms (at the beginning, 5 years and 10 years later), there was a consistent increase in those of endocrine-metabolic (5.6% vs. 7.9 vs. 10.6%) and musculoskeletal systems (5.6% vs. 8.7 vs. 11.1%), but a consistent decrease in those of nervous (27.1% vs. 26.2 vs. 20.9%) and skin systems (6.5% vs. 5.5 vs. 2.1%). Regarding diagnoses of mental disorders in these patients, depressive disorders were the most common but later adjustment disorders were the most common. However, depressive disorders were the most common throughout a ten-year period when adjustment disorders with depressed mood were included in depressive disorders. Organic mental disorders steadily increased, while somatoform disorders steadily decreased. However, it was later reported that organic mental disorders, especially delirium, was the most common in diagnostic distribution, followed by depressive disorders among patients referred for psychiatric consultation in another university hospital (Kim et al. 2011). However, there were no changes in the diagnosis of psychosomatic disorders (psychological factors affecting medical conditions) during the same period. That might be because other physicians were willing to manage these patients (Fauman 1983) or the patients themselves showed resistance to psychiatric consultation (Koh et al. 1988). The consultants' recommendations of medication markedly increased but those of transfer to psychiatry steadily decreased. In addition, follow-up evaluations were routinely recommended after the establishment of the C-L service. These results suggest that the extent of consultants' activity may greatly influence the rate of referral and that education for medical students, interns, residents of other departments as well as residents of psychiatry is crucial for effective C-L activity (Koh et al. 1988).

19.4 Psychosomatic Education in Korea

Education programs for psychosomatic specialists had been systematically carried out by the Korean Psychosomatic Society during the period from 2008 to 2009 in an attempt to introduce C-L subspecialty board system for psychiatrists in the future (Seo 2012). In addition, education for psychiatric residents and primary physicians was being carried out in some university hospitals, but in general the quantity and quality of training for them was found to be scanty and poor except a few university hospitals which had regular and systematic programs including case conferences, journal reviews and individual supervisions (Byun 1988; Kim 2012). Most of education for medical students was being carried out through lectures but they indirectly participated in clinical clerkships in some university hospitals by observing consultation activities by psychiatric residents or staffs and attending a variety of programs for psychiatric residents. Moreover, liaison activities were limited to some departments and done intermittently for collaborative research and lectures except psycho-oncology in which psychiatrists regularly evaluate and manage cancer patients with psychiatric problems at the outpatient department of cancer centers, although in some university hospitals. However, biannual academic meetings such as the meeting of the Korean Psychosomatic Society and the Korean Society of Stress Medicine have offered a variety of educational programs for nonpsychiatric physicians, Oriental medicine doctors, nurses and clinical psychologists as well as psychiatrists (Koh 2011).

As obstacles to the development of C-L psychiatry, in addition to patients' prejudice against psychiatry, nonpsychiatric physicians' and psychiatrists' negative attitude toward C-L psychiatry, lack of financial support, especially poor medical reimbursement, and limited number of staff related to this field were pointed out. In particular, education for medical students at the closed ward rather than the open ward might make them have prejudice against psychiatry and psychiatric patients, leading to their difficulty in evaluating and managing patients with both physical symptoms and psychiatric problems practically (Koh 2011).

However, there were a few positive factors for the development of C-L psychiatry in Korea (Koh 2011). First, both the Korean Neuropsychiatric Association and the Korean Medical Association ruled that training programs for the third and fourth psychiatric residents must include consultation-liaison psychiatry. In addition, medical care delivery system across the nation carried out for a period of long time had the potential for encouraging and strengthening the psychiatrists' role of teaching for nonpsychiatric physicians in regard to C-L psychiatry. In this respect, it could be emphasized to have medical students learn how to approach patients based on biopsychosocial model of diseases rather than biomedical model during their clinical clerkships (Lew 1989). Strategically, it could be practically effective to get them to have an opportunity to learn about some common disorders they might face, such as adjustment disorders, depressive disorders, and organic mental disorders (Koh et al. 1988). Education on psychopharmacology is very important because medication was the most frequently recommended during psychiatric consultation. Particularly

that may be because caution should be made in the use of psychiatric agents in patients with physical diseases and drug interactions between psychotropics and other medical drugs should be carefully assessed as well (Koh 2011).

19.5 Psychosomatic Research in Korea

In Korea, the Korean Psychosomatic Society was founded in 1992, and the Korean Journal of Psychosomatic Medicine started to be published in 1993 (Koh 2011). Nearly at the same time, the Korean Society of Stress Medicine was also founded and thereafter the Korean Journal of Stress Research was published. The Korean Psychosomatic Society mainly consists of psychiatrists, whereas the Korean Society of Stress Medicine consists of a variety of specialists such as family physicians, psychiatrists, Oriental medicine doctors, nurses, psychologists and basic scientists.

Before 1980, most of journals, especially on C-L psychiatry, revealed general trends in psychiatric consultation. After 1980, however, there were a number of articles on the interaction between nonpsychiatric physicians and psychiatrists, such as consultees' acceptance for consultants' recommendation and physicians' attitudes toward psychiatry as well as problems encountered during psychiatric consultation (Bang 1988).

The articles published in two journals, the Korean Journal of Psychosomatic Medicine and the Journal of Korean Neuropsychiatric Association, during the period from 1988 to 1992 before the Korean Psychosomatic Society was founded, were classified by Lipowski's method (Lipowski 1986c). As a result, regarding research methodology, clinical studies was the most common (67%), followed by epidemiological studies (20%). In regard to subjects of research, somatopsychic relationship (53%) was the most common, followed by C-L psychiatry (17%). However, experimental studies were scarce, especially on psychophysiology, psychoneuroendocrinology and psychoimmunology (Koh 1993).

The articles published in the same two journals during the period from 1997 to 2011 were also classified by the same method (Ko 2012). Regarding research methodology, clinical studies were the most common (68.0%), followed by literature review (21.9%). In regard to subjects of research, somatopsychic relationship (39.3%) was the most common, followed by others (mainly related to stress) (30.1%). In contrast, C-L psychiatry as well as psychophysiology, psychoneuroendocrinology and psychoimmunology was scarce (Table 19.1). During the two periods, some changes were noted: literature review increased but epidemiological studies decreased; research on stress increased but research on C-L psychiatry decreased. However, the data used in this classification did not include other Korean journals as well as international journals, although there seemed not to be so many articles related to psychosomatic medicine in those journals.

As a whole, the number of articles relevant to psychosomatic medicine increased after the Korean Psychosomatic Society was founded. In addition, recent research methodology and subjects became more diversified, research on consultation-liaison

Table 19.1 Classification of Psychosomatic Research in Some Korean Journals during the Two Periods (1988–1992* vs. 1997–2011**)

Classification	N = 76* N(%)	N = 356** N(%)
I. By methodology		
1. Experimental studies	7(9)	17(4.8)
(1) Human	5	13
(2) Animal	2	4
2. Clinical studies	51(67)	242(68.0)
3. Epidemiological studies	15(20)	19(5.3)
4. Literature review	3(4)	78(21.9)
II. By subjects		
1. Psychophysiology	4(5)	12(3.4)
2. Psychoneuroendocrinology	2(3)	13(3.7)
3. Psychoimmunology	4(5)	8(2.2)
4. Etiology of disease	2(3)	24(6.7)
5. Somatopsychic relationships	40(53)	140(39.3)
(1) Psychosocial reaction to physical illness	24	55
(2) Influence of physical illness on psychological functioning	12	72
(3) Influence of medical and surgical therapies on mental health	4	13
6. Therapeutic effectiveness of psychiatric methods in physical illness	2(3)	29(8.1)
7. Consultation-liaison psychiatry	13(17)	23(6.5)
8. Geriatric psychiatry	4(5)	0(0)
9. Others (mainly related to stress)	5(7)	107(30.1)

psychiatry tended to be dynamic rather than phenomenal, and there were more research on specific diseases. New terminologies such as stress perception, coping strategies, vulnerability, social support, illness behavior, and biopsychosocial approach also began to be used, and collaborative studies with other physicians became more popular (Koh 2011).

At that time, it was pointed out that there were scanty research on intermediate mechanisms between mind and body, especially psychophysiology, psychoneuroendocrinology and psychoimmunology, although some articles on these topics appeared later. There were also few studies on the application of behavioral medicine and psychotherapeutic techniques in psychosomatic medicine as well as the effect of C-L activities, for example, their cost-effectiveness. Therefore, it was emphasized that future studies needed to include these topics (Koh 2011). In addition, as Cohen-Cole et al. (1986) mentioned, epidemiological studies, the development of reliable instruments for diagnoses, and improvement of research methodology using a computer were more emphasized than before.

In the past, research in psychiatry tended to focus on psychoanalysis so that *brainless psychiatry* became the mainstream of psychiatry, whereas recently it tends to focus on biology due to the development of biology and pharmacology so that it is feared that *mindless psychiatry* becomes the mainstream of psychiatry (Eaton 1986; Eisenberg 1984). From this perspective, we will have to pay attention to not only new information related to each of biological, behavioral,

psychological and social development but also their integration in order to continue to develop psychosomatic medicine (Koh 2011).

19.6 Attitudes Toward Psychiatry in Korea

Obstacles to the development of C-L psychiatry were known to be patients' insufficient concept of psychiatry, social prejudice, nonpsychiatric physicians' prejudice against psychiatry and dissatisfaction with the outcome of consultation, negative and persecutory ideation about psychiatrists' roles and fear of patients' refusal to accept psychiatry, psychiatrists' negative views about C-L psychiatry and limited contacts with other physicians (McKegney 1985; Lee 1977a; Chung et al. 1984; Koh 1987a; Lee and Koh 1994; Steinberg et al. 1980). Among them, nonpsychiatric physicians' attitude toward psychiatry was reported to make the greatest impact on the frequency of referral for psychiatric consultation in general hospitals (Lipowski 1986a). Thus, attitudes toward psychiatry and psychiatric consultation in medical students, called future physicians, and nonpsychiatric physicians were reviewed, along with patients' concept and acceptability of psychiatry.

19.6.1 Medical Students' Attitudes Toward Psychiatry

A study found that a majority of senior medical students were favorable about psychiatric education, psychiatric consultation, and psychoanalysis. Students with more interest in psychiatry as a career showed both positive and negative views about psychiatry. They were more aware of psychiatry's drawbacks: psychiatrists' low income and other physicians' criticism. However, such views seemed to be changed more positively in recent years along with increasing concern over mental health and changes in medical support system (e.g., reduced medical cost for patients with serious mental disorders by financial support of the government) as well as socioeconomic development in Korea. Future surgeons were more negative about psychiatry than were future nonsurgical physicians. These results suggested that C-L psychiatry deserved an expansion of its role in clinical clerkships for medical students so that it would help not only improve their negative views but also enhance their positive views about psychiatry (Koh 1990b).

19.6.2 Nonpsychiatric Physicians' Attitudes Toward Psychiatry

A study found that a majority of nonpsychiatric physicians were favorable about psychiatric education, psychiatric consultation, psychoanalysis, students' choice of psychiatry as a career, and psychiatrists. Staffs were more positive about psychiatry than residents, and senior staffs were more positive about psychiatry than junior

staffs. Overall, however, no significant differences were found in attitudes toward psychiatry between nonsurgical physicians and surgeons, although staffs or residents in nonsurgical departments were more favorable about some aspects of psychiatry than those in surgical departments. The physicians with more interest in psychiatry as a career in the past were more likely to be positive about psychiatry as a comprehensive science and a rapidly expanding field of medicine. Nonpsychiatric physicians with older age were more likely to be positive about the status and efficacy of psychiatry, role and functioning of psychiatrists than those with younger age. The results suggested that previous interest in psychiatry, age and clinical experience might favorably influence nonpsychiatric physicians' attitude toward psychiatry (Koh and Lee 1998).

19.6.3 Nonpsychiatric Physicians' Attitudes Toward Psychiatric Consultation

Staffs tried to refer their patients to the department of psychiatry for consultation more frequently than residents, whereas nonsurgical physicians than surgeons. Psychiatric consultation was requested most frequently for overt psychiatric symptoms and past history of psychiatric treatment. The most frequent causes of not referring to the department of psychiatry were found to be the patients' rejection and nonpsychiatric physicians' dissatisfaction with the results of consultation. Nonsurgical physicians tended to explain the reasons for psychiatric consultation to their patients more adequately than surgeons (Lee and Koh 1994).

In addition, other studies found that most of other physicians as consultees tended to accept psychotropic medication recommended by consultant psychiatrists but a considerable number of physicians showed resistance to transfer of their patients to psychiatry (Min 1982; Koh 1991).

19.6.4 The Concept and Acceptability of Psychiatry in Patients Referred for Psychiatric Consultation

Patients referred for psychiatric consultation were compared with psychiatric outpatients and the general public regarding the concept and acceptability of psychiatry during the period from 1984 to 1985. In each of the three groups, a large proportion of people viewed psychiatry as dealing with only psychoses, while most of them did not view mental disorders as including only psychoses. This suggested that their resistance to psychiatric approach might arise from the misconception of psychiatry rather than of mental disorders. In addition, both the consultation patients and the general public did not distinctly recognize the differences between psychiatry and neurology. Thus, it was emphasized that education and guidance for the general public as well as patients were necessary to make them understand psychiatry

correctly. Those patients consulting a psychiatrist showed less acceptability of psychiatric treatment for somatic symptoms than the general public. They also more likely tended to primarily consider their nonpsychiatric physicians' recommendation for psychiatric treatment than did the psychiatric outpatients (Koh 1987a).

19.6.5 The Concept and Acceptability of Psychiatry in Patients with Psychosomatic Disorders

Patients with psychosomatic disorders, those with major depressive disorder, those with anxiety disorders and the general public were compared with each other, regarding the concept and acceptability of psychiatry. Misconception of psychiatry was found to be more remarkable than misconception of mental disorders in all the groups. The psychosomatic disorder patients recognized the differences between psychiatry and neurology better than patients with major depressive disorder. They showed more positive response than patients with major depressive disorder and the general public when they were diagnosed with a mental disorder. However, they felt more incredible in such a situation than patients with anxiety disorders. They also showed more negative response in relation to the prognosis of mental disorder than the general public. They less likely tended to accept psychiatric treatment than patients with major depressive disorder and those with anxiety disorders. In particular, they also showed more negative response to psychiatric treatment for somatic symptoms than all the other groups of subjects. These results suggested that psychosomatic patients' resistance to psychiatric approach might be due to their underlying psychological motivation in addition to their misconception of psychiatry. On the other hand, it was likely that patients' acceptance of psychiatric approach might depend upon the nature of symptoms (either emotional or physical) (Koh 1987b).

19.7 Social Aspect in Psychosomatic Medicine

Although the general public's needs for medical care considerably increased, the medical insurance did not cover reimbursement sufficiently for not only psychiatrists' but also physicians' psychosocial assessment and management for patients including history taking. As a result, physicians tended to avoid such approach and instead abuse expensive medical instruments or laboratory tests. This trend was at risk for conflicts in doctor-patient relationship as well as higher medical costs (Koh 2011).

In contrast, there were a few positive changes in association with psychosomatic medicine. For example, the general public's interest in mental health and stress was heightened by higher economic levels of individuals and the influence of mass media. Stressors were also regarded as one of the causes associated with the onset of serious physical diseases, and the employees with such stress-related diseases

were able to receive either compensation or pension from their companies through judicial decisions. In addition, a variety of mental health lectures for employees at workplaces and for the elderly took place and mass media such as newspapers, radios, televisions and internet also dealt with such mental health knowledge and programs. Therefore, the general public's views on psychiatry and mental health changed more positively than before. Patients with physical symptoms referred for psychiatric consultations at the outpatient clinic as well as during admission more likely tended to accept physicians' offer for them to see psychiatrists. Integration, the core value and philosophy of psychosomatic medicine, was also more likely to affect the society as well as medicine than before (Koh 2011). Recently the name of the department of psychiatry was officially and legally changed to the department of mental health medicine in Korean, although the former continues to be used in English, in order to diminish the general public's prejudice against psychiatry in Korea.

On the other hand, not a few psychosomatic patients visited Oriental medicine clinics in Korea, where they were not labeled as mentally ill so that their sick role was easily accepted by the family and society. Among patients referred for psychiatric consultation, psychiatrists could often see patients, especially elderly ones who had used Oriental medicine clinics and taken some herbal medicine. However, the number of such patients tended to decrease in recent years probably due to the development of health supplement food (e.g., ginseng products) and drugs enhancing sexual function (e.g., Viagra).

19.7.1 Oriental Medicine in Korea

Korea has had a long history of traditional medicine. In the United States and many other European countries, Oriental medicine is considered a part of alternative medicine, but in Korea, Oriental medicine or traditional Korean medicine is not included in alternative medicine. That is, anything other than orthodox conventional Western medicine and traditional Korean medicine is considered to be an alternative medicine (Chun 2004, 2008).

Korea maintains a dual licensing system of medical doctors, including doctor of Western medicine (M.D.) and doctor of Oriental medicine (O.M.D.). There are 41 medical schools of Western medicine and 11 medical schools of Oriental medicine in Korea (Kim and Kim 1994).

19.7.2 Differences Between Western Medicine and Oriental Medicine

There are a lot of differences between Western medicine and Oriental medicine as Chun (2013) mentioned in detail. First, Western medicine is primarily based on science and technology, while Oriental medicine is based on philosophy and

metaphysics. Oriental medicine emphasizes the concepts of ki (Qi) which is a vital force or natural healing energy, or um-yang (or yin-yang) which involves the relative establishment of balance and harmony. Second, Western medicine emphasizes a logical and objective perception, whereas Oriental medicine emphasizes an intuitive and subjective perception. Third, in order to understand natural phenomena, Western medicine takes an analytical approach, but Oriental medicine takes a holistic approach. Fourth, Western medicine observes and confirms phenomena by means of experiments, while Oriental medicine takes accumulated experience as a means of confirmation.

Fifth, Western medicine takes a ‘technological’ approach, whereas Oriental medicine takes a ‘humanistic’ approach. In Western medicine the doctor is a ‘doer’ and the patient is a ‘passive recipient,’ while in Oriental medicine, the patient becomes a ‘doer’ and the doctor plays a role as an ‘instructor.’

Finally, Western medicine is ‘disease-oriented,’ while Oriental medicine is ‘health-oriented.’ In Western medicine, the main focus is how to eliminate disease. In Oriental medicine, however, the main focus is how to maintain health and how to return to normal health. So Oriental medicine tends to identify the problem from inside such as a lowered immune mechanism requiring defensive methods such as tonics (liver-tonics, stomach-tonics, etc.), dietary regimen, or self-trained exercises.

The human condition can be divided into three stages: a healthy stage, unhealthy stage, and diseased stage. The first ‘healthy stage’ is when the vital force (natural healing energy or ki) is well-balanced and harmonious. The second ‘unhealthy stage’ is when the vital force has lost its balance and harmony, but there is no mechanical damage yet. The third ‘diseased stage’ is when there is actual mechanical damage to tissues (pathological changes) (Chun 2013).

As mentioned earlier, the concept of mind and body in traditional Korean medicine is similar to holistic or biopsychosocial approach in Western medicine. However, the differences are that Western medicine seeks both analytic and integrative approach, whereas traditional Korean medicine seeks integration without analysis. Traditional Korean medicine approach is suitable for patients’ acceptance for care because they are not labeled as mentally ill, but there are limitations in the scientific development of diagnostic tools and treatment techniques. In contrast, Western medicine focused on more analytic approaches in the past, which became an obstacle to the development of psychosomatic medicine, later leading to seeking integration as a counter-action (Koh 2011).

19.8 Cultural Aspect of Psychosomatic Medicine in Korea

19.8.1 *Hwa-Byung*

The name *hwa-byung* itself is culture-related. *Hwa-byung* literally means ‘fire disease’ or ‘anger disorder.’ *Hwa-byung* was most frequently reported in middle-aged or older women of lower socioeconomic status, who seemed to have kept the Korean

traditional culture (Min et al. 1990). *Hwa-byung* was also reported to have been seen in Korean elderly immigrants in the United States (Lin 1983; Pang 1990).

When diagnosis of self-labeled *hwa-byung* was made according to the criteria of the DSM-III-R or DSM-IV, many of them were diagnosed with major depressive disorder, generalized anxiety disorder, atypical somatization disorder, or their comorbid state (Min et al. 1990).

The precipitating factors of *hwa-byung* were reported to be traumatic experiences to one's self-esteem. The most common precipitating factor was domestic violence: husbands and/or mother-in-laws committing violent acts toward wives/daughter-in-laws (Min et al. 1987). However, if the anger-provoking situation is repeated, then the suppressed anger accumulates, finally resulting in *hwa-byung* (Min 2013). So *hwabyung* is known as an anger syndrome specific to Korean culture and characterized by a variety of somatic symptoms such as a feeling of a mass in epigastrium, hot sensation, palpitation, dyspnea, and fatigue resulting from long-standing anger suppression (Lin 1983; Lee 1977b; Mezzich et al. 2000; Min et al. 1986). *Hwa-byung* has also been argued to be the result of incomplete suppression and somatization of anger (Min et al. 1987).

The symptoms of *hwa-byung* were described in detail by Min (2013). The typical psychological symptoms of *hwa-byung* include subjective pent-up anger (*hwa*), a feeling of unfairness, and hate/hostility and revengeful mind toward someone who caused the anger. Patients also typically complain of grudge, embitterment, or distress. The most typical somatic symptoms of *hwa-byung* including a heat/hot sensation in or on the body, appear mainly in the upper trunk. The 'pushing-up' usually extends up to 'the end of the head' and causes the head to become hot, resulting in a headache. Patients with *hwa-byung* sometimes complain of respiratory stuffiness (chest oppression or chest tightness), which is relieved by letting out a deep sigh. Less frequent but typical symptom is epigastric mass or a feeling of mass formation in the neck, chest, or abdomen.

Behaviorally, these patients are generally polite and docile, but at times, they show irritability, verbal aggression, or, rarely, aggressive behavior such as throwing things or quarreling. They are generally reluctant to talk about their inner and familial life, which suggests their anger suppression. Patients with *hwa-byung* are intolerant to a warm and closed space. To cool down the heat, they use fans and ice cubes, ventilate the air, or go out to feel the cool air. Nevertheless, typical *hwa-byung* patients work hard, eat well, sleep well, and associate well with others. They usually express a strong will to live and do not have any thoughts about suicide.

19.8.2 Somatizing Tendency of Koreans

In an epidemiological study in Korea (Lee et al. 1989), using the DIS-III, the life time prevalence of somatization disorders was reported to be 0.06% of the general population. However, when the Korean version of DIS-III was used, including the

Korean culture-related somatic symptoms (i.e., heat sensation, respiratory stuffiness, and a feeling of something pushing-up in the chest) in the diagnostic criteria of somatization disorders, the prevalence rate increased to 5.45%. This result suggested that there is a high tendency of somatization in Koreans along with the influence of Korean culture on naming of certain symptoms or a selection of symptomatic organs.

Traditional philosophies including Confucianism and the traditional patriarchal authoritative culture have underlain the unique familial collectivism developed in Korea. In this culture, fathers, teachers, and kings are identified to be in the same authority. People have been taught to suppress anger and not to jeopardize social or familial harmony with those authority figures. These traditional cultures have also been supportive of gender discrimination and social class-related oppression, which has contributed to the social unfairness for women and lower-class people in their socio-political life. Under the influence of such traditional cultures, the socially weak, especially women, have adopted somatization or *hwa-byung* as a way for a non-verbal communication of their suffering and also as a help-seeking method in order for the people around them to understand their feeling or suffering, while saving their faces, in the Korean cultural context (Min 2013). In other words, such sociocultural restraints may play a role in a variety of somatic symptoms by blocking emotionally charged feelings or ideas from being expressed (Guggenheim 2000).

It was reported that Korean depressives tended to somatize their depression, especially in visceral symptoms such as indigestion, abdominal discomfort, heart pounding, and respiratory stuffiness (Min and Kim 1988). It was also known that emotional expression was inhibited in Chinese culture (White 1982). In China, a physical term such as neurasthenia is used instead of major depressive disorder, although it corresponds to the diagnostic criteria of major depressive disorder (Ford 1986). In the past, somatization was known to be more prevalent in non-Western cultures than Western cultures (Kleinman 1982; Pfeiffer 1968; Mezzich and Raab 1980; Bhatt et al. 1989). However, epidemiological data have not shown cross-national differences in the somatization of depression (Parker et al. 2001; Simon et al. 1999). Thus, somatization is now considered a universal psychopathology (Kim 2003; Becker and Kleinman 2000).

19.8.3 Changes in Somatic Symptoms Over Time within Korea

It was reported that during a period of 15 years between 1950s and 1970s in Korea, the number of admitted patients with hysterical disorder had decreased (Min and Suh 1979). Moreover, the classical symptoms such as convulsion, fainting, or other motor-sensory symptoms had decreased in patients with this disorder, whereas pain or visceral symptoms had increased. These changes were considered related to the sociocultural changes in Korea, from a simple agrarian undeveloped culture, to a more industrialized, educated, and sophisticated culture (Min 2013).

19.8.4 Cross-Cultural Comparative Studies

Cross-cultural comparative studies were done for people in Asian countries. One study (Nakane et al. 1991) found that Korean depressives were more likely to show a depressive mood, psychic anxiety, somatic anxiety, and gastrointestinal and genital symptoms than the Japanese and Chinese depressives. In addition, Koreans had relatively more frequently complained of palpitation, indigestion, general weakness, and loss of libido.

However, another study (Kim et al. 1999) revealed that Korean depressives in Korea had complained of more psychological symptoms, Chinese depressives of more somatic symptoms, and Korean-Chinese depressives of symptoms that lied between the other two groups on a somatic–psychological continuum. The differences between this study and the above study may be explained by time differences of the studies. During the period from 1991 to 1999, the Korean society had been significantly changed in its cultural context (Min 2013).

19.9 Future Directions of Psychosomatic Medicine in Korea

As mentioned earlier, there is a need in Korea for the expansion of liaison activities, strengthened and systematized education for medical students and residents, and research on intermediate mechanisms between mind and body as well as the application of behavioral medicine and psychotherapeutic techniques in psychosomatic medicine. In addition, C-L models suitable for Koreans should be developed for effective C-L activity in Korea (Koh 2011).

Lee (2001) proposed that psychosomatic medicine should play a leading role in the humanization of medicine and integrate the biological knowledge of Western medicine and Tao of Oriental medicine, emphasizing the necessity for reviewing Korean traditional culture and customs from a modern psychosomatic perspective. Chun (2013) posited that if all the complementary components existing in the various healing arts are integrated into one form of medicine, a new holistic medicine will be produced and will be useful in the field of psychosomatic medicine. In his view, Western medicine, Oriental medicine, and alternative medicine are all complementary to each other, and alternative medicine and psychosomatic medicine share much in common in terms of being ‘whole person oriented’ and employing an ‘integrative approach.’

19.10 Conclusions

In Korea, most psychiatrists in a majority of general hospitals participate in consultation activity, but their liaison activity is limited to psycho-oncology in some general hospitals. C-L psychiatry is one of mandatory training programs for

psychiatric residents. Regarding research methodology, clinical studies were the most common, and in regard to subjects of research, somatopsychic relationship was the most common, followed by stress. In Korea, there are two academic societies associated with psychosomatic medicine: the Korean Psychosomatic Society and the Korean Society of Stress Medicine. As a whole, after the Korean Psychosomatic Society was founded, recent research methodology and subjects became more diversified, research on C-L psychiatry tended to be dynamic rather than phenomenal, and there were more research on specific diseases. As obstacles to the development of C-L psychiatry, in addition to patients' prejudice against psychiatry, nonpsychiatric physicians' and psychiatrists' negative attitude toward C-L psychiatry, lack of financial support, especially poor medical reimbursement, and limited number of staff related to this field were pointed out. In particular, attitudes toward psychiatry in medical students and nonpsychiatric physicians as well as patients were reviewed. Finally, sociocultural aspects of psychosomatic medicine in Korea were addressed.

Questionnaire Response

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry in your (or your chapter's) Country.

Please return this as an attachment to your email

Country on which you are reporting: South Korea

Your Name: Kyung Bong Koh

Institution: Department of Psychiatry, Yonsei University College of Medicine

City & Country (e.g. London, UK): Seoul, Korea

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?

Yes () No (X) In some sense ()

 - a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes () No (X)
 - b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes () No (X)
2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?

Yes (X) No ()
3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?

Yes (X) No ()
4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No (X)
 - a. If YES, which?

Psychosomatic Medicine () Consultation-Liaison Psychiatry ()
 - b. If YES, the status of such certification is:
 - i. Independent Medical Specialty ()
 - ii. Subspecialty of Internal Medicine ()
 - iii. Subspecialty of Psychiatry ()
 - iv. An independent non-medical discipline, as Psychology, Social Work ()
 - v. Other (Specify):[]
5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes (X) No ()

If YES, please list names of the organizations and the websites if available:
 Korean Psychosomatic Society: www.psychosomatics.or.kr
 Korean Society of Stress Medicine: www.stressfree.or.kr
6. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:

Korean Journal of Psychosomatic medicine,
 Korean Journal of Stress Research

7. Is there formal training in psychosomatic medicine/consultation -liaison psychiatry/biopsychosocial model in your country? Yes () No ()
- a. If YES, where does it occur? Check all that apply:.
- Medical School () Residency () Fellowship ()
8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes () No ()
9. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)
- a. It is insignificant ()
- b. Some subgroups (e.g. ethnic, religious) practice it ()
- c. A significant part of the general population practice it ()
- d. Is the most prevalent healing method used ()
- e. It is often used in combination with Western medicine ()
- f. More widely used methods are as follows (Please list, e.g., spiritual healing, meditation, herbal, etc): herbal, meditation, acupuncture, finger pressure therapy, cupping
10. Please add any comments to your response here:

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Chapter 20

Psychosomatic Medicine and Consultation-Liaison Psychiatry in Indian Subcontinent



Beena S. Nair

20.1 Introduction

Psychosomatic medicine deals with the relationship between mind and body. It describes how psychological factors and intrapsychic conflicts manifest as physical symptoms, diseases, and disorders and how medical conditions and medications can cause psychiatric symptoms and syndromes. It involves effective collaboration between patient, family, physician, and other health-care team in the management of a patient presenting with medical and psychiatric symptoms. Psychosomatic medicine helps to understand the interplay of biological and psychosocial factors in the development, course, and outcome of diseases. It involves a holistic biopsychosocial understanding of a patient as a person presenting with medical problems in a general hospital and having some emotional, behavioral, and cognitive symptoms. This concept was developed by Adolf Meyer who advocated the study of a person in the context of his physical, psychological, and social environment.

Consultation-liaison (CL) psychiatry is the clinical derivative of psychosomatic medicine and incorporates clinical service, teaching, and research at the interface of psychiatry and medicine. Implied in the task of CL psychiatry is the education of the consultee, nursing, and ancillary staff on the psychiatric issues seen on the medical setting. Participation of the CL psychiatrist in the interdisciplinary rounds and team meetings helps in the early detection and management of these psychiatric issues.

Different models of CL psychiatry have been described in literature and clinical practice based on the function of consultation (Grover 2011). These include consultation model, liaison model, bridge model, hybrid model, and autonomous model. In the consultation model, the patient is the focus. Liaison model involves

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consultation for the patient and teaching psychiatric and psychological aspects of patient's problem to the consulting physician and the team. Bridge model involves teaching role of the CL psychiatrist for the primary care physicians and helping them to manage mild to moderate psychiatric issues in the primary care setting. In the hybrid model, psychiatrist is part of the multidisciplinary team. In the autonomous model, CL psychiatrist is hired by the primary care services. Depending on the model and the available resources, the composition of CL team varies from a single remote consultant to multidisciplinary team.

20.2 Psychiatry Training in India and the National Deficit

India has the second highest population in the world with the estimated current population of 1.25 billion (World Bank 2016). Prevalence of serious mental disorder is 6.5% which is roughly 71 million (NCMH 2005). In the National Survey of Mental Health Resources carried out by the Directorate General of Health Services in 2002, the average national deficit of psychiatrist in India is estimated to be 77% with a huge diversity across the Indian states. Four states (Chandigarh, Delhi, Goa, and Pondicherry) have a surplus of psychiatrists, ranging from 244% surplus in Chandigarh to a 13% surplus in Pondicherry. In all the other states and union territories, there is a serious deficit of psychiatrists. Nine states have more than 90% deficit. The undergraduate medical curriculum devotes only 1.4% (20 hours) of lecture time and 3.8–4.1% of internship time to psychiatry (Thirunavukarasu and Thirunavukarasu 2010). This leaves the general practitioners and the non-psychiatry specialists unprepared to competently deal with mental illness in their practice. Indian medical education is considered to be well rounded so that after graduation the general practitioners are trained to treat a variety of conditions, including uncomplicated childbirths, infectious diseases, pediatric conditions, common ophthalmological and ENT conditions, skin disorders, minor injuries, etc. Unfortunately, in the case of psychiatry, the undergraduate education does not prepare doctors to handle the huge burden of psychiatric illnesses because of the minimal amount of teaching and clinical experience in psychiatry as per the curriculum designed by the Medical Council of India. Amendment in 2008 incorporated 2 weeks of mandatory training in psychiatry during the internship year and another 2 weeks of elective rotation to mitigate some of the deficit.

In the last few years, Indian Psychiatric Society has taken up the issue of improving psychiatry training at undergraduate level with the Government of India and Medical Council of India, but still psychiatry has not received the status of a separate subject in terms of certification during the MBBS (Bachelor of Medicine and Bachelor of Surgery) licensing examination. MBBS is the official undergraduate degree awarded to students who graduate from medical schools or universities to enter medical profession.

Psychiatry training in India is available in the form of MD (3 years) or Diploma in Psychiatric Medicine (2 years) after MBBS, with minimal focus on the subspecialties. In the last few years, some centers have started subspecialty mental health

courses in geriatric psychiatry (King George Medical University, Lucknow), child and adolescent psychiatry (National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru; Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh), and addiction psychiatry (PGIMER, Chandigarh). Postdoctoral fellowship program of 1 year is available in NIMHANS for CL psychiatry (Medical Council of India [n.d.](#)).

20.3 Consultation-Liaison Psychiatry in India

From a review of the history of general hospital psychiatric units, postgraduate training, and CL psychiatry in India, published in the *Indian Journal of Psychiatry* (Grover 2011), mental health services in India were confined to mental asylums until 1930. Dr. Girindra Shekhar at RG Kar Medical College and hospital started the first general hospital psychiatric unit (GHPU) in 1933. Till 1960 only a few GHPUs were established in India as there was a strong resistance from the medical community and health administrators to integrate mentally ill patients with the general population. These GHPUs were established in collaboration with neurology and were called the neuropsychiatric units. By late 1960s, there was a major rise in the number of GHPUs addressing wide range of clinical problems including psychosis, neurosis, personality disorders, drug dependence, and organic brain disorders. All India Institute of Medical Sciences in Delhi was the first GHPU unit to start postgraduate psychiatric training in 1962 with the first batch of fellows graduating in 1964. Over the years GHPUs became more popular, and CL psychiatry services were established, and psychiatrists helped in the management of neurotic and psychosomatic disorders. In a survey of postgraduate training centers in India in the 1980s, it was reported that 75% of the postgraduate training centers were in the general hospital setting. A national workshop on general hospital psychiatry was held in Chandigarh in 1984, and a series of articles were published in the *Indian Journal of Psychiatry* with emphasis to organize training programs to provide training in liaison psychiatry, psychosomatic medicine, and organic brain disorder.

Currently postgraduate psychiatry training in India is more or less confined to the general hospitals. Per recent data from the medical council of India, there are 112 centers providing postgraduate psychiatric training and 246 graduates per year. One hundred nine of 112 are in the general hospital setting (Grover 2011). CL psychiatry has never been the focus of psychiatric training in India. Over the years Indian Psychiatric Society has developed specialty sections and task forces for various subspecialties, yet CL psychiatry has not received a subspecialty status.

Practice of CL psychiatry is mostly in line with the consultation model in which psychiatric input is provided by the general psychiatrist to the referring physician and surgeon who request the consult.

The Department of Psychiatry at Postgraduate Institute of Medical Education and Research, Chandigarh, is one of the premier training centers in general hospital psychiatry in India, providing CL psychiatry training opportunity. The model followed here is emulated at the other centers. The Department runs CL psychiatry

services round the clock providing psychiatry input to the inpatients and emergency room patients referred for psychiatric evaluation. Outpatients are usually referred to psychiatry outpatient walk-in clinic. Faculty members provide regular supervision to residents on the service. Cases are first evaluated by trainees under supervision of a senior resident and finally reviewed by the faculty psychiatrist. Diagnosis is made according to ICD system. Appropriate treatment plan is formulated and implemented and periodically reviewed. All patients are followed up by the CL psychiatry team till discharge or death. Documentation is done in the primary treating team case records, but CL team maintains their own records for periodic review. After discharge of the patient from the hospital, the records are transferred to psychiatric outpatient service where the same psychiatric team provides the outpatient continuity of care. The psychiatry team regularly communicates with the treating primary physician and other staff involved in patient care about the diagnosis and treatment plan and the relationship of psychiatric morbidity on medical illness. Family members are involved in the care of the patient. Patient and family are advised to follow up at the outpatient clinic if they require intensive psychiatric aftercare.

CL service is also involved in teaching residents in psychiatry and other clinical specialties and having joint academic rounds. The academic activities involve monthly psychosomatic rounds with internal medicine, general surgery, pediatrics, and neurology. It is attended by faculty members from different specialties. A case of common interest is presented by a junior resident followed by discussion.

In a study published in 2013 on the pattern of psychiatric referrals in a tertiary care teaching hospital in Southern India (Keertish et al. 2013), out of a total of 520 patients referred for psychiatric consultation over a period of 2 years, they found a referral rate of 0.42%. A majority of the psychiatric referrals (59%) were from the department of medicine, and the most common reason for referral was medically unexplained somatic complaints (23.1%), followed closely by anxiety (21%) and abnormal behavior (13.1%). The most commonly diagnosed psychiatric disorders were neurotic, stress-related, and somatoform disorders (41.7%) followed by mood disorders (12.9%) and substance use disorders (12.7%).

20.4 Role of Culture in Psychiatric Illness

Culture plays a major role in how an individual feels or expresses their emotions. Collectivistic culture like those of Asia and Latin America promote interdependence of individuals with emphasis on the needs and desires of the group. Individuals in collectivistic cultures are believed less likely to express emotions in fear of upsetting the social harmony. Individualistic culture like those of North America and Western Europe promote individual autonomy and independence. Individual needs, wishes, and desires are emphasized and personal attainment is encouraged. Emotions are independent internal experiences, occurring within an individual. People tend to express emotions more freely. There is high prevalence of somatization in

collectivistic cultures where psychological distress is experienced and expressed as somatic symptoms. This may be initiated and/or perpetuated by emotional responses like anxiety and depression. Multiple or unexplained physical symptoms cause substantial disability in patients, excess use of medical services, disappointment for therapists, and frustration for physicians (Markus and Kitayama 1991).

Somatization is common in all ethnocultural groups and societies. Even with equitable access to health-care resources, significant differences in somatization exist across ethnocultural groups. Analysis of illness expression collected from diverse cultural groups suggests that somatic symptoms are located in multiple systems of meaning that serve diverse psychological and social functions. Depending on the circumstances, these symptoms can be seen as an index of disease or disorder, an indication of psychopathology, a symbolic condensation of intrapsychic conflict, a culturally coded expression of distress, a medium for expressing social discontent, and a mechanism through which patients attempt to reposition themselves within their local worlds (Kirmayer and Young 1998).

In a review article on the cultural aspects of major mental illness from an Indian perspective, Viswanath describes in detail the transcultural variations in pharmacokinetics, pharmacodynamics, psychotherapeutic approaches, traditional healing practices, and clinical expression and outcome of major mental disorders (Viswanath and Chaturvedi 2012).

20.4.1 Cultural Influence on Phenomenology

Cross-cultural differences in language and thought result in cross-cultural differences in symptoms and subtypes. Greater linguistic competence results in more elaborate, systematized delusions. Low linguistic competence prevents delusional elaboration and manifests as catatonia. Themes of delusions are related to patient's social background, cultural beliefs, and expectations. Religious delusions are common in Christian societies but rarer in Hindu, Muslim, and Buddhist societies (Kala and Wig 1982). Magical religious delusions are more common in rural societies especially in women over 30 years. The cultural content of the delusions recurs in future episodes of psychosis (Sinha and Chaturvedi 1990). The first large-scale cross-cultural evaluation of hallucinations (Ndeti and Vadher 1984) found that visual hallucinations were more common in Africa. Indian studies have found higher prevalence of grandiose delusions, delusions of persecution and reference, and those of sexual and religious themes than in the West (Sethi and Khanna 1993).

The prevalence of affective disorders is found to be lower in most Indian studies than the West (Math et al. 2007). Culture greatly influences the way in which depressive symptoms are expressed. Indian studies have found guilt to be less common among Indian patients than those in the West (Sethi and Dube 1982), and they report guilt of an impersonal nature: The present suffering is attributed to

possible bad deeds of previous life (consequence of “karma”) rather than due to self-failure as in the West. Studies in India have reported physical symptoms to be common presenting symptoms in depression (Teja et al. 1971). A comparison of depression in Western and non-Western societies noted that disorders of conduct and somatic complaints were more common in non-Western cultures (Aichberger et al. 2008). Indian bipolar patients have a preponderance of mania in contrast to patients in Western countries (Chopra et al. 2006).

20.4.2 Cultural Influence on Treatment

20.4.2.1 Pharmacotherapy

Cultural differences exist in how drugs are prescribed and metabolized and how individuals respond to these medications. Genetic and environmental factors, e.g., compliance, availability, affordability, and explanatory models about illness, play a major role in the way drugs are prescribed, metabolized, and excreted and the way individuals respond to medications.

20.4.2.2 Pharmacokinetics

Cytochrome P450 (CYP) enzymes are the most important enzymes for drug metabolism. CYP2D6 metabolizes many psychotropic medications, including antidepressants and antipsychotics. Based on how the drugs are metabolized, there are ultrarapid metabolizers (UM), extensive metabolizers (EM), intermediate metabolizers (IM), and poor metabolizers (PM). These variations are secondary to allelic variations of the CYP2D6 gene (Aitchison et al. 2000). The frequencies of variant alleles differ among ethnic groups. The frequency of poor metabolizers is much higher in the Asian population than in the Caucasian or African population (Bertilsson 1995). Slower drug metabolism leads to poorer drug response and more adverse effects. Nongenetic factors like diet and smoking can also affect CYP450 enzymes.

20.4.2.3 Pharmacodynamics

Pharmacodynamic variations in transporters, receptors, and key enzymes in neurotransmitter biosynthesis and catabolism can lead to alterations in drug responses between ethnocultural groups. For example, Asian subjects with schizophrenia require lower doses of haloperidol and lower plasma concentration for drug responses than Caucasians, possibly mediated by dopamine receptor-related mechanism. Side effects are also common on low doses (Lin et al. 1989).

20.4.3 Cultural Influences on Clinical Practice and Outcome

Physical treatments like ECT are more often used in India and other developing countries. Family plays a significant role in the treatment and outcome. The international pilot study of schizophrenia (IPSS) identified differences in the course and outcome of schizophrenia between cultures. A 5-year follow-up on 1202 patients from 9 countries showed a more favorable outcome in developing countries compared to developed countries (Leff et al. 1992). DOSMED study (Jablensky et al. 1992) used an epidemiological sample from 12 centers in 10 countries and recruited 1379 subjects in 2 years. There was favorable outcome in developing countries in comparison with that in developed countries. The Madras longitudinal study (Thara 2004) and the study of factors associated with the course and outcome of schizophrenia demonstrated that two-thirds of schizophrenia patients in India have partial to full remission of symptoms.

20.4.3.1 Psychotherapy

The Western-model psychotherapy may not be suited for a diverse culture like India. Modifications like the use of religion and spirituality, more family involvement, and active participation by the therapist are suggested.

Incorporating other forms of treatment in Psychiatric practice in India

Ayurvedic medicine, yoga, meditation, and mindfulness are alternate forms of treatment commonly practiced in India. Ayurveda is derived from the Sanskrit words, *ayus* (life) and *veda* (knowledge/learning), which means the “science of life.” It is a comprehensive and holistic system of medicine with the focus on body, mind, and consciousness. It is based on ancient Sanskrit texts like *Sushruta Samhita*, *Charaka Samhita*, and *Ashtanga Hridaya*. These texts expound the influence of the fundamental elements of nature – air, water, fire, space and earth – on the physical and mental well-being of human beings and the need to keep a harmonious balance of these elements.

Ayurveda recommends traditional dietary and lifestyle modifications, along with yogic exercises and herbal treatment. It has proved to be an effective alternative form of treatment, which not only includes treating the physical and psychological disorders but also bringing in a change in the lifestyle of the person to prevent future illnesses. NIMHANS (National Institute of Mental Health and Neuroscience) in Bengaluru has established an ayurvedic division within the mental health department.

According to ayurvedic texts, human being is a constitution of the mind (*manas*), body (*sarira*), soul (*atma*), and senses (*indriyas*). A perfect harmony of the functions related to these results in good physical and psychological health (*swasthya*). The body is believed to be formed from the nature and is made of three psychobiological elements: air (*vata*), fire (*pitta*), and earth (*kapha*). These elements are also known

as the *tridoshas* (three faults). A good balance of these biological elements (*samadoshas*), the digestive fire (*agni*) needed for the absorption of essential nutrients needed by the body while burning away the waste matter (*samagnischa*), and the seven-tissue structures (*dhatu*s) such as the muscle, plasma, blood, fat, bone, etc. (*samadhatu*), combined with the proper disposal of metabolic waste (*malakriya*), ensures good physical health. This combined with a balanced, calm, and content mind (*prasanna manaha*), a happy and capable of discriminating the right and wrong soul (*prasanna Atma*), and the appropriate functioning and usage of the five senses for right purposes (*prasanna indriyas*) ensures the physical and mental well-being of the human being. An imbalance of any of these results in a physical or mental disorder.

Just as *tridoshas* is to the physiological makeup of a person, the *trigunas*, namely, *sattva*, *rajas*, and *tamas*, is to the mental makeup of the person. The *guna* decides the character or qualities of a person. The *tridoshas* and *trigunas* are intertwined through the five fundamental elements of nature (*pancha mahabhutas*), namely, sky (*akasa*), air (*vayu*), fire (*agni*), water (*jala*), and earth (*prithvi*). *Sattva* *guna* is characterized by all good things – positive attitude, happiness, knowledge, discriminating capability, self-control, etc. *Sattvic* state can be considered as disease-free body. *Rajas* *guna* is the active one characterized by action – violent, desirous, passion, and zeal to achieve. *Tamas* *guna* is characterized by lethargy and resistance to change leading to being dull, inactive, and lazy with negative thoughts and a general apathy. Among the three *gunas*, *rajas* and *tamas* are referred to as *manadoshas* or *doshas* of the mind. Imbalance of these *doshas* leads to mental illnesses known in Ayurveda as *Manovikara* (Ramu and Venkataram 1985).

Ayurveda describes three broad categories of mental personalities or *prakritis* – *sattvik prakriti*, *rajasik prakriti*, and *tamasik prakriti*. These three personalities (*prakritis*) are further divided into 16 *manas prakritis* or mental traits. These 16 personality traits are characterized with unique features, which may predispose individuals to specific mental illness.

In Ayurveda, mental illness results from unhealthy interaction between the individual and their environment. This interaction operates through three fundamental factors: *kala* (time rhythm), the deficient, excessive, or perverted aspects of seasons; *indriyarthas* (sensorial inputs), i.e., deficient, excessive, or perverted use of senses; and *buddhi* (intellect), i.e., volitional transgression. Ayurveda believes in the theory of *punarjanma* (reincarnation) and *karma* (actions of past life) (Srikanth et al. 2007).

Mental illness in Ayurveda is characterized by altered behavior. The clinical diagnosis is done on the basis of pattern of alteration in behavior and certain associated symptoms and signs. The common psychiatric illness described in Ayurveda includes different kinds of *unmade* (psychosis), *apasmara* (convulsive disorders), *chittodvega* (anxiety disorders), *chittavasada* (depressive illness), *mada* (alcoholism and drug abuse), *murcchha*, and *smanyasa* (condition associated with unconsciousness).

20.4.3.2 Role of Yoga and Naturopathy in Mental Illness

Yoga and naturopathy are integral components of Ayurveda. It is practiced for the prevention and treatment of mental illness and for maintaining mental well-being by daily practice. Through yoga, control of the mind is achieved. Yogic practice includes yogic exercises (*yogasanas*), breathing practices (*pranayama*), and meditation (*dhyana*). Yoga has been found to have a calming effect on the agitated mind, increasing awareness of one's self and surroundings, increasing attention span, an increase in acceptance and adaptability, and an increase in a sense of security when integrating back to society (Nagendra 2013).

In a systematic review examining the evidence of yoga in the treatment of selected major psychiatric disorders, out of a total of 124 trials of which 16 met rigorous criteria for the final review, there was supporting evidence of benefit for yoga in depression (4 randomized controlled trials (RCTs)), as an adjunct to pharmacotherapy in schizophrenia (3 RCTs), and in children with ADHD (2 RCTs) and some evidence in sleep (3 RCTs) (Balasubramaniam et al. 2013).

20.5 Current Clinical Practice in India

To understand CL psychiatry practice in India, the author contacted two leading psychiatrist in two different States of India: Dr Bhavesh M Kotak MD, DPM (Diploma in Psychological Medicine), graduated in 1993. He inherited his father's 54-year-old private practice, who was also a psychiatrist, serving a population about 2 million in the state of Gujarat. He provides consultation service to nearby general hospitals; and Manish K Jain MBBS, DPM, practicing as a Consultant Psychiatrist, Manas Hospital Noida, Uttar Pradesh.

Below are based on their responses.

20.5.1 Psychiatric Referrals in India

Referrals from the general hospitals are for the cases of delirium, dementia, other cognitive and mental disorders due to medical conditions, delusional and other psychotic disorders, somatoform disorders, dissociative disorders, alcohol and drug addiction, OCD, and other mental disorders.

20.5.2 Treatment Practices

In India many people still consider allopathy or the Western medical science as experimental, dangerous, with side effects, and a treatment that can only suppress the symptoms without curing the disease. They consider ayurvedic treatment as

natural treatment containing natural herbs and free of side effects, making the body strong from within, and removing/curing the ailments from its roots. It is not routinely used in medical practices but used more as a complementary treatment. Yoga and meditation is part of almost all prescription. It is advised to all patients especially with anxiety disorders. It is routinely recommended for prevention of relapse of psychiatric illness.

20.5.3 Management of Suicide Attempt or Suicidal Patient in the Medical Setting

Socially suicide or suicide attempt is still considered as taboo. It is considered as a sign of weak mind and failure. Family considers it as a social disgrace. When a patient is admitted to the hospital for attempted suicide, it is mandatory for the doctor to make a police report as suicide is considered illegal. Police then takes the declaration from the patient and the family, and usually the matter goes to media and becomes public. This police reporting is mandatory, especially if the patient goes to a government hospital. The patient and family are usually not ready to talk to a counselor or a psychiatrist. Psychiatric referrals are made especially if there is a history of multiple attempts or more serious psychopathology.

20.5.4 Management of Behavioral Problems in Delirium and Dementia

Behavioral problems in delirium is addressed by treating the underlying cause. Psychiatric referrals are made for behavioral control. Quetiapine is most commonly used and titrated per patient's need. Other second-generation antipsychotics like risperidone and aripiprazole are also sometimes used in low doses. In aggressive and uncooperative patients, injectable haloperidol is used.

In patients with dementia, donepezil and memantine are commonly used to slow the progression of the disease as well as for better behavioral outcome. Low doses of atypical antipsychotics are commonly used for behavioral control.

20.5.5 Psychiatric Issues in Chronic Medical Illness

Primary physicians tend to handle milder symptoms of depression and anxiety on their own using benzodiazepines for anxiety symptoms and serotonin reuptake inhibitors for depression. When the symptoms are more severe, psychiatric referrals are made. Some big centers have more comprehensive care with psychiatrist and counselors providing bedside counseling.

20.5.6 Somatic Symptom Disorders

Patients with somatic symptom disorders frequently visit medical and surgical outpatient clinics. They are over-investigated and referred to different specialties for consultation based on symptom clusters, and extensive laboratory and imaging tests are performed, and they are given symptomatic treatment. When the consultant suspects psychological overlay, psychiatric referral is suggested, but it may not be acceptable to the patient because of the stigma. This usually results in doctor shopping for second and third opinion. Many primary physicians hesitate to make psychiatric referral for fear of losing the patient for their own financial gain.

20.6 Pakistan

A PubMed search for consultation-liaison psychiatry and Pakistan revealed only one entry as of March 20, 2017, that indicates a low rate (12%) of psychiatric referral in a private teaching general hospital, although the prevalence of psychiatric diagnosis based on interview was high (180/487 patients) (Abidi and Gadit 2003).

The need to introduce mental health in primary care has been recognized in Pakistan (Gadit 2006), and psychiatric consultation-liaison services have sprung up in major cities (MInhas and Bender 2015). Depression is recognized as a major comorbid condition in many medical illnesses. A PubMed search for Pakistan and psychosomatic medicine reveals three articles. One dealing with alternative and traditional therapy (Shaikh and Hatcher 2005) states “alternative therapies have been utilized by people in Pakistan who have faith in spiritual healers, clergymen, hakeems, homeopaths or even many quacks. These are the first choice for problems such as infertility, epilepsy, psychosomatic troubles, depression and many other ailments. The traditional medicine sector has become an important source of health care, especially in rural and tribal areas of the country.” The CAM healer may be preferred because of the proximity, affordable fee, availability, family pressure, and the strong opinion of the community. Pakistan has a very rich tradition in the use of medicinal plants for the treatment of various ailments. Traditional Islamic mind-body medicine is discussed in Chap. 7, Traditional Psychosomatic Medicine in India.

20.7 Sri Lanka

The status of psychiatry in Sri Lanka seems to roughly parallel that of India, including the training programs. There is significant literature concerning the post-traumatic stress disorders related to the civil war and tsunami in Sri Lanka. Sri Lanka is reported to have the highest suicide rate in the world probably related to

the traumas mentioned above. To deal with this situation, attempts have been made to integrate mental health with primary care by “training the trainers” which have been highly successful (Jenkins et al. 2012). A PubMed search for consultation-liaison psychiatry and Sri Lanka returned no entries.

20.8 Bangladesh

There are almost 100 private and public medical colleges in Bangladesh (Wikipedia, accessed 3/20/17). The Bangladesh Association of Psychiatrists was founded in 1975 and has approximately 150 members according to its website (<http://bapbd.org>, accessed 3/20/2017). PubMed searches for Bangladesh consultation-liaison psychiatry and Bangladesh psychosomatic medicine yielded no results. It is presumed that Bangladesh probably shares similar traditions and challenges with Pakistan.

20.9 Conclusion

Psychiatric and psychosomatic practices in the Indian subcontinent involve a combination of Western and traditional psychiatric/mind-body practices. With the increasing demand of the population and the severe deficit of psychiatrists in the area, intense psychiatric training during medical school and training the primary care physicians to recognize and treat psychiatric conditions are of utmost importance. The role of culture in the phenomenology of mental illness, drug metabolism, treatment, and outcome cannot be emphasized enough in treating a culturally diverse population. Understanding and incorporating some of the traditional practices of medicine as complementary treatment can help to gain trust of the patient and add value to the treatment.

It should be noted that although psychiatry, especially consultation-liaison psychiatry, is still in early stages of acceptance in the Indian subcontinent, many physicians from the Indian subcontinent are major contributors in these fields abroad, particularly in the United Kingdom and the United States.

Acknowledgments Dr. Bhavesh Patel and Dr. Manish Jain for their input into the clinical practice of CL psychiatry in India.

Questionnaire Response

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry

Please return this as an attachment to your email

Country on which you are reporting: Indian subcontinent

Your Name: Beena Nair

Institution: Kaiser Permanente, UCSF-Fresno

City & Country (e.g. London, UK): Fresno, US

Name(s) and Country of Others who provided information: Bhavesh Kotak-India

Manish Jain-India

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?
Yes () No () In some sense (x)
 - a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes () No (x)
 - b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes () No (x)

2. Is there a Department (or equivalent) of Psychosomatic Medicine in institutions in the country?
Yes () No (x)

Is teaching of psychosomatic medicine in medical schools required by law or health care system in the country? YES () No (x)

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in the institution or other institutions in the country?
Yes (x) No ()

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in the country? Yes (x) No ()
 - a. If YES, which? Psychosomatic Medicine () Consultation-Liaison Psychiatry (x)

- b. If YES, the status of such certification is:
- i. Independent Medical Specialty ()
 - ii. Subspecialty of Internal Medicine ()
 - iii. Subspecialty of Psychiatry (x)
 - iv. An independent non-medical discipline, as Psychology, Social Work ()
 - v. Other (Specify): []
5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in the country? Yes () No (x)
- If YES, please list names of the organizations and the websites if available:
6. Please list the names of professional journals published, if any, in the country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:
- Indian Journal of Psychiatry
7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in the country? Yes () No (x)
- a. If YES, where does it occur? Check all that apply:
 - b. Medical School () Residency () Fellowship ()
8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in the country? Yes (x) No ()
9. Concerning traditional/folk/indigenous practice of healing in the country (please check all that apply)
- a. It is insignificant ()
 - b. Some subgroups (e.g. ethnic, religious) practice it ()
 - c. A significant part of the general population practice it (x)
 - d. Is the most prevalent healing method used ()
 - e. It is often used in combination with Western medicine (x)
 - f. More widely used methods are as follows (Please list, e.g., spiritual healing, meditation, herbal, etc): herbs, spiritual healing
10. Please add any comments to your response here:

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Part IV
Contemporary Psychosomatic Medicine
and Consultation-Liaison Psychiatry in
Africa: Development, Research, Education,
and Practice

Chapter 21

Psychosomatic Medicine in Egypt and North Africa: Development, Research, Education and Practice



Tarek A. Okasha

21.1 Introduction

The inclusion of the diagnosis of “unexplained somatic symptoms” in the primary version of ICD-10 and Somatic Symptom and related disorders in DSM 5 is a cornerstone in identifying somatization and somatic presentations of psychiatric disorders. The majority of our psychiatric patients (80–90%) are not aware that their somatic symptoms can be secondary to a psychiatric disorder. Therefore, their first encounter is usually either with primary care physicians or with traditional or religious healers depending on attributing factors, i.e., patients’ belief systems.

Religion plays an important role in symptom formation, attribution and management of somatization disorders. In the Egyptian and North African culture physical symptoms are more socially accepted than are psychological ones, as psychological ones can be taken to indicate personal weakness or lack of faith. The public would accept, tolerate and sympathize with suffering of somatic symptoms more than psychological complaints, which people tend to perceive more as under the control of the person’s will. In the countryside somatization is attributed to the wrath of God, possession of evil spirits and magical doing. The treatment may vary from a pseudo religious or traditional intervention, to cognitive or behavioral therapy, or psychotropic medication; the latter preferably by parenteral route. Our religious culture with its external locus of control, extended family, family care and concern of the elderly, disabled children and the attribution of illness to God’s will and the solid belief in the determined fate, can color and affect somatization. There is however increasing evidence that somatization as such is not necessarily a culturally bound phenomenon. What may be unique for each country is its clinical image and the challenges it puts on the existing mental health care facilities. The latter should be a prime area of input and concern, to the benefit of a considerable percentage of our psychiatric population.

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21.2 Research

Research is very limited in the field of psychosomatic medicine in Egypt and North Africa. Most of the available research is of a one – directional nature, that is the somatic presentation of patients with different psychiatric disorders and how this affects them seeking treatment and the pathway that they use. However, little research is available on psychiatric or psychological factors as an etiological factor in physical disorders. Research has been conducted as joint collaboration between different medical specialties and psychiatry to detect the presence of anxiety and depressive symptoms or disorders as a comorbidity with the physical illness.

Recently, in an attempt to highlight the contrast in psychiatric morbidities among medically ill patients in Egypt and other countries, an Egyptian study evaluated 400 patients distributed as follows: 100 ischemic heart disease (ISHD) patients, 100 heart failure (HF) patients, 100 diabetes mellitus (DM) patients, and 100 thyroid patients enrolled from Ain Shams University Hospital wards and outpatient clinics. Radwan et al. (2013) evaluated and compared the frequency of the psychiatric morbidities among Egyptian patients with ISHD, HF, DM, and thyroid diseases. In addition, they appraised the quality of life of the cardiac and endocrine patients with and without psychiatric morbidities. The different groups of medical diseases in this study were also compared to each other as regards their quality of life scores. Egypt bears a heavy burden from cardiovascular and endocrine diseases (Sharraf et al. 2003; Almahmeed et al. 2012; Ellabany and Abel-Nasser 2005–2006; El-Mougi et al. 2004), and as both diseases are prone to have a comorbid psychiatric disorder which affects negatively the outcome of the initial medical disease, hence, a greater emphasis should be placed on the early diagnosis of psychiatric morbidity among those patients (Okasha and Radwan 2015).

In the Egyptian study, the frequency of psychiatric morbidity found was to be 20%, according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria. Mood disorder was the most frequently encountered diagnosis reaching 19% of patients with ISHD. Anxiety disorders were found in 3% of the patients. Among those patients, 2% had comorbid depression and anxiety. A prior Egyptian study (Abd El-Hay et al. 2005) reported a similar prevalence of major depression (16.26%) in patients with ISHD. Similar rates of psychiatric morbidities were also reported in other studies (Bunevicius et al. 2013).

In the selected Egyptian study, 36% of HF patients displayed psychiatric diagnoses. The most common diagnostic category was mood disorder, with a prevalence of 34%. As for anxiety disorders, 9% of the HF patients were labeled with at least one anxiety disorder. Comorbidities between mood and anxiety disorders were identified in 7% of the patients. These results concurred with those of other studies (Holzapfel et al. 2007; Yu et al. 2009), including one African study (Adewuya et al. 2006).

Among the sample of both type I and type II diabetic patients, 36% were diagnosed with psychiatric disorders. The prevalence of mood and anxiety disorders was

29% and 12%, respectively. Comorbidity between mood and anxiety disorders was diagnosed in 5% of the patients (Radwan et al. 2013; Okasha and Radwan 2015).

These results are consistent with those of Bouwman et al. (2010) and Lin et al. (2009) and in contradiction with the findings of Khuwaja et al. (2010) who found higher prevalence of psychiatric morbidity. The fact that 24.3% of the study participants in Khuwaja et al. (2010) had comorbid ISHD, which they found to be significantly associated with both depression and anxiety, may explain the difference between both results, as none of the Egyptian study participants had comorbid ISHD.

Among the sample of thyroid patients in Radwan's (2013) study, 34% of them were labeled with psychiatric disorders. Twenty-six percent fulfilled the criteria of a mood disorder and 19% that of an anxiety disorder according to DSM-IV. Comorbidity between mood and anxiety disorders represented 11% of the sample. Such rates have also been reported by other studies (Zainal et al. 2010), though they were higher than that found in Patten et al. (2006).

Some of the interesting clinical factors associated with the presence of psychiatric morbidity included the presence of pathological Q wave which was significantly associated with dysthymia. Pathological Q wave is an ECG finding which signifies the presence of a prior MI; it indicates a permanent transmural cardiac damage. So it can be safely presumed that actually prior MI is significantly associated with mood disorders. Same results were reported in Naqvi et al. (2007), while in van Melle et al. (2006), both the history of previous MI and the presence of Q wave were not significantly associated with mood disorders. Inflammation is the link that may explain the relation between recurrent MI and depressive symptoms, as the inflammatory response induced by myocardial damage promotes the expression of depressive symptoms (Roriz Dias and Koike 2013). There was also a significant association between the presence of certain complications in HF and DM patients and psychiatric morbidity. Major depression in HF appeared to be associated with hepatic complication. It seems that the burden produced by hepatic disorders exceed that induced by other diseases, as shown in Goodwin et al. (2003) who found that major depression was significantly more associated with liver diseases compared to other medical diseases including renal impairment. DM patients with a history of diabetic coma were significantly more diagnosed with major depression and dysthymia. Dysthymia was also more frequently encountered among diabetic patients complicated with CVS.

Similar results were found in other studies. While on the other hand, Bener et al. (2011) found no association between diabetic complications and mood disorders. This difference may have arisen from the fact that the impact of each diabetic complication on psychiatric morbidity was studied individually in Radwan et al. (2013), but in Bener et al. (2011), the impact of complication was studied holistically.

In the Egyptian study, dysthymia was less frequently diagnosed among HF patients treated with angiotensin-converting enzyme inhibitors (ACEIs). These

results were inconsistent with the findings of Adewuya et al. (2006) and Chung et al. (2011) who found no association between ACEIs and mood disorders. However, some literatures have hinted to the possible role that ACEIs may play in the treatment of depression (Roger and Pies 2008). Nevertheless, larger randomized trials have not been performed yet. Comparing ISHD, HF, DM, and thyroid disease as regards the prevalence of psychiatric morbidity, the prevalence of major depressive disorder showed a significant difference between the four medical groups of patients, so did the prevalence of social phobia, and that of anxiety disorders in general. The prevalence of major depression was highest in HF, and lowest in ISHD, while anxiety disorders and social phobia were most frequently diagnosed in thyroid patients and least in ISHD patients (Radwan et al. 2013). The significant association of anxiety disorder with thyroid diseases may have arisen from the pronounced overlap between the symptoms of hyperthyroidism and anxiety symptoms. The difference in the prevalence of social phobia may result from the morphological changes associated with thyroid diseases, which are not present in the other medical diseases studied. These results were consistent with the findings of Strine et al. (2008) who reported no significant difference between cardiovascular diseases and diabetes mellitus as regards depressive and anxiety symptoms.

In the four medical conditions studied in the present Egyptian study, patients with psychiatric morbidities (whether generally speaking or specifically speaking of major depression, dysthymia, and anxiety disorder) had a significantly lower quality of life score than patients without psychiatric morbidities (Okasha and Radwan 2015).

Comparing the quality of life of the patients diagnosed with psychiatric morbidities in ISHD, HF, DM, and thyroid groups against each other, a significant difference was found. HF patients with psychiatric morbidity had the poorest quality of life, followed by ISHD patients, then thyroid patients; and finally, DM patients with psychiatric morbidities had the highest score in the quality of life assessment (Radwan et al. 2013). This ranking may result from the degree of physical inactivity owed to each disorder; as Arne et al. (2009) demonstrated in their study, for every chronic disorder, the lower the level of physical activity is, the lower the quality of life would result.

21.2.1 Research in Somatic Presentation in Different Psychiatric Disorders

21.2.1.1 Somatoform Disorders

For Arabs “Pain” is the main indication of illness. A number of writers have stressed the importance of viewing pain as a multidimensional experience with more similarity to emotional states than sensory processing (Pearce and Miles 1993). The Arabic language tends to be overemphatic and hyperbolic. It expresses emotionality

at the expense of rationality. Patients and relatives exaggerate their verbal reports of distress. Somatizers are usually young, more histrionic, and exposed to a multitude of stress factors (de leon et al. 1987).

Okasha and Okasha (1998) studied 120 Egyptian patients (84 men and 36 women) in a psychiatric inpatient and outpatient setting with ages ranging between less than 20 years to over 60 years of age (27). Symptom clusters involved CNS symptoms (90%), gastrointestinal symptoms (87.5%), pain and headache (80%), fatigue (90%), chest symptoms (82%), cardiovascular symptoms (72.5%), genitourinary symptoms (52.5%) and muscular symptoms (52.5%). Diagnoses given to the 72 inpatients were as follows: depressive disorder (31.9%), schizophrenia (29.1%), anxiety and phobic disorder (13.8%), delusional disorder (12.5%), somatoform disorder (8.3%) and acute polymorphic psychotic disorder (7.1%). Among the 48 outpatients 25% had depressive disorder, 25% had somatoform disorder, 25% had anxiety and phobic disorder, 18.75% had bipolar manic disorder and 6.25% had neurasthenia.

In Bahrain, the general health questionnaire (GHQ) and the BSI (Bradford Somatic Inventory) were applied and showed psychiatric morbidity presenting with somatization in 19.4% of general hospital patients (Haddad and Charlotte 1996). The prevalence of psychological morbidity in the general hospital was in agreement with other studies conducted in India and the UK, where it has been estimated that approximately 20–25% of the patients attending the general medical outpatient department and the primary care facilities do so for symptoms due to psychological or social factors (Wig and Verma 1973 and Lipowski 1988). Symptoms involved tension, fatigue, abdominal symptoms, panic, pain all over, urinary symptoms, symptoms in lower limbs and cold and heat sensations. A similar study in Saudi Arabia revealed a prevalence of 56% for somatic symptoms and 16% somatization in a sample of 270 patients. Also, Fahmy investigated 100 Somatizers, and found 34% to suffer from depression, 30% from anxiety, 16% from adjustment disorders, 4% from Somatoform disorders, and 2% from somatization. Women with somatization were significantly more illiterate, culturally deprived and depressed (Fahmy 1996).

Hamdi et al. (1997) argue that cross cultural variation in the frequencies and modes of expression of depressive symptoms may influence the validity of depression rating scales. Evaluation of the face validity of HDRS by studying symptom frequency, factor structure and symptom clusters in 100 UAE depressed patients showed that the Hamilton Depression Rating Scale was sensitive to severity of depression in UAE culture. However, it was found to measure heterogeneous aspects of the disorder and its internal consistency suffered as a result. High levels of retardation and somatization contributed significantly to the total score in socially developing countries. In agreement with that are the findings of Ragurum et al. who studied Indian patients and found depressive symptoms unlike somatic symptoms to be construed as socially disadvantageous depending on the degree of stigma associated with particular symptoms (Ragurum et al. 1996).

Somatizers in primary care are usually characterized by low level of psychological distress, are less introspective, show less concern about having an emotional

problem, and are less likely to attribute their suffering to psychological causes. They show little use of mental health services, and are usually unable to talk about personal problems and are less likely to seek help for anxiety or sadness.

21.2.1.2 Schizophrenia

Schizophrenia appears relatively similar across a range of cultures; however, variability has been noted in symptom presentation and development (Swartz 1998). The WHO international study of schizophrenia found that schizophrenia was a fairly ubiquitous disorder with an almost similar picture over many cultures. However, the way in which the particular types of symptoms appear may vary from individual to individual and culture to culture (WHO 1973). Furthermore, owing to differences in social customs and expectations, cultures differ in their assessment of the importance of different symptoms (Edgerton and Cohen 1994; Lucas and Barret 1995).

Historically, there are a number of studies comparing the manifestations of schizophrenia across cultures (Varma 2000). Differences in the symptomatology of schizophrenia in Arab and Islamic cultures have been a subject of many investigations with interesting results. While Taleb et al. (1996) found few clinical differences in his comparative study between schizophrenic patients from Morocco and France, Gawad et al. (1981) showed a number of important differences in the diagnosis of schizophrenia in Egypt compared to USA and UK. Gawad and his colleagues studied the cross-national differences in symptom importance in the diagnosis of schizophrenia among the three countries. They found that restriction and incongruity of affect ranked first in the Egyptian study compared to the British and American ones. Their results are in agreement with other studies which stated that what is normal emotional expression in an Anglo Saxon culture may suggest a schizoid reduction of emotional response in a Mediterranean culture (Lehman 1967). The top ten symptoms in the Egyptian hierarchy for diagnosis of schizophrenia were incongruity and restricted affect, formal thought disorder, thought block, thought withdrawal, incoherence, passivity feeling, neologism, hallucination, delusions and ideas of reference. While in the British study, formal thought disorder ranked first followed by incongruity of affect, neologism, thought block, passivity of feeling, paranoid delusions, stereotype of other delusions, thought withdrawal and ideas of references (Willis and Bannister 1965). The Americans ranked symptoms of importance for diagnosis of schizophrenia as follows: formal thought disorder, delusions, paranoid delusions, incongruity of affect, hallucinations, ideas of reference, neologism, depersonalization and thought block (Edwards 1972).

There was a striking difference in ranking neologism, while it is the third in the Anglo American study, it was the seventh in Egyptian study because neologism is perhaps among the commonest symptom in hysterical dissociation particularly occurring in religious pseudomystic ceremonies (Okasha 1966). The same finding was reported in Libya (Khalid 1977). The cultural and religious heritage absorbs

many features, which would otherwise be considered symptomatic of a psychiatric disorder (El Islam 1980; Barakat 1993; Frindlay 1994).

Clinical analyses have shown differences in the clinical presentations of schizophrenia as a result of cultural pathoplastic influences (Rakhawy et al. 1987; Okasha 1988).

Findings highlighting these influences are summarized in the following sections.

Delusions

The themes of delusions are affected by the individual characteristics of the patients in relation to their culture. The most frequent themes of delusions in Egypt are religious, political, and social delusions related to health while autistic delusions are less common (Rakhawy et al. 1987). Religious delusions are more common among Muslims and Christians. Religious delusions are frequent due to high religiosity in Egypt. Sexual delusions are commoner in groups in whom sexual behavior is severely suppressed e.g. delusions of sin are frequent in the masturbators in the younger, single and the students group (Okasha 1988; Ashour et al. 1986). Political delusions are positively correlated to the level of political sanctions and pressure. Fear of political persecution is a reality of life for people living under totalitarian regimens. Such fears may contribute to a higher prevalence of paranoid delusions (Westermeyer 1988).

The content of the patient's delusions varies directly in relation to his/her social class and education. For most of the lower class men and women, the delusional symptoms are fantasized in terms of the cultural religious institutions. Middle and upper class patients, however, far more frequently "secularized" their restitutive narcissistic and self-esteem delusions in terms of science and class conception of power (El-Sendiony 1976).

The fate of delusions in schizophrenia in an Arabian population was studied by El-Islam (1980), who found that the involution of delusion may be effected through their disappearance into the system of socially shared delusory cultural beliefs or their metamorphosis into less sinister symptoms (e.g. dreams and fantasies). The culturally shared belief system provides a container for delusions that lose their pathological quality and content.

Hallucinations

There are cultural variations in the frequency of different kinds of hallucinations within and between cultures (Sartorius et al. 1986). Many investigators in the Arab and Moslem countries studied the phenomenology and frequency of visual, kinesthetic and tactile hallucinations. It is concluded that these types of hallucinations in schizophrenia are of common occurrence in these countries. However, the part

played by cultural and other factors needs further investigations (Zarroug 1975; Khalil 1990).

The cross cultural study of the content of auditory hallucinations in schizophrenics living in Saudi Arabia compared to those living in UK showed striking differences. Much of the content of the hallucinations of Saudi Arabian schizophrenics were religious and superstitious in nature, whereas instructional themes and running commentary were common in the UK schizophrenic patients (Kent and Wahass 1996). Patients from both cultures had several coping mechanisms with auditory hallucinations, but these varied between cultures. The majority of Saudi patients used strategies associated with their religion whereas UK patients were more likely to use distraction or physiologically based approaches. This study suggests that clinicians, when they attempt to facilitate the use of coping strategies, may find greater patient acceptance and efficacy if they are familiar with culture-specific factors (Wahass and Kent 1997a).

The cross cultural differences in the attitudes of mental health professionals towards auditory hallucinations were studied by Wahass and Kent (1997b) and their results suggest that the cultural view of the causes and treatment of auditory hallucinations could affect attitudes.

Behavior

Behavioral problems in schizophrenia are traditionally attributed to acts of possession by spirits (jinn), sorcery or envy by the evil eye. Families who entertain these beliefs take their patients to native healers who are endowed with powers of exorcising evil spirits, undoing sorcery or ending the harm of envy. When efforts along these lines are judged to have failed, and this may take months or years, the patient is finally brought under medical care (El Islam 1980).

Positive and Negative Symptoms

Negative symptoms in many Moslem countries may be attributed to religious asceticism, so patients can be accepted and assimilated in the society and is considered as a social trait. Families usually do not go for medical or psychiatric help until the appearance of positive symptoms which leads to the delay in seeking proper therapy for many years, thus increasing the duration of untreated psychosis (Okasha and Maj 2001).

21.2.2 Obsessive Compulsive Disorder

The impact of Egyptian culture is evident in many aspects of transcultural studies in Egypt.

The religious nature of upbringing and education in Egypt, the emphasis on religious rituals, especially related to ablution remaining for hours washing, and the warding-off of blasphemous thoughts through repeated religious phrases such as “I seek refuge with the Lord from the accursed Satan” can explain the high prevalence of religious obsessions and repeating compulsions among our Egyptian sample, even if the subjects are not practicing their religious duties (Okasha et al. 1991; Okasha and Okasha 2016).

To elaborate further, Moslems, who constitute almost 90% of the Egyptian population, are required to pray five times a day. The five daily prayer times are: Dawn (2) genu flexion followed by prostration; Noon (4); Afternoon (4); Sunset (3); Evening (4). Each prayer is preceded with a ritualistic cleansing process (*El Woodoo or ablution*), which involves the washing of several parts of the body in a specific order, each three times. Woodoo involves ritualistic washing of mouth, nose, face, ears, hands to elbow and feet each three times, provided he/she urinated or defecated between two prays (he should wash the orifices after these physiological functions).. The emphasis on cleanliness’ (In Arabic, Tahara; in Hebrew, Taharat) or ritual purity is the cornerstone of most of the compulsive rituals. The number of prayers, the verbal content can be a subject of scrupulous, checking and repetition. A bath is necessary after ejaculation, and excretion whatever its nature (Okasha et al. 1991).

Women are not allowed to pray or touch the Koran during their menstruation, after which they should clean their bodies through a ritualistic bath. The prayers themselves are different in length and consist of certain phrases and “*souras*” from the Holy Koran that have to be read in certain sequence (Okasha et al. 1994).

The ritualistic cleansing procedures also can be a source of obsessions and compulsions about religious purity, e.g., in some compulsives, the color red (reminder of menstruation) may trigger a compulsive washing. Another evidence of the religious connotation inherent in OCD in Moslem culture lies in the term “*El Weswas*.” (*in Arabic*). This term is used in reference to the devil, and at the same time is used as a name for obsessions.

It is also characteristic of a conservative society like that of Egypt to expect sexual obsessions to be among the most frequent in female patients. Although it is accepted socially (but prohibited religiously) for Egyptian males to have a wide range of sexual freedom in all stages of their lives, sexual matters remain an issue of prohibition, sin, impurity, and shame for Egyptian women. The female gender is surrounded by so many religious and sexual taboos that the issue becomes a rich pool for worries, ruminations, and cleansing compulsions in women susceptible to developing OCD (Okasha et al. 1994).

Christians represent approximately one tenth of the population in Egypt, which is equivalent to their number in the study sample (about 10%). The presenting symptoms were almost similar in terms of obsessions, where religious and sexual thoughts were predominant. However, there was a marked difference in rituals, which were more frequent in Moslems, emphasizing the role of ritualistic Islamic upbringing as compared with Christian upbringing in our community (Okasha et al. 1994).

Table 21.1 Common themes of obsessions in Egypt, India, England and Jerusalem

Country	No.	Contamination (%)	Aggressive (%)	Ordering (%)	Sexual (%)	Religious (%)
Egypt (Okasha et al. 1994)	90	60	41	53	47	60
India (Akhtar et al. 1975)	82	46	29	27	10	11
England (Stern and Cobbs 1978)	45	38	23	11	9	0
Jerusalem (Greenberg 1984)	10	40	20	10	10	50

A comparison in this context was also drawn between the most prevalent symptoms in the study sample and those of other studies performed in India, England, and Jerusalem (Table 21.1). Contamination obsessions were the most frequently occurring in all studies. However, the similarities of the contents of religious obsessions e.g. blasphemous between Moslems and Jews as compared with Hindus and Christians signify the role played by cultural and religious factors in the presentation of OCD. The obsessional contents of the samples from Egypt and Jerusalem were similar, dealing mainly with religious matters and matters related to cleanliness and dirt. Common themes between the Indian and British samples, on the other hand, were mostly related to orderliness and aggressive issues. It is interesting to note that English sample had no religious obsession (Okasha et al. 1994) as seen in Table 21.1.

Another cultural characteristic of Egyptian psychiatric patients is reflected in the Y-BOCS rating of the severity of OCD in our sample. The majority of patients were rated between moderate and severe, and the total Y-BOCS score was in the severe range in most of the cases (71.1%), indicating the high tolerance Egyptian patients have for their psychiatric morbidity before they decide to seek help. Native healers, religious people, friends, and family elderly are the primary caregivers for psychologically disordered individuals. When those lines of intervention fail, the general practitioner, followed by the psychiatrist, are the next resort (Okasha et al. 1994).

This delay in seeking help may also explain the fact that males outnumber females in our sample, which is in contrast with most of the literature concerning OCD. An explanation could be attributed to the reluctance of females to seek help for a complaint that could be managed within the household. Although males could have difficulty incorporating, e.g., washing, repeating, or checking rituals into their work life, these compulsions or related obsessions could be tolerated in the context of housework and a long day spent at home, away from the exposure to public life. Also, local surveys on health-related behaviors in Egypt have shown that women meet their health needs only after children and husband's needs have been fulfilled (CAPMAS 1992) Therefore, this sex difference does not reflect the rate of morbidity in the population, but rather the sociocultural variables that influence the pattern of referrals to psychiatric clinics.

21.2.3 Depressive Disorders

The WHO collaborative study on depression (Sartorius et al. 1980; Jablensky et al. 1981) identified a core of depressive symptoms in the majority of cases in the 5 participating centres. These include sadness, joylessness, anxiety and tension, lack of energy, loss of ability to concentrate and ideas of inadequacy and worthlessness. There was also evidence for existing differences. Psychotic features were completely lacking in the Tehran subjects and the delusion of poverty considered common in depressed patients was completely absent in the Tokyo patients. Guilt feelings were commoner in European and Canadian patients. Traditional communities in Tehran and Tokyo showed a lesser incidence of suicidal thoughts and they tended to report a smaller number of symptoms. Iranian patients tended to have the highest frequency of somatisation.

El-Islam and colleagues screened symptoms of depression in 100 subjects in Kuwait using the Schedule for Standardised Assessment of Depressive Disorders (Sartorius et al. 1980; El-Islam et al. 1988). They revealed that ideas of inadequacy, hopelessness, guilt feelings and suicidal ideation and behaviour were not frequently present. This active research group in Kuwait also identified four principal component factors which could explain much of the variance in the clinical presentation of depression. First is the endogenous factor accounted for by early morning wakening, guilt, ideas of reference, and feeling worse in the morning. The second factor describes the distress caused by the depressive symptoms as experienced in the form of tightness and hopelessness. The third factor comprises symptoms describing attitudes to self and others, lack of self-confidence, social dysfunction and feelings of insufficiency. The fourth factor describes hallucinatory experiences and illusions interfering with the sleep.

In a study by Okasha (1988), they found that both depressive symptoms and depressive disorders were higher in a rural population compared to an urban population of Egyptian patients.

21.2.3.1 The Experience of Depressed Mood

Research studies and anecdotal reports from Arab and Moslem depressed patients suggest that depressed mood may not present as the primary complaint. Depressed patients may not readily volunteer or verbalise feelings of sadness, and low mood as is often the case in Western patients. These can be elicited, however, by appropriate enquiry (Hamdi et al. 1997; El-Islam et al. 1988). Reports from the developing world seem to agree about the difficulty in demonstrating depressive affect in these patients. Afghani patients did not have the words to describe their feeling of sadness. They were aware of the presence of a distinct feeling, they could differentiate these feelings from the feeling of grief caused by the loss of a dear one (Keegstra 1986). He also added that many of his patients described their feeling of sadness as if a strong or hard hand was squeezing their hearts.

Arab patients rarely use the Arabic equivalents of the expression ‘I feel depressed’, ‘sad’, or ‘down’ to describe depressive feelings (Hamdi et al. 1997). These expressions are mainly used when a person is suffering from grief after a loss. Instead the words ‘kattma’ and ‘fikr’ are frequently used. Literally, the meaning of “kattma” means “oppression”, feelings of confinement, suffering and hardship. Its connotation has links to feeling heavy and tense. The word “Fikr” literally means “thought” in the singular sense and implies a morbid state of brooding or preoccupation. The exact nature of the preoccupation is frequently not verbalised, but the word conveys the impression of the whole mind driven into gloom. A certain degree of inference is required to equate these expressions with the clinical description of a depressed mood.

Irritability is a more frequent symptom of depression than depressed mood especially in Arab women (Ghubash et al. 1992; Amin and Hamdi 1995). The symptom is often mild and takes the form of intolerance and expressions of anger towards the woman’s own children.

21.2.3.2 Guilt Feelings

Similar to reports from developing countries in Africa (Prince 1968) and Asia (Yap 1965) several studies referred to the rarity of guilt and self reproach in depressed patients in the Islamic and Arab countries. In a cohort of 157 Egyptian depressive outpatients, El-Islam (1969) reported that 62.7% presented with guilt feelings. However, the definition of guilt used was broad. It involved self reproach, death wishes and attempted suicide. The experience of self-reproach in the sample ranged over a wide spectrum of behaviour e.g. being irritable to imagined inadequacy at work, neglect of family affairs, letting down friends, or minor peccadilloes in which the patient had caused harm. Guilt feelings were not found to correlate statistically with religion in this culture. There was no significant difference between Christians and Moslems. However, anecdotal reports seem to indicate that guilt feelings are more common in the Christian depressed patients in Egypt. Guilt feelings appear to be over represented in the literate and psychotic groups of patients.

It has been stipulated that the Arab Islamic culture is a culture of shame rather than guilt, and the individual, in his subjective life, cherishes his association and link with the family, tribe or society. Wrong doing, actual or imagined, generates feelings of loss of status and belonging shame more than feelings of painful personal responsibility and loss of integrity. The emotional link to the group may also invite the individual to project his problems on to others. Okasha (1984) holds a similar view of the Egyptian individual. He assumes that individuation is less developed and the assumption of one’s responsibility for personal acts and the role of the individual is viewed here as a part of a social system and thus the guilt takes an impersonal turn and it is externally directed.

21.3 Undergraduate Education of Somatic Presentation of Psychiatric Disorders

Egypt has around 19 medical schools, including 4 under construction; all of them have psychiatric departments, seven of which are departments of neuropsychiatry. They have offered a diploma of neuropsychiatry for more than 60 years, a master's degree in psychiatry for the past 55 years and a doctorate for the past 50 years. Students must complete a thesis and written, oral and clinical examinations.

Studying in medical schools in Egypt is for 6 years, psychiatry is taught in the fifth year. At the Institute of Psychiatry, Faculty of Medicine Ain Shams University in Cairo; for example; students are divided into groups and each group comes to the Institute of Psychiatry for a 3 week period, from 9 am to 2 pm. Teaching utilizes lectures, workshops, interactive sessions, clinical rounds and videos about the topics in the curriculum. The outline of the curriculum used can be seen in Fig. 21.1.

Emphasis in education is made on the somatic presentations of psychiatric disorders using terms such as unexplained somatic symptoms or somatic symptoms in psychiatric disorders and given a high priority in the curriculum. The aim is for medical students to be able to pick up these disorders and initiate treatment and refer when necessary.

21.4 Conclusion

Egypt has made substantial progress since the 1950s in reducing infant and child mortality, improving life expectancy and increasing access to health care. Major problems, however, remain. Public health challenges include high rates of maternal mortality, malnutrition, wide disparities between rural and urban areas, emphasis on curative rather than preventive care, the relative weakness of public health institutions, the variable quality of health care, lack of capacity in policy-making, and unresponsive and inequitable health systems.

The Arab Human Development Report (2002) links current development status with external and internal conditions. The main external factor is military spending as a direct impediment to development, channeling resources away from development priorities such as health (including mental health). Alternative strategies conducive to development would be greater spending on technological development, empowerment of vulnerable groups, such as women and children, and promotion of democracy and human rights. In view of the lack of human resources, mental health policies and legislation in the majority of the countries of the world, developing countries such as Egypt should develop partnerships with other agents (such as non-governmental organizations, consumer groups etc.) to provide psychiatric patients with the best care possible.

Subjects in the curriculum are categorized into 4 levels:

Level A: Learn diagnosis, investigations, detailed management plans including drug doses.

- Delirium
- Unipolar depression
- Anxiety disorders (panic, phobia and generalized anxiety disorders)
- Somatoform disorders
- Psychosomatic disorders
- Conversion and dissociative disorders
- Adjustment and acute stress disorders
- Insomnia
- Nocturnal enuresis
- Psychiatric emergencies
- Ethical and legal issues

50% OF CURRICULUM AND EXAM

COMMON AND SERIOUS

Level B: Learn diagnosis, investigations, and major approaches to treatment and when to refer to a psychiatrist.

- Schizophrenia other psychoses
- Bipolar disorder
- OCD
- PTSD
- Smoking cessation
- Self-destructive behaviors

25% OF CURRICULUM AND EXAM

LESS COMMON BUT SERIOUS

Level C: Learn diagnosis, differential diagnosis and when to refer to a psychiatrist.

- Dementia
- Personality disorders
- Eating disorders
- Child psychiatry
- Substance use disorders
- Hypersomnia, parasomnia

20% OF CURRICULUM AND EXAM

SUBSPECIALITIES OR RELATIVELY RARE OR NOT SERIOUS

Level D: Nice to know for enthusiastic students only!!

- Forensic psychiatry
- Cognitive behavioral therapy

5% OF CURRICULUM AND EXAM

Fig. 21.1 The outline for the curriculum used for fifth year medical students at the Institute of Psychiatry, Faculty of Medicine, Ain Shams University

Questionnaire Response

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry in your (or your chapter's) Country.

Please return this as an attachment to your email

Country on which you are reporting: **EGYPT**

Your Name: **PROF. TAREK A. OKASHA**

Institution: **INSTITUTE OF PSYCHIATRY, FACULTY OF MEDICINE, AIN SHAMS UNIVERSITY**

City & Country (e.g. London, UK): **CAIRO, EGYPT**

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?
 Yes () No () In some sense (X)
 - a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes () No (X)
 - b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes () No (X)

2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?
 Yes () No (X)

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?
 Yes (X) No ()

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No (X)
 - a. If YES, which?
 Psychosomatic Medicine () Consultation-Liaison Psychiatry ()
 - b. If YES, the status of such certification is:
 - i. Independent Medical Specialty ()
 - ii. Subspecialty of Internal Medicine ()
 - iii. Subspecialty of Psychiatry ()
 - iv. An independent non-medical discipline, as Psychology, Social Work ()
 - v. Other (Specify): []

5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No (X)
If YES, please list names of the organizations and the websites if available:
6. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:
Papers related to psychosomatic medicine and/or consultation-liaison psychiatry are published in psychiatric journals
7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in your country? Yes (x) No ()
a. If YES, where does it occur? Check all that apply:
Medical School (x) Residency (x) Fellowship (x)
8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes () No (x)
9. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)
- It is insignificant (x)
 - Some subgroups (e.g. ethnic, religious) practice it ()
 - A significant part of the general population practice it (x)
 - Is the most prevalent healing method used (x)
 - It is often used in combination with Western medicine (x)
 - More widely used methods are as follows (Please list, e.g., spiritual healing, meditation, herbal, etc): **Religious, spiritual and herbal**
10. Please add any comments to your response here:

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Chapter 22

Psychosomatic Medicine in South Africa: Concepts and Practices in a Low-and Middle-Income Country



Eileen Thomas, Jacqueline Hoare, and Dan J. Stein

22.1 Brief History

South Africa is an interesting country from which to explore questions about mental health in general and psychosomatic illness in particular. This is partly because of its unique history - including the transition from apartheid to democracy, and partly because of its ongoing diversity – across the nine provinces of South Africa there are 11 official languages and wide variation in terms of population density, socio-economic status, and ethnic and cultural background. Health services reflect this history; they range from well-resourced private hospitals, through to public institutions that vary in accessibility and quality, and on to a range of alternative and traditional practices. This chapter considers key theoretical debates that are important locally, as well as local services, research, and training in psychosomatic medicine. To begin we provide a brief historical context.

Key to South Africa's history is the influence of colonialism, apartheid, and subsequent democracy. The first Dutch settlers arrived in 1652 in the Western Cape, forcibly displacing indigenous inhabitants. Southward migrations of Nguni-speaking nations to the Eastern Cape also occurred. During this time (1652–1800) health care was provided by traditional (indigenous) healers, European trained doctors, midwives and missionaries; while psychiatric care was largely provided in jails or general hospitals (Coovadia et al. 2009; Gillis 2012). During British colonial rule (1800–1900) traditional healers increasingly became marginalized, replaced by Western medicine, with the first mental asylums established towards the mid nineteenth century on Robben Island (later converted to a prison for political inmates).

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The Apartheid (“separate development”) regime (1948–1994) further entrenched colonial segregation and marginalization of particular groups, with access to hospital and treatment based on race and class. During this time, the field of psychiatry evolved globally, becoming part of mainstream medicine. In South Africa, academic departments of psychiatry were established in general hospitals such as Groote Schuur Hospital in Cape Town (Gillis 2012). The dissolution of apartheid following the first multiracial democratic elections in 1994, ushered in several reforms, including the hope of transforming the mental health system from centralized, institutionalized care towards decentralized, community based care within a human-rights framework.

South Africa’s healthcare systems continue to evolve. While steps have been taken towards more equal distribution of resources and more equitable access to care, large gaps remain, and mental health services continued to be underfunded relative to the contributions of mental disorders to the national burden of disease (Petersen and Lund 2011). Disparities established during the eras of colonial and Apartheid rule remains visible today in the form of key social determinants of health and mental health; with ongoing inequalities impacting on the nature of local epidemics, such as HIV/AIDS, TB, and substance use disorders (Coovadia et al. 2009). At the same time, there is a strong focus on health as a human right, and this has led, for example, to widespread availability of antiretroviral agents, and to mental health act which emphasizes access to equitable care.

22.2 Current Status

Emerging from this history, at least two conceptual systems of illness co-exist, the western biomedical healthcare framework and the traditional health care model, each of which embraces different ideas about the body and the origin of illness. Neither is, however, homogenous; traditional health practitioners include herbalists (*inyanga*), diviners (*sangoma*), faith healers (*umthandazi*), traditional surgeons who perform circumcisions (*iingcibi*), and traditional birth attendants (*abazalisi*) (Peltzer 2009; Truter 2007). Traditional healers may view mental illness as having many causes, most frequently witchcraft and possession by evil spirits (Sorsdahl et al. 2010). Similarly, practices within the western biomedical healthcare framework can be quite diverse, partly reflecting socioeconomic disparities due to apartheid.

It has been argued that colonial rule attempted to repress African traditions, and negatively skewed perceptions of traditional health care; marginalizing traditional practices as illegitimate, irrational and inferior (Abdullahi 2011; Flint 2008). On the other hand, it has been argued that more needs to be done to ensure that traditional healers appropriately diagnose and treat mental disorders (Sorsdahl et al. 2010); this is one of several theoretical debates we will consider in the next section. In 2004 South Africa officially legalized the practice of traditional medicine and in 2007 the Traditional Health Practitioners Act (TPHA) was promulgated in order to register and regulate traditional healing practices in South Africa (Flint 2008). The Health Professions Council of South Africa also recognizes a range of complementary and

alternative medicine practices such as osteopathy, chiropractic, homeopathy, and naturopathy. Approximately 200,000 traditional healers and 3600 alternative and complementary practitioners are registered (Gqaleni et al. 2007).

Patients may adopt multiple models of illness, and may use allopathic and alternative/traditional health systems concurrently or sequentially (Nxumalo et al. 2011). Traditional health systems are more accessible than government services in some parts of the country (Mayosi et al. 2014); overall there is a critical shortage of health care workers (Willcox et al. 2015). Approximately 84% of South Africa's national population of 52 million people are reliant on the public health care sector for their health care. The public health sector is staffed by only 30% of doctors; the remaining 70% work in the private healthcare sector (Lehlola 2013). National surveys have indicated that the majority of South Africans with mental disorders first consult the public healthcare system with only 0.5–11% utilizing traditional healers (Nxumalo et al. 2011; Social and Regulator 2014; Sorsdahl et al. 2009).

As in other parts of the world, mental disorders are a major contributor to the local burden of disease. In Sub-Saharan Africa, mental illness and substance use accounts for 19% of years lived with disability (YLDs) (Whiteford et al. 2013). This burden is estimated to increase by 130% by 2050 (Charlson et al. 2014). In Sub-Saharan Africa, the treatment gap between the number of people who require and those who receive treatment for mental disorders is estimated at 70% (Williams et al. 2008). Thus in the post-apartheid era, scaling up of mental health care through integration into primary care has been identified as the most cost-effective strategy to address existing mental health care needs (Petersen and Lund 2011). From this perspective, there is a key need to integrate mental health services into general medical services, consistent with views around the world on the value of collaborative care (Raney 2015). South Africa is in the process of introducing a healthcare reform plan, the National Health Insurance (NHI) in an attempt to lessen the divide between public and private health sectors. By integrating mental health with other chronic disease care it is also hoped that parity will be created between mental and physical illness (Petersen et al. 2015).

The primary health vision does allow for care at secondary and tertiary levels, and psychosomatic medicine has been recognized as also having an important role at these levels. Indeed, psychosomatic medicine (also known as consultation-liaison or hospital psychiatry) has been linked to the provision of clinical psychiatric and psychological care to medically complex patients in South African hospital settings (Vythilingum and Chiliza 2011; Schlebusch 1983). In line with this, in the past decade consultation-liaison psychiatry was successfully established as a recognized sub-specialty. First, the University of Cape Town introduced a sub-specialty training program in consultation-liaison psychiatry. Second, the College of Psychiatry of South Africa recognized consultation-liaison psychiatry as a sub-specialty of psychiatry. Finally, the Health Professions Council of South Africa promulgated consultation-liaison psychiatry as a formal sub-specialty. Those working in consultation-liaison psychiatry locally have focused in particular on women's mental health, on HIV/AIDS, and on other areas of practice that are particularly relevant to the South African context (Hoare et al. 2015a, b; Vythilingum et al. 2013; Vythilingum 2010).

22.3 Theories

As noted above, within South Africa's healthcare system, there are several competing frameworks for understanding illness. The traditional healthcare model is often considered to be holistic in its approach, yet limited research exists to substantiate this view. Concerns that have been raised regarding the practice of traditional medicine include delays in diagnosis and treatment, and the potential use of ineffective or toxic herbal medication (Smyth et al. 1995). Nevertheless, our knowledge regarding the practices, training and the beliefs that underlie the traditional healthcare model however remains limited, and there is a lack of data on patient outcomes and cost-efficiency of treatment. Given the scarcity of resources in low and middle income-countries (LMICs) the potential complementary role of the traditional healthcare system requires further attention and investigation.

Another area of controversy is the extent to which low- and middle-income countries should embrace task-shifting and task-sharing, versus the extent to which they should also engage in specialty and even sub-specialty training. The training of consultation liaison sub-specialists has been part of a broader debate about the advantages and disadvantages of psychiatric sub-specialization in the low-and middle-income context (Stein et al. 2010). In a LMIC with limited resources, few psychiatrists and large healthcare-disparities; there is a view that the focus should be on improving primary care services. On the other hand, the view has been put forward that consultation-liaison (CL) sub-specialists would bring much needed expertise to the care of patients with complex tertiary problems, and would also assist in the education, training, and support of primary healthcare providers and general psychiatrists (Stein et al. 2010).

A third debate is whether general health outcomes (for example, length of stay) could potentially be improved by strengthening CL-services within hospital settings. In high-income settings, this has been demonstrated; Muskin et al. reported on a quality improvement program whereby the psychiatrist became a member of a general medical team, which resulted in decreased LOS and significant annualized savings (Muskin et al. 2016). There are however few data on this particular issue from low- and middle-income country contexts.

There is a real need for more conceptual and empirical work on the question of how to best provide collaborative care in the LMIC primary care context (Farooq 2013). There has been debate about whether mental health services should be integrated vertically (in the form of a mental health case manager at community health centre level) or horizontally (integration of mental health services in primary care, using a collaborative model of care) (Petersen et al. 2016). Even if there is agreement on moving forwards with the introduction of non-specialized mental health care workers into the system, more work is needed to establish the optimal scope of their activities, and the best ways to train, roll-out, and up-scale their activities (Lund et al. 2016).

22.4 Research

Consultation-liaison psychiatry research in South Africa has addressed key contributors to the local burden of disease. South Africa is home to the largest HIV/AIDS epidemic in the world; with 5,6 million people living with HIV (UNAIDS 2010). Researchers have emphasized the high prevalence of mental disorders and of HIV-associated neurocognitive disorders (HAND) locally (Cross et al. 2013). A number of papers has been published on the use of brief measures to assess for HAND and other mental health disorders (Breuer et al. 2012; Joska et al. 2011). There are significant numbers of children with vertically transmitted HIV; local research has addressed distinctions between rapid and slow progressors (Hoare et al. 2012) and investigated correlates of emotional and behavioural problems in vertically infected children (Louw et al. 2016). In South Africa, patients are more likely to have Clade Class C HIV infection, and researchers have addressed the neuroimaging correlates of this type of infection (Hoare et al. 2011). Finally, a number of papers have focused on improving adherence to ARVs, with an emphasis on the use of lay mental health workers (Robbins et al. 2011).

Limited CL research has been conducted on a range of other neuropsychiatric conditions including delirium and myasthenia gravis. (Freeman et al. 2014; Hatherill et al. 2010). A range of work has also contributed to work on cultural conceptualizations of illness, for example, through the examination of dysregulated eating behaviours among young black females (Morris and Szabo 2013). Falling within the range of CL concerns has been a range of research on the psychometrics of common mental disorders in South Africa (Smit et al. 2006), the epidemiology of pain and mental-physical comorbidities in LMIC contexts (Scott et al. 2013), and work on screening for common mental disorders in general medical settings (Carey et al. 2003).

In a low and middle-income country setting, where health resources are scarce, CL research needs to focus on locally relevant solutions. Work on prenatal and postnatal mental health care is particularly pertinent in this setting, given that it is one area in which improving diagnosis and treatment may have particularly long-lasting effects, extending into the next generation. A stepped care approach has been advocated to screen and provide care for pregnant women with mental health problems (Honikman et al. 2012; Vythilingum et al., 2013). Important contributions to the area of women's mental health include work on screening tools to identify at-risk pregnancies (Vythilingum et al. 2013), work on the pathophysiology of antenatal distress (Vythilingum and Chiliza 2011) and the exploration of substance use risk factors during pregnancy (Vythilingum et al. 2012).

Finally, a number of studies, including the PRIME research consortium led by the Alan J Flisher Centre for Public Mental Health at the University of Cape Town, are generating research evidence on the implementation of district level mental health care plans that are embedded within existing services and programs. The hope is that these collaborative care packages will provide efficacious and

cost-effective treatment for common mental health disorders in primary health care contexts in resource-constrained settings (Petersen et al. 2016). Such work will also help address theoretical debates raised earlier in this chapter, including the question of horizontal versus vertical integration of mental health services.

22.5 Education

South Africa's transforming healthcare landscape has required that teaching and learning occurs within different educational contexts. One such an example is the Longitudinal Integrated Clerkship (LIC) model at the Ukwanda Rural Clinical School established in 2011, modelled on international LIC experience, but adapted for the South African context (von Pressentin et al. 2016). In this teaching model, undergraduate medical students spend their final year of medical training in the clinical team of a rural district hospital and its associated primary care platform. Training takes place at district hospital under the supervision of family physicians and the clinical team, who act as clinical educators for the students. This training occurs with support from general specialists at the regional hospital as well as their other health professionals.

Apprenticeship is a system of training where a generation of practitioners acquire some skill. In South Africa, traditional healthcare practices have been passed from one generation to another through training and apprenticeship. Traditional healthcare is a potentially important component of available resources in South Africa as these services provide not only cultural acceptability but greater geographical coverage. Ongoing efforts to address the diagnosis and treatment of mental disorders by traditional healers may however be important.

The attitude of non-psychiatric physicians towards psychiatry plays a critical role in the development of integrative healthcare systems. At the University of Cape Town, CL teaching of undergraduate medical students now occurs during their medical and surgical rotations in order to emphasize the integration of medicine with psychiatry. Early exposure to the emerging field of psychosomatic medicine may be crucial in destigmatizing psychiatry and in generating a more positive attitude towards the management of mental illness in the medically ill with inputs from CL psychiatrists or in collaborative care models.

22.6 Practice

Consultation liaison psychiatry in South Africa operates in a range of hospital settings and attempts to respond to local demands and pathways to care.

22.6.1 Consultation-Liaison Psychiatry/Mental Health in the Primary Care Setting

Primary health care is defined as the provision of essential health care services within communities. In practice medical and mental health comorbidities are under-recognized, under-diagnosed and under-treated globally and locally (Agüera, et al 2010; Myers et al. 2014; Pence et al. 2012). A greater awareness of the escalating public health impact of non-communicable diseases, including chronic medical conditions and mental health conditions has provided the impetus to develop and integrate mental healthcare into primary health care.

Mental health service provision has gradually begun to move from tertiary-institution based care to more community/hospital based care locally. However, one of the current difficulties South Africa faces with regards to the successful integration of mental health care into primary health care is the lack of human resources. Similar to other LMICs, South Africa suffers from an absence of qualified mental health care workers. Only 0.9% of all registered psychiatrists in SA practice in primary health care settings (De Kock and Pillay 2017). Fortunately, there is increasing evidence from LMIC's that treatment for common mental disorders can be delivered by lay or community health care workers via task-shifting (Petersen et al. 2011, 2014).

Task-shifting involves the transfer of certain responsibilities and skills from highly skilled professional to community health care workers, and has emerged as an efficient and cost-effective way to improve mental health accessibility where human resources are scarce (Mendenhall et al. 2014) Existing research indicates the potential for task shifting in the local context (Spedding et al. 2015). Further efforts are now needed to obtain the resources to evaluate and scale-up such work, and CL psychiatry may be able to play an important role in advocating for this.

22.6.2 Consultation Liaison Psychiatry Certification

The Consultation Liaison Fellowship is a Health Professions of South Africa (HPCSA) accredited subspecialist training program which is completed over a 2-year period, following completion of training in and registration as a general psychiatrist. The HPCSA officially recognized Consultation Liaison as a sub-specialty of Psychiatry in August 2015 (Gazette and Notice 2015). The training program consists of both a clinical and a research component that is completed at an accredited tertiary university hospital site. The fellowship is intended to provide a broad-based clinical experience, with a strong multidisciplinary emphasis, and opportunities to learn skills in research, education and administration. Fellows rotate through different clinical services in order to obtain in-depth understanding of psychiatric issues pertinent to specific medical and surgical specialities, including: surgery, endocrinology, obstetrics and gynaecology, gastroenterology, infectious disease and HIV/AIDS, nephrology, pulmonology, rheumatology, transplant

medicine. Fellows also work in outpatient specialty clinics (such as oncology, chronic pain, neuropsychiatry, eating disorders, gender dysphoric disorder and womens' health clinics).

In addition, fellows are provided with an educational program, which includes regular clinical case conference and literature reviews presented by the fellows. Fellows are involved in teaching; responsibilities include supervising psychiatry residents and undergraduate medical students (fourth- and sixth year) who rotate through the Consultation-Liaison Service as part of their training. As part of the curriculum, fellows are expected to complete an original research project, as well as at least one cognitive-behaviour (CBT) or mindfulness-based(MBCBT) supervised therapy case for a CL based indication, e.g. nonadherence, chronic pain, eating disorder or somatic symptom disorder. Satisfactory completion of a fellowship qualifies each graduate to sit for the subspecialty board examination in Consultation Liaison which is administered by the Colleges of Medicine of South Africa.

There remain uncertainties locally, however, about the funding of CL Fellowships. To date constrained hospital budgets have not allowed financing of Fellows. A range of non-hospital funding sources have therefore been used, but this raises questions about sustainability.

22.7 Conclusion

South Africa provides an instructive context in which to think about psychosomatic medicine; a number of issues in this context may be unique given the country's specific history, but others will be relevant to other low- and middle-income countries and perhaps even to under-resourced areas within high-income countries. There have been a number of advances in psychosomatic medicine in South Africa in recent years, including the recognition of psychosomatic medicine as a sub-specialty, but much more work remains to be done. Here we have argued that the health system in South Africa is in need of revitalizing and restructuring, and that psychosomatic medicine can play a key role in thinking through such transformation given its emphasis on interdisciplinary collaboration and collaborative care models.

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Part V
Contemporary Psychosomatic Medicine
and Consultation-Liaison Psychiatry in
North and South America: Development,
Research, Education, and Practice

Chapter 23

Psychosomatic Medicine and Consultation-Liaison Psychiatry in the United States



Hoyle Leigh

23.1 History & Theories

The term, “psychosomatic” was coined by the German physician, Johann Heinroth in 1818 (Muskin 2008). He proposed a theory of the mind consisting of Uberuns (conscience), the ego (mind, emotions and will) and the Fleish (basic drives, which included man’s sinful nature), which antedated Freudian structural theory consisting of superego, ego, and the id (Heinroth 1818). The term, “psychosomatic *medicine*” was first used by the Viennese psychoanalyst Felix Deutsch in the 1920s. Felix Deutsch and his wife Helen, also a psychoanalyst, emigrated to the United States in 1936 and were active in Boston Psychoanalytic Institute.

For more detailed sweep of history of psychosomatic medicine in North America to the 20th Century, please refer to the chapter in Part I of this book.

Psychosomatic medicine in the United States is usually traced to Franz Alexander, who founded the Chicago Psychoanalytic Institute. Alexander and colleagues utilized psychoanalytic methods on patients with physical diseases and proposed that specific psychological conflicts led to excessive autonomic arousal resulting in symptom formation and tissue damage. Alexander postulated that there were seven diseases that were particularly “psychosomatic” in that specific psychological conflicts resulted in specific autonomic arousal causing disease. They were: peptic ulcer, essential hypertension, bronchial asthma, ulcerative colitis, thyrotoxicosis, rheumatoid arthritis, and neurodermatitis. In peptic ulcer, for example, Alexander postulated that unresolved conflict over dependency needs requiring oral gratification vs. independence may result in independent strivings causing an

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unconscious perpetual state of hunger, resulting in overproduction of gastric acids resulting in peptic ulcer (Alexander and Benedek 1950; Alexander et al. 1948).

Flanders Dunbar, who was a faculty at Columbia Medical School in New York, proposed that specific personality profiles conferred vulnerability to psychosomatic disease rather than specific conflicts. She founded the American Psychosomatic Society in 1942 and was the first editor of the journal, *Psychosomatic Medicine* (APS 2015).

23.1.1 *Alexithymia*

An attempt to elucidate possible neurobiologic underpinnings of somatization was the concept of alexithymia, proposed by Peter Sifneos and John Nemiah of Harvard in 1973 (Apfel and Sifneos 1979; Sifneos 1996). Alexithymia (from Greek meaning “no words for emotions”) is the inability to express emotions in language often observed in patients who tend to somatize. A number of scales have been developed to measure alexithymia (Haviland and Reise 1996; Koch et al. 2015) which has recently been associated with functional alterations in the anterior cingulate gyrus (Colic et al. 2015; Goerlich-Dobre et al. 2015a, b).

23.1.2 *Stress and Adaptation*

In early twentieth century, Harvard physiologist Walter B. Cannon showed how the biological organism automatically mobilized its physiological and biochemical resources by a built-in “wisdom of the body,” to defend itself against real or threatened assault. As an example of defensive mobilization, the organism responds to fear and rage as though preparing for fight or flight, by shutting down energy-storing functions and activating energy-releasing ones (Cannon 1915, 1970). According to Cannon’s model, psychophysiological disturbance occurs as a result of dysregulation of homeostasis by stress.

In the 1940s, Harold G. Wolff and his associates at Cornell proposed a generalized notion of “stress and disease,” according to which disease was the “inept” version of a normally “apt protective reaction pattern” that allowed the human organism to mobilize against stressful situations or events (NIH 2011; Wolff 1953).

Hans Selye was born in Vienna and educated in Prague as a physician and biochemist. He settled at McGill University in Montreal, Canada, in the 1930s. Selye proposed, in 1950, what he called the “General Adaptation Syndrome.” Selye’s theory was that various “stressors” (cold, heat, solar radiation, burns, “nervous stimuli”) produce a generalized, stereotyped response in the biological organism as it works to “perform certain adaptive functions and then to reestablish normalcy.” As the organism automatically mobilizes its defense mechanisms, the hypothalamus is excited first, followed by the pituitary gland and the secretion

of adrenocorticotropin, which results in the adrenal glands producing glucocorticoid hormones (HPA Axis). Corticoid hormones cause a characteristic set of somatic reactions including the development of gastrointestinal ulcers (Fortier and Selye 1949; Selye 1974; Selye and Fortier 1949). Selye's model of psychophysiological dysregulation is that of HPA activation due to stress.

George Engel was an internist who became interested in psychosomatic medicine and created the psychiatric liaison service at the University of Rochester in New York. He collaborated with Franz Reichsman in the Monica Project. Monica was an infant with congenital blockage of the esophagus, necessitating a gastric tube for feeding. Engel and his associates designed a study in which they measured her gastric secretion continuously and correlated their observations with Monica's moods. They found that Monica's physiological activity increased when she was engaged with the members of the group, whether joyfully or angrily, and especially on reunion after separation. By contrast, her gastric secretion ceased entirely, and even became unresponsive to histamine (which normally stimulates gastric secretion), when she withdrew physically and emotionally from a stranger who replaced the familiar members of the group. Monica's behavior made sense as a psychological and physiological shutdown that served to conserve her organismic resources. It also helped put into perspective the separately collected clinical data on patients who articulated feelings of "giving up" or being "given up" shortly before the onset or exacerbation of a variety of somatic diseases.

Engel and the Rochester group developed a stress theory called "conservation-withdrawal." Like Selye, Engel focused on psychobiological threats to an individual's well-being. But instead of considering threats as "stressors" that elicited defensive and protective behaviors from the hyperaroused organism, the Rochester group conceptualized the most important of these behaviors in terms of "losses" and "deprivations" that caused the organism to become withdrawn, depressed and shut-down (Schmale 1958). The Rochester group was committed to preserving psychoanalytic theory and developed a complex psychodynamic sequences of disrupted relationships between individuals, affects of "helplessness" and "hopelessness," and a state of "conservation-withdrawal" in which physiological function was depressed rather than activated as in Selye's model to the point of creating a "final common pathway" to illness and death (Engel and Schmale 1972; NIH 2011).

In a large scale study of draftees undergoing the stress of basic training, Weiner, Thaler, Reiser, and Mirsky who were at the time at Walter Reed Army Hospital, showed that those who developed evidence of peptic ulcer had a high serum pepsinogen level as well as psychological conflict over dependency, and proposed an interactional model of genetic vulnerability, psychological conflict and stressful life situation in health and disease (Mirsky et al. 1957). This led to the formulation of a somato-psycho-somatic model of disease.

In the 1970s, the role of Type A Behavior in coronary disease showed that a simple behavior pattern that may be stress-enhancing could contribute to heart disease (Friedman and Rosenman 1974; Friedman and Ulmer 1984; Jenkins 1976). Occupational stress such as that of air traffic controllers was shown to be associated

with an increased incidence of hypertension, peptic ulcer, and diabetes (Cobb and Rose 1973). Accumulation of life changes, even positive ones, were shown to be stressful and contributing to morbidity (Rahe 1975; Rahe et al. 1970). The role of social support in health and disease also began to receive attention (Caplan et al. 1975; Cobb 1976; Cobb and Erbe 1978).

Also notable in the seventies was the translation of new theoretical insights into practical intervention strategies, a prelude to today's established field of *translational medicine*. Meyer Friedman and Ray Rosenman in San Francisco, who originally described the Type A personality, published a popular book which included practical chapters on how to "reengineer" one's daily life and develop "drills" to replace old and harmful habits (Friedman and Rosenman 1974). Herbert Benson of Harvard promoted a simple, non-religious technique to elicit the "relaxation response" as a counter to the stress-induced "emergency response." Relaxation response could be taught by physicians to patients as either a preventive or therapeutic strategy (Benson et al. 1975).

Biofeedback involves operant conditioning of both somatosensory and autonomic nervous systems, such as feeding back to the patient heart rate and blood pressure information as well as muscle tension by electromyogram. Biofeedback began to be utilized as practical clinical methods for managing hypertension and a variety of other conditions (Ciarica and Leigh 1981; Kluger et al. 1985; Leigh 1978; Schwartz 1979; Shapiro and Schwartz 1972).

The implication of these developments was that there was no single model or theory to explain psychophysiological pathogenesis, but that different models may co-exist for different conditions and individuals. It also became difficult to distinguish psychosomatic medicine theoretically from the rest of medicine, especially in view of the burgeoning development of new disciplines such as psychoneuroendocrinology and psychoneuroimmunology.

Thus, the idea that there are specific "psychosomatic diseases" became untenable. Psychosomatic medicine therefore became an attempt to understand the psychosocial aspects, including the role of stress, in health and illness (Engel 1997; Leigh and Reiser 1977).

23.1.3 Biopsychosocial Model

George Engel published a paper in *Science* in 1977 in which he proposed the "biopsychosocial model" to replace the dominant, reductionistic, "biomedical model" of disease (Engel 1977). Utilizing a general systems model, Engel proposed that health and disease must be understood considering the biological, psychological, and social factors that interact with each other. Even before Engel, Adolf Meyer of Johns Hopkins, among others, had proposed forms of comprehensive, biological, psychological, and social approaches to illness as early as 1915 (Christiansen 2007), but Engel's paper, published in the prestigious journal *Science* in 1977 when medical science was finally coming of age, was widely noticed and timely.

This model received much attention and acceptance particularly in psychiatry and psychiatric education. Biopsychosocial rounds, presentations, and biopsychosocial formulation became popular pedagogic tools. When it came to actual practice, however, it was not clear just how to gather the biopsychosocial data and utilize them. Attempts were made to operationalize the model, for example by Leigh, Feinstein, and Reiser at Yale who proposed the Patient Evaluation Grid. Patient Evaluation Grid is a nine field table of data formed by intersection of the three dimensions (biological, psychological, and social) and the three time contexts (current state, recent stresses and social support, and background- genetic, childhood, etc) (Leigh et al. 1980; Leigh and Reiser 1982, 1992).

Another similar attempt is the Intermed developed by Frits Huyse and colleagues in the Netherlands (Huyse et al. 1999; Stiefel et al. 2006). The Intermed is a similar grid to the Patient Evaluation Grid, but includes an additional domain (dimension) of Health Care, and the time perspectives of history, current state, and prognoses, resulting in a 12 field table. A significant feature of Intermed is that it defines 20 variables in the fields, which are scored. The score leads to different levels of management plan. Intermed has been adopted in a number of facilities in Europe, but neither of the operationalization attempts have gained much acceptance in the United States.

23.1.4 Consultation-Liaison Psychiatry and Psychosomatic Medicine

Consultation-liaison psychiatry, the practice of psychiatry and psychiatrically informed evaluation and treatment in general hospital settings, also tended to sub-specialize depending on the patient population, and specialized areas such as psychooncology, psychodermatology, and psychonephrology developed.

“Psychosomatic medicine” officially became a subspecialty of psychiatry in 2003 as a result of the efforts of the Academy of Psychosomatic Medicine (APM), which is composed mostly of consultation-liaison psychiatrists. APM explicitly states that the subspecialty is primarily concerned with the psychiatric co-morbidities of patients with medical, surgical, obstetrical, and neurological conditions, particularly for patients with complex and/or chronic conditions (“the complex medically ill”) (Gitlin et al. 2004). APM was successful in re-branding the subspecialty of “Psychosomatic Medicine” to “Consultation-Liaison Psychiatry” with the approval of the American Board of Psychiatry and Neurology (ABPN) as of January 1, 2018. APM also changed its name to Academy of Consultation-Liaison Psychiatry (ACLP) (Boland et al. 2018). For a comprehensive review of the development of Psychosomatic Medicine/Consultation-Liaison Psychiatry leading up to the re-branding, I would recommend Lipsitt’s *Foundations of Consultation-Liaison Psychiatry: The Bumpy Road to Specialization* (Lipsitt 2016).

Unlike APM, the American Psychosomatic Society, originally founded by Flanders Dunbar, continues to be a research-oriented, interdisciplinary organization (Lipsitt 2001). Complementary and Alternative Medicine (CAM) approaches con-

tinue to exist and some, such as mindfulness meditation and yoga are gaining increasing attention. These are discussed in some detail in Part I of this book as well as in the next section on research.

23.2 Current Research

As discussed above, psychosomatic research has become indistinguishable from general medical research in the United States, especially in the fields of psychoimmunology, psychoneuroendocrinology, epigenetics, as well as basic neuroscience research.

Even within consultation-liaison psychiatry, there is an abundance of research in subspecializations such as psychooncology, psychonephrology, psychodermatology, as well as with specialized patient populations such as those with HIV/AIDS, neurologic conditions, heart disease, etc. For up to date research in these fields, journals and publications dealing with the specific subjects are recommended.

I will here discuss three current areas of research that epitomize the two directions of investigation—basic science of stress and health care delivery.

23.2.1 *Stress and Epigenetics*

It was once believed that genes, once inherited, were fixed destiny. No more. Now it is known that what happens after conception and birth may turn on or off the gene entirely or in part.

DNA molecule itself is modified and inactivated by methylation of the cytosine rings in the dinucleotide sequence CG in vertebrates (Weaver 2007; Weaver et al. 2005). In addition, histone molecules around which the DNA is wrapped determines accessibility of the gene for transcription.

In the vertebrate genome, DNA methylation occurs in different patterns in different cell types. Since DNA methylation is part of the chemical structure of the DNA itself, it is more stable than other epigenetic markers. It is generally accepted that DNA methylation plays an important role in regulating gene expression. The methylation of DNA in distinct regulatory regions is believed to mark silent genes. Epigenomic screening of human chromosomes suggests that a third of the genes analyzed show inverse correlation between the state of DNA methylation at the 5' regulatory regions and gene expression (Lupien et al. 1998; McEwen 2007; Milutinovic et al. 2007). Aberrant silencing of tumor suppressor genes by DNA methylation seems to be a common mechanism in cancer (Razin and Kantor 2005; Rountree et al. 2001).

The DNA methylation pattern is established during early development and is maintained faithfully through life. DNA methylation pattern probably represents a balance of methylation and demethylation in response to physiological and environmental signals.

The epigenome consisting of both histone configurations and DNA methylation status determines the accessibility of the transcription machinery (Gould et al. 1997) and thus determines which genes are accessible for transcription. Inaccessible genes are therefore silent whereas accessible genes are transcribed. In addition, another level of epigenetic regulation by small, non-coding RNAs (microRNAs) has recently been described (Sapolsky et al. 1986).

23.2.1.1 Animal Studies in Epigenetics

Increased maternal licking and grooming (LG) behavior during the first week of life in rats causes DNA demethylation, increased histone acetylation, and increased hippocampal Glucocorticoid (auto)Receptor expression (Szyf et al. 2007), leading to decreased HPA activation to stress. Thus, the hippocampal GR promoter is methylated and hypoacetylated in offspring of low LG mothers and demethylated and hyperacetylated in offspring of high LG mothers. Weaver et al. also report that the central infusion of the histone deacetylase inhibitor trichostatin A (TSA) eliminated the maternal effect on histone acetylation, DNA methylation, hippocampal GR expression, and HPA responses to stress in the adult offspring of low LG mothers (Tremolizzo et al. 2002). On the other hand, central infusion of the adult offspring of high LG mothers with a methyl-donor, L-methionine, a precursor to *S*-adenosyl-methionine, resulted in increased methylation of the NGFI-A binding site on the hippocampal GR promoter, decreased GR expression, and increased HPA responses to stress (Taverna et al. 2007).

The difference in the methylation status between the offspring of High and Low LG mothers emerged over the first week of life, was reversed with cross-fostering, and persisted into adulthood. Weaver et al. have also shown that maternal care early in life affected the expression of hundreds of genes in the adult hippocampus (Szyf et al. 2007).

Physical environment, including environmental chemicals and toxins which interact with the epigenetic machinery during this critical period might also have a profound impact on behavior later in life by interfering with the maternal care driven epigenetic programming.

The epigenetic gene expression determined by the quality of maternal care during the first week of life seems to be potentially reversible as there is a dynamic equilibrium in methylation-demethylation reactions (Gould et al. 1997).

How does licking by mother or foster-mother affect the pup's gene methylation status in many parts of the brain? The perception of licking by the pup results in memes, i.e., new neural connections and potentiation of existing ones that may represent, in homo sapiens terms, "I am loved". It is these patterns of neural connections (memes) that affect other neural connections to result in neurotransmitter release and affect genes. The affected genes, in turn, affect the individual's perceptual bias and interpretation of life experiences in the future, and thus stress vulnerability or resilience (Leigh 2010).

23.2.1.2 Epigenetics—SERT (5-HTTLPR) Polymorphism as an Exemplar

An example of a single gene that codes for the vulnerability to multiple psychiatric and medical conditions is the serotonin transporter gene (SERT) and its promoter region polymorphism (5-HTTLPR). SERT is highly evolutionarily conserved, and regulates the entire serotonergic system and its receptors. DNA screenings of patients with autism, attention-deficit hyperactivity disorder, bipolar disorder, and Tourette's syndrome have detected signals in the chromosome 17q region where SERT is located (Murphy et al. 2004). The 5-HTTLPR polymorphism consists of short (s) and long (l) alleles, and the presence of the short allele tends to reduce the effectiveness and efficiency of SERT and individuals carrying the "s" allele tend to show increased anxiety responses and seem to show an increased risk of depression (Caspi et al. 2010; Lotrich and Pollock 2004; Sugden et al. 2010; Uher et al. 2011). The short-allele carriers have also been reported to have an increased risk for irritable bowel syndrome (Yeo et al. 2004) and migraine (Gonda et al. 2007). 5-HTTLPR short-allele carriers with neuroticism have been found to be more likely to smoke, especially to reduce negative mood and to feel stimulated, and have the most difficulty in quitting smoking (Hu et al. 2000; Lerman et al. 2000). On the other hand, the long allele has been reported to be associated with increased cardiovascular disease and reactivity (Brummett et al. 2011). A dietary deficiency in the serotonin precursor, tryptophan, has been shown to induce depression in healthy women with the 5-HTTLPR s/s, regardless of their family history of depression, while those with l/l were resistant to depression regardless of family history of depression (Neumeister 2003; Neumeister et al. 2006).

Caspi et al. have shown, in an elegant longitudinal study, that stress during the previous 2 years in adulthood and maltreatment in childhood interacted with the 5-HTTLPR status. Individuals with 2 copies of the short allele who also had the stressors had greatest amount of depressive symptoms and suicidality than heterozygous individuals, and those with only the long alleles had the least amount of depression (Caspi et al. 2003; Enoch 2006; Machado et al. 2006; Stein et al. 2008). Thus, the 5-HTTLPR short allele, in conjunction with childhood stress, may confer an individual with a trait of responding to later stress with increased anxiety, neuroticism, and subclinical depression (Gonda et al. 2005), which, in turn, may predispose the individual for later major depression, suicidality, bulimia (Ribases et al. 2008) and psychophysiologic disorders. There is evidence in humans that the methylation pattern of 5HTTLPR is altered with early stress and grief (Beach et al. 2014; Philibert et al. 2008; van et al. 2010). Studies in monkeys have shown that the anxiety-enhancing effect of the short allele is mitigated, i.e., turned off, with good mothering in infancy (Barr et al. 2004; Suomi 2003, 2005). SERT gene may be also be epigenetically affected by such stresses as bullying (Ouellet-Morin et al. 2013).

5-HTTLPR may also determine the response to drugs. Depressed individuals with the short allele were found to respond better to antidepressants that are both serotonergic and noradrenergic (i.e., mirtazapine), rather than serotonin specific reuptake blockers. On the other hand, individuals with the long allele may have more side effects with exactly those drugs that are more effective for those with the

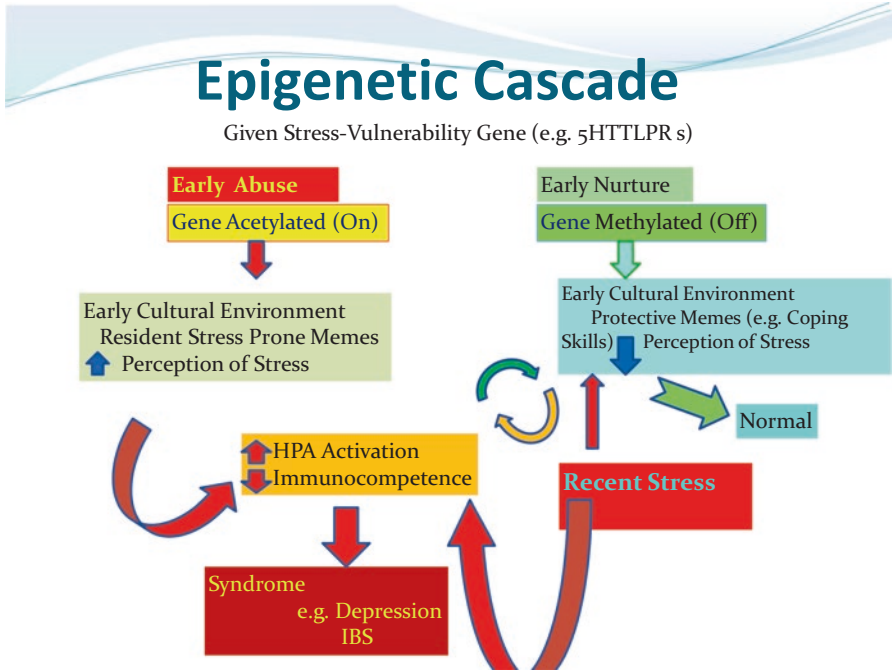


Fig. 23.1 An example of epigenetic cascade

short allele (Geller et al. 2004). This is an elegant example of genetic polymorphism interacting with stress and producing susceptibility to anxiety and depression, and influencing the treatment choice.

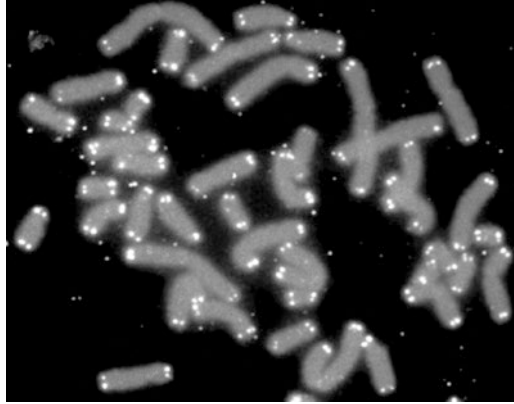
There are many other epigenetic research projects in nearly all fields of medicine, especially in cancer research (Cava et al. 2015; El-Awady et al. 2015; Harb-de la Rosa et al. 2015; Januar et al. 2015; la Rosa et al. 2015; Mehta et al. 2015; Stefanska and MacEwan 2015; Swierczynski et al. 2015) (Fig. 23.1).

23.2.2 Stress and Telomeres

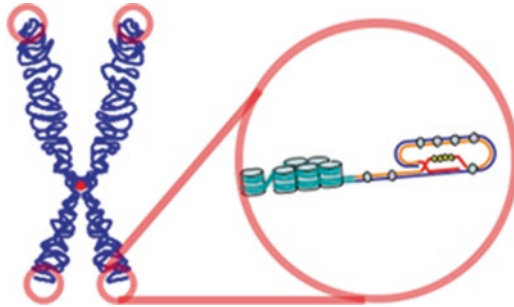
A *telomere* is the region at each end of a chromosome. Telomeres consist of repetitive nucleotide sequences which protects the end of the chromosome from deterioration or from fusion with neighboring chromosomes. For vertebrates, the sequence of nucleotides in telomeres is TTAGGG, which is repeated approximately 2500 times in humans (Hirai et al. 2012; Hukezalie and Wong 2013; Renciuik et al. 2009). The telomeres are shortened with each cell replication and their length is often considered to represent cellular aging. Telomeres can be replenished by the enzyme, telomerase (also known as telomere terminal transferase) (Blackburn 2005).

Human **chromosomes** (grey) capped by telomeres (white)

U.S. Department of Energy Human Genome Program—Transferred from [en.wikipedia](http://en.wikipedia.org/); transfer was stated to be made by User:gustavocarra (Original text: http://science.nasa.gov/media/medialibrary/2006/03/16/22mar_telomeres_resources/caps.gif)



“Telomere”. Licensed under CC BY-SA 3.0 via Commons—<https://commons.wikimedia.org/wiki/File:Telomere.png#/media/File:Telomere.png>



Elizabeth Blackburn from Australia, while working as a postdoctoral fellow at Yale University with Joseph Gall, discovered the unusual nature of telomeres, with their simple repeated DNA sequences capping chromosome ends. Their work was published in 1978 (Blackburn and Gall 1978). Later, at University of California, first Berkeley (UCB) and then San Francisco (UCSF), she and her colleagues further elaborated the role of telomeres and discovered that telomeres could be replenished by the enzyme, telomerase. She further elucidated the role of telomeres and telomerase in cancer and other disease states (Bhattacharyya and Blackburn 1994; Greider and Blackburn 1996; McEachern and Blackburn 1995).

Elizabeth Blackburn was awarded the 2009 Nobel Prize in Physiology or Medicine, together with Carol Greider of Johns Hopkins and Jack Szostak of Harvard, for the discovery of how chromosomes are protected by telomeres and the enzyme telomerase.

Telomere shortening and replicative senescence is thought to be indicative of bodily aging. Several genetic premature aging syndromes are characterized by cell senescence (Werner Syndrome, Progeria Hutchinson Guilford, and ataxia teleangiectasia). Many studies show that telomere length is linked to a variety of disease states. Shorter telomere length is related to aspects of cardiovascular disease, such as plaques, heart attacks (Erusalimsky and Kurz 2005), greater calcific aortic valve stenosis, vascular dementia and degenerative conditions such as osteoarthritis and osteoporosis (Benetos et al. 2004; Brouillette et al. 2003; Dudinskaya et al. 2015; Kota et al. 2014; Kurz et al. 2006; Pignolo et al. 2008; Valdes et al. 2007; von Zglinicki et al. 2000; Willeit et al. 2014; Zhai et al. 2006).

It has also been related to diabetes and general risk factors for chronic disease, including obesity and insulin resistance (Buxton et al. 2011; Chen et al. 2014a; Mundstock et al. 2015; Nordfjall et al. 2008; Valdes et al. 2005; Zannolli et al. 2008). Telomere length in leukocytes predicted earlier mortality in a community sample, and in samples with Alzheimer's disease and history of stroke (Epel et al. 2009; Honig et al. 2012; Jenkins et al. 2006).

Elissa Epel and her colleagues at UCSF, working with Blackburn, found that perceived stress and chronicity of stress in healthy pre-menopausal women was significantly associated with higher oxidative stress, lower telomerase activity, and shorter telomere length in peripheral blood mononuclear cells. They found that women with the highest levels of perceived stress had telomeres shorter on average by the equivalent of at least one decade of additional aging (Epel et al. 2004). It is now well established that stress, including abuse, causes telomere shortening (Chen et al. 2014b; Cohen et al. 2013; Epel et al. 2004; Humphreys et al. 2012; O'Donovan et al. 2011; Shalev et al. 2013) and telomere shortening may play a role in psychiatric illnesses including depression, anxiety disorders, and PTSD (Lindqvist et al. 2015).

Dispositional mindfulness, i.e. the tendency to describe and accept experiences, was shown to reduce corticosteroid stress response (Daubenmier et al. 2014; Epel et al. 2009). Does mindfulness meditation increase telomere length? In a study of 47 overweight/obese women, the UCSF group compared mindfulness-based intervention for stress eating and a wait-list control group. The changes in telomerase activity were examined from pre- to post-intervention. Both groups increased in mean telomerase activity over 4 months in intent-to-treat and treatment efficacy analyses ($p < 0.001$). Nonsignificant trends showed that greater attendance was associated with increases in telomerase, and telomerase increases were 18% higher among "as treated" participants compared to controls. While there was no clear effect of the intervention on telomerase activity, there was a striking pattern of correlations between improvements in psychological distress, eating behavior, and metabolic health and increases in telomerase activity. These findings suggest that telomerase activity may be in part regulated by levels of both psychological and metabolic stress (Daubenmier et al. 2012).

There is some evidence that comprehensive approaches directed at life style and psychological well-being may be conducive to enhancing telomere length and thus reduce cellular aging (Lin et al. 2012; Ornish et al. 2013; Shalev et al. 2013).

Both epigenetic research and research in cellular aging as represented by telomere length underscore the interaction among genes and life experiences including stress and nurturance in health and disease.

23.2.3 Health Care Delivery Research

23.2.3.1 Psychiatric disorders, Chronic Medical Disease, Primary Care

An area of research that is receiving increasing attention is how to provide mental health care to patients who are not usually aware of their mental health needs, who are usually found in primary care settings, and who are often patients with chronic medical disease.

Multiple community-based and primary care studies show that patients with anxiety and depressive disorders report significantly higher numbers of medically unexplained physical symptoms compared to those without psychiatric disorders (Katon et al. 1991, 2001, 2007; Kroenke and Price 1993; Simon et al. 1996, 1999). There seems to be a “dose–response” relationship with an increasing number of anxiety and depressive disorders associated with a linear increase in medically unexplained physical symptoms (Katon et al. 1991; Russo et al. 1994).

Katon and colleagues reviewed existing literature to examine the association of comorbid depression or anxiety with medical symptom burden in patients with arthritis [both rheumatoid arthritis (RA) and osteoarthritis (OA)], diabetes, heart disease [both coronary artery disease (CAD) and congestive heart failure (CHF)] and pulmonary disease [both asthma and chronic obstructive pulmonary disease (COPD)]. These illnesses were chosen because of their high prevalence rate and public health importance with each present in over 12 million Americans (Rundall et al. 2002). They found that patients with chronic medical illness and comorbid depression or anxiety, compared to those with chronic medical illness alone, reported significantly higher numbers of medical symptoms when controlling for severity of medical disorder. Across the four categories of common medical disorders examined, somatic symptoms were at least as strongly associated with depression and anxiety as were objective physiologic measures. Two treatment studies also showed that improvement in depression outcome was associated with decreased somatic symptoms without improvement in physiologic measures (Katon et al. 2007).

23.2.3.2 Coordinated Care, Collaborative Care, Integrated Care

In spite of the high prevalence of psychiatric co-morbidities with chronic medical disease, a majority of the co-morbid patients either delay or do not seek mental health care (Kessler 2005; Wang et al. 2005). Furthermore, The National Institute of Mental Health (NIMH) states that an estimated 26.2% of Americans ages 18 and

older—about one in four adults—suffer from a diagnosable mental disorder in a given year, which translates into 57.7 million people (NIMH 2008). Most of these patients do not seek mental health care per se, but it is reported that as many as 70% of primary care visits stem from psychosocial issues (Robinson and Reiter 2007). While patients typically present with a physical health complaint, data suggest that underlying mental health or substance abuse issues are often triggering these visits. Unfortunately, most primary care doctors are ill-equipped or lack the time to fully address the wide range of psychosocial issues that are presented by the patients.

A number of collaborative models between primary care and mental health care were developed in the late 1990s and early 2000s in an attempt to address the inadequacy of mental health services (Kathol et al. 2006).

Historically, innovative programs in collaboration and integration were first developed in settings like the Veterans Health Administration, and health maintenance organizations (HMOs), such as Kaiser Permanente. The Bureau of Primary Health Care within the U.S. Health Resources and Services Administration (HRSA) has also supported a number of initiatives around the country. Foundations such as the John A. Hartford Foundation, the John D. and Catherine T. MacArthur Foundation, the Robert Wood Johnson Foundation, and the Hogg Foundation for Mental Health have also funded projects that have helped define the field. Many of the projects have focused on the treatment of depression in primary care—an obvious choice because of depression's ubiquity in the population (Pautler and Gagne 2005).

The aims of collaborative care and integrated care are similar, but the difference is that collaborative care involves behavioral health working *with* primary care while integrated care involves behavioral health working *within* and as a part of primary care (Strosahl 1998).

In collaborative care, patients perceive that they are getting a separate service from a specialist, albeit one who collaborates closely with their physician. In integrated models, behavioral health care is part of the primary care and patients perceive it as a routine part of their health care.

There are three categories of mental health collaboration: Coordinated, Co-located, and Integrated.

Coordinated Care involves routine screening for mental health problems, e.g., depression, in the primary care setting, referral relationship between primary care and mental health, routine exchange of information between mental health and primary care and the primary care provider delivering mental health care utilizing simple algorithms.

Co-located Care occurs when medical services and mental health services are located in the same facility or location, with referral relationships. There is enhanced informal communication between the primary care provider and the mental health provider due to proximity, consultation between the two provider groups enhancing skills in both, and significant reduction of “no shows” for mental health treatment.

Integrated Care may occur in the same or separate locations between medical services and mental health services. Mental health service is provided by a team, usually consisting of a psychiatrist, and one or more of: care manager (who may be

a physician's assistant, nurse practitioner, nurse), social worker, family advocate, and behavioral health therapist. Routine screening for mental health problems in all patients, and one treatment plan with mental health and medical elements is devised for each patient with mental health problems usually following a protocol utilizing a step up care model. There is routine use of electronic database in tracking patients screened into mental health services (Collins et al. 2010). An evidence of successful care in this setting may be an improvement in the overall score on a screening instrument for depression, e.g., PHQ 9.

Currently, many integrated care initiatives are under way in the United States (Weaver 2008) and there have been many reports of successful outcome in various settings and populations (Asarnow et al. 2015; Awan et al. 2015; Bridges et al. 2014; Ho et al. 2015; Knowles et al. 2015; Ratzliff et al. 2015).

Basic Concepts of Integrated Care

There are four concepts common to all models of integrated care. Those concepts are the medical home, the health care team, stepped care, and the four-quadrant clinical integration (Collins et al. 2010).

The first of the four concepts, the *medical home*, or *health care home*, has become a mainstream theory in primary care. It has also recently gained national attention in recognition of its importance in caring for the chronically ill. The medical home concept is also one of the centerpieces of the Affordable Care Act (Obamacare) (Bartels et al. 2015; Lantz 2013; Sorrell 2013). The National Committee for Quality Assurance (NCQA) has defined criteria for a medical home—the patient-centered medical home—which includes standards that apply to disease and case management activities that are beneficial to both physical and mental health (NCQA 2008). These criteria include the following:

- patient tracking and registry functions
- use of nonphysician staff for case management
- the adoption of evidence-based guidelines
- patient self-management support and tests (screenings)
- referral tracking

Most medical homes are compensated by a “per-member-per-month” (PMPM) fee, and this fee may be enhanced if integrated physical–behavioral health care is incorporated.

The second concept common to all models of integrated care, is the *health care team*. In this approach, the doctor-patient relationship is replaced with a team-patient relationship. Applied to integrated care, members of the health care team share responsibility for a patient's care, and the message to the patient is that the team is their doctor.

The third concept, *stepped care*, is widely used in integrated care models. In stepped care model, except for acutely ill patients, health care providers should offer care that (1) causes the least disruption in the person's life; (2) is the least extensive needed for positive results; (3) is the least intensive needed for positive

Table 23.1 Four quadrants of clinical integration based on patient needs

	Quadrant II	Quadrant IV
High ↑ Behavioral health risk/Complexity	Patients with high behavioral health and low physical health needs Served in primary care and specialty mental health settings (Example: patients with bipolar disorder and chronic pain) Note: when mental health needs are stable, often mental health care can be transitioned back to primary care.	Patients with high behavioral health and high physical health needs Served in primary care and specialty mental health settings (Example: patients with schizophrenia and metabolic syndrome or hepatitis C)
Low ← Behavioral health risk/Complexity	Quadrant I	Quadrant III
	Patients with low behavioral health and low physical health needs Served in primary care setting (Example: patients with moderate alcohol abuse and fibromyalgia)	Patients with low behavioral health and high physical health needs Served in primary care setting (Example: patients with moderate depression and uncontrolled diabetes)
	Low ←	Physical health risk/Complexity → High

Source: Adapted from Mauer (2006) and Milbank Report (Collins et al. 2010)

results; (4) is the least expensive needed for positive results; and (5) is the least expensive in terms of staff training required to provide effective service. In stepped care, if the patient’s functioning does not improve through the usual course of care, the intensity of service is customized according to the patient’s response. The first step of behavioral care involves basic educational efforts, such as sharing information and referral to self-help groups. The second level “steps up” the care to involve clinicians who provide psycho-educational interventions and make follow-up phone calls. The third level involves more highly trained behavioral health care professionals who use specific practice algorithms. If a patient does not respond to these progressions of care (or if specialized treatment is needed), the patient is then referred to the specialty mental health system (Strohsal 2005).

The final concept is referred to as *four quadrant clinical integration*, which identifies populations to be served in primary care versus specialty behavioral health. Different types of services and organizational models are used depending on the needs of the population in each quadrant (Mauer 2006). This concept may also be used as a template for planning local health care systems (Table 23.1).

Implications and Challenges of Integrated Care

Integrated care, to the extent that mental health is an integral part of the medical team, is reminiscent of liaison psychiatry of the early part of the twentieth century, when psychiatrists made rounds with the medical team and tried to educate the primary physicians about the somato-psycho-somatic relationships and patient’s personality needs (See Part I of this book).

Liaison psychiatry prospered when funded by NIMH and when hospitals were prosperous, but withered with the advent of managed care with attendant cost-consciousness, i.e., hospitals and medical/surgical departments were unwilling to pay for psychiatric services that were either not billable or adequately reimbursed, even if such services were seen to improve patient care.

The impetus for today's integrated mental health movement comes from a genuine realization that providing mental health care to the vast number of hitherto underserved primary care patients would not only improve patients' health but also reduce the cost of medical care. The cost-consciousness led to the extensive use of physician extenders and non-psychiatrist care managers, and the use screening, algorithms, and stepped up care. Integrated care is continuing to develop and innovate in the United States (Chen et al. 2018; Grunauer and Mikesell 2018; Huitema et al. 2018; Kennedy-Hendricks et al. 2018).

This population-based approach with mass screenings clearly makes a form of mental health care available to a larger number of underserved patients albeit the quality of care may be diluted (e.g., patient first being seen and managed by a care manager than a psychiatrist). Intervention (treatment) based on mass screening is effective when the intervention has a high degree of effectiveness and a low degree of potential harm, e.g., immunization. If intervention has a low to moderate degree of effectiveness and a moderate degree of potential harm, as with most antidepressant drugs, it is doubtful that an algorithm-based treatment for depression without a careful evaluation by a psychiatrist actually does more good than harm, even if the PHQ 9 may show a little drop in depression.

23.2.4 *Research in Complementary and Alternative Medicine (CAM)*

23.2.4.1 **General Considerations**

There has always been a diversity of healing methods in the United States, and those that are not considered strictly orthodox fall in the category of CAM (Eisenberg et al. 2001; Kaptchuk and Eisenberg 2001a, b; Micozzi 2015).

Many Americans—more than 30% of adults and about 12% of children—use health care approaches developed outside of mainstream Western, or conventional, medicine. When describing these approaches, people often use “alternative” and “complementary” interchangeably, but the two terms refer to different concepts: If a non-mainstream practice is used **together with** conventional medicine, it's considered “complementary.” If a non-mainstream practice is used **in place of** conventional medicine, it's considered “alternative.” True alternative medicine is uncommon. Most people who use non-mainstream approaches use them along with conventional treatments (NCCIH 2015a).

The term, Integrative Medicine, is often used to denote the use of conventional and complementary approaches together in a coordinated way. The use of integra-

tive approaches to health and wellness has grown within care settings across the United States. There has been an explosion of research concerning the potential benefits of integrative health in a variety of situations, including chronic pain management, relief of symptoms in cancer patients and survivors, and programs to promote healthy behaviors.

The upshot of CAM research in terms of effectiveness is still rather controversial, though the efficacy of acupuncture in pain seems to be reasonably well established, as well as certain herbal treatments (Eshkevari et al. 2013; Hashmi et al. 2014; Micozzi 2015; Vase et al. 2015; Zeng et al. 2010, 2014, 2015) and Yoga (Doria et al. 2015; Garg et al. 2015; Innes et al. 2013; Kankane 2013; NCCIH 2015b; Rao et al. 2014). Mindfulness meditation and other types of meditative and relaxation techniques have also been found to be effective in a number of medical and psychiatric conditions (See Part I for more of this) (Buchholz 2015; Crowe et al. 2016; Lomas et al. 2015; Schellekens et al. 2016; Shapiro and Karceski 2015; Williams and Mercer 2015). There are also methodological issues in evaluating CAM research (Micozzi 2015).

It is of note that the 2015 Nobel Prize was awarded to Youyou Tu of China for *her discoveries concerning a novel therapy against Malaria* utilizing a traditional Chinese herbal medicine (Nobelprize.org 2015).

The Office of Alternative Medicine (OAM) was established as a part of National Institutes of Health (NIH) in October 1991, which was re-established as the National Center for Complementary and Alternative Medicine (NCCAM) in 1998, which subsequently became National Center for Complementary and Integrative Health (NCCIH) in 2014. NCCIH has funded a number of significant research projects in CAM.

There are CAM research oriented journals including, Journal of Complementary and Alternative Medicine, Complementary Therapies in Clinical Practice, Culture, Medicine and Psychiatry, and there are specialized journals on such CAM areas as in chiropractic, acupuncture, and massage therapy.

23.2.4.2 Placebo Effect

The Merriam Webster dictionary defines “placebo” as a usually pharmacologically inert preparation prescribed more for the mental relief of the patient than for its actual effect on a disorder (Merriam-Webster 2015). The term is used more broadly to include any effect of a substance or procedure that is given with the expectation of relief.

Placebo effect is usually considered to be the underlying mechanism for any unexplainable efficacy associated with CAM therapies. Placebo effect is important not only in relation to CAM but also in traditional research designs, i.e., placebo-control group vs. active treatment group. However, it is becoming clear, of late, that placebo is not inherently inert, but can have powerful effects, both beneficial and noxious (“nocebo” effect), through demonstrable physiologic and neural mechanisms, i.e., placebo is not “inert” (Benedetti et al. 2005; Freeman

et al. 2015; Stein and Mayberg 2005). For example, placebo efficacy in depression treatment was associated with regional metabolic increases in the prefrontal, anterior cingulate, premotor, parietal, posterior insula, and posterior cingulate and metabolic decreases involving the subgenual cingulate, parahippocampus, and thalamus. Regions of change overlapped those seen in those who responded to fluoxetine. Fluoxetine response, however, was associated with additional subcortical and limbic changes in the brainstem, striatum, anterior insula, and hippocampus which are sources of efferent input to the response-specific regions identified with both agents (Mayberg et al. 2002). Placebos have been found to cause reduced activity in single neurons in the subthalamic nucleus of placebo-responsive Parkinsonian patients. These changes in activity were tightly correlated with clinical improvement; no decrease in activity occurred when the clinical placebo response was absent (Benedetti et al. 2004; Shetty et al. 1999). Placebo analgesia in some subjects is reversed with naloxone, suggesting an endorphinergic mechanism, among others (Amanzio and Benedetti 1999; Benedetti and Amanzio 1997).

Acupuncture analgesia also seems to be mediated through mostly endorphinergic mechanisms (Cao 2002; Nezhentsev and Aleksandrov 1993; Omana et al. 1994; Staud 2007; Staud and Price 2006; Zhang et al. 2011). Hypnoanalgesia, on the other hand, is not reversed with naloxone (Spiegel and Albert 1983).

The nature of placebo effect including genetic influences as well as novel uses of placebos are being investigated (Grelotti and Kaptchuk 2011; Hall et al. 2014, 2015; Jensen et al. 2012; Kaptchuk and Miller 2015; Raicek et al. 2012; Vase et al. 2013; Wells and Kaptchuk 2012). Of note is that “non-deceptive” placebo, i.e., patients being presented with “placebo pills made of an inert substance, like sugar pills, that have been shown in clinical studies to produce significant improvement in IBS symptoms through mind-body self-healing processes” was shown to be more effective in improving the symptoms of irritable bowel syndrome and quality of life compared to controls with same amount of physician contact in one study (Kaptchuk et al. 2010).

23.3 Education

23.3.1 *Medical School Undergraduate Education*

In the United States, there are 157 accredited medical schools (MD) (AAMC 2015) and 35 osteopathic schools (DO) (AACOM 2015). As discussed above, contemporary research in medicine, particularly in the neurosciences, is indistinguishable from “psychosomatic” research, and thus a comprehensive approach in diagnosis and treatment, i.e., the biopsychosocial model, is widely accepted in medical school curriculum. However, the translation of this approach to actual medical practice is at best spotty due to, among others, a lack of a widely accepted operational model and the time constraints in a managed care environment.

A more formal education in consultation-liaison psychiatry occurs in many medical schools through rotation of medical students in the psychiatric consultation-liaison service. Students who have special interest in mind-brain-body issues and psychiatry often choose psychiatry for their residencies, and then often enter a fellowship program in psychosomatic medicine.

23.3.2 Psychosomatic Medicine & Consultation-Liaison Psychiatry Training in Psychiatry Residency Programs

Accreditation Council for Graduate Medical Education (ACGME) requires a 2 month FTE experience in consultation-liaison (CL) psychiatry for accredited psychiatric residency programs (ACGME 2014). The CL experience may be in full time blocks or part-time longitudinal experience, e.g., half time for 4–6 months. Many programs provide more than 2 months full time experience, including elective rotations later in residency. The CL experience may be with medical/surgical inpatients in a general hospital, or with ambulatory care patients in a primary care setting, or both.

23.3.3 Mental Health Training in Primary Care Residencies

Perhaps more so than in medical schools, the amount of mental health training in postgraduate residencies in the United States seems to depend on the specialty and the specific program.

In a survey of 1365 directors of accredited residency training programs IM, FP, Ob/Gyn and Peds, Leigh et al. (2006a, b) found that mental health training occurred most often in didactic sessions and case conferences across specialties. Only FP programs offered special courses and joint rounds in significant numbers (25%). All types of primary care programs utilized the ambulatory care setting extensively for psychiatric teaching, regardless of whether it was done by mental health professionals or primary care physicians. A great majority of IM (71%), Ob/Gyn (92%) and Peds (85%) training directors felt that the training was minimal or suboptimal, as compared to 41% of FP training directors, a statistically significant difference.

23.3.4 Postgraduate Psychosomatic Medicine Programs

There are 56 ACGME accredited Psychosomatic Medicine Fellowship programs in the United States as of October, 2015 (ACGME 2015b). The training program is usually 1 year in duration, and must meet the ACGME requirements for supervision

and resources (ACGME 2015a). As of 2013, there were 1284 psychiatrists were certified in the subspecialty of Psychosomatic Medicine (ABMS 2014).

Psychosomatic medicine (PSM or CL Psychiatry) specialists usually work in CL settings in general hospitals and, increasingly, in medical/surgical subspecialty settings such as oncology, HIV/AIDS clinics, etc. There will be increasing need for PSM in the team settings in integrated care settings (see above Research section).

23.3.5 Health Psychology

Psychologists participated prominently in psychosomatic research but the discipline of psychology did not have distinct branch related to health and disease until Health psychology began to emerge as a distinct discipline of psychology in the United States in the 1970s. In the mid-twentieth century there was a growing understanding in medicine of the effect of behavior on health (Wikipedia 2005). For example, the Alameda County Study, which began in the 1960s, showed that people who ate regular meals (e.g., breakfast), maintained a healthy weight, received adequate sleep, did not smoke, drank little alcohol, and exercised regularly were in better health and lived longer (Belloc and Breslow 1972). Relationships between psychological processes and physiological ones continued to be developed (Sterling and Eyer 1981). These discoveries include a better understanding of the impact of psychosocial stress on the cardiovascular and immune systems, and the finding that the functioning of the immune system could be altered by learning (Ader and Cohen 1975).

The American Psychological Association (APA), led by Joseph Matarazzo, added a division devoted to health psychology in 1977. At the first divisional conference, Matarazzo delivered a speech that played an important role in defining health psychology. He defined the new field in this way, “Health psychology is the aggregate of the specific educational, scientific and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, the identification of diagnostic and etiologic correlates of health, illness and related dysfunction, and the analysis and improvement of the healthcare system and health policy formation.” (Matarazzo 1980).

Stemming from clinical psychology, four divisions within health psychology and one related field, occupational health psychology (OHP) developed over time. The four divisions include clinical health psychology, public health psychology, community health psychology, and critical health psychology. Health psychologists typically hold a doctoral degree (Ph.D. or Psy.D.) in psychology. Applied health psychologists are licensed for the independent practice of psychology in areas such as clinical and counseling psychology. Advanced credentialing in the US as a clinical health psychologist is provided through the American Board of Professional Psychology.

23.3.6 Social Work Schools

Social Workers perform a broad spectrum of duties ranging from providing support to those faced with difficult situations, emotional stresses, or significant change in their lives to clinically diagnosing emotional, behavioral, or mental health disorders in individuals. Not only do they help the individuals cope with the situation at hand, they advocate for them and seek out valuable resources and other means of support for the affected person(s). Social work degrees may be at the bachelor's, master's, and doctorate level. State licensing boards usually require a master's degree in social work to be licensed. The Council on Social Work Education (CSWE) accredits baccalaureate and master's level social work programs within the United States (SocialWorkLicensure.org 2015).

23.3.7 Complementary and Alternative Medicine (CAM) Education

A 1997 national survey estimated that in the previous year 42.1% of the adult population in the United States had used at least one of the complementary/alternative therapies included in the survey. This is an increase from 33.8% in 1990. The therapies included in the survey were relaxation techniques, herbal medicines, massage, chiropractic, spiritual healing by others, megavitamins, self-help groups, imagery, commercial diets, folk remedies, lifestyle diets, energy healing, homeopathy, hypnosis, biofeedback, and acupuncture (WHO 2001).

23.3.7.1 Medical Schools and Schools of Osteopathic Medicine

The push to bring CAM into medical training began in 1999 when the National Center for Complementary and Alternative Medicine (NCCAM) launched the CAM Education Project (Howell 2012). Currently, a group of more than 50 U.S. and Canadian medical schools and teaching hospitals, called the Consortium of Academic Health Centers for Integrative Medicine, includes CAM in its curricula. CAM education in medical schools is not geared to training CAM practitioners, but to provide physicians with knowledge concerning it so that they can discuss the pros and cons and precautions concerning CAM with their patients.

Manipulation taught in osteopathic schools may be considered a CAM technique.

23.3.7.2 Chiropractic Schools

Doctor of chiropractic (DC) degree is granted by chiropractic colleges accredited by the Council on Chiropractic Education (CCE), which is recognized by the US Department of Education. There are 15 accredited chiropractic colleges in US (CCE 2015).

Chiropractors are eligible to seek licensure in all jurisdictions. The minimum prerequisite for enrollment in a chiropractic college set forth by the CCE is 90 semester hours, and the minimum cumulative GPA for a student entering is 2.8 on a 4.0 scale. Common prerequisite classes include those of the biological, chemical, and physical sciences, including anatomy, physiology, embryology, cell biology, kinesiology, toxicology/pharmacology, biomechanics, etc. During the 4 years of chiropractic college, students are taught basic sciences, “physiological therapeutics”, chiropractic techniques, as well as diagnostic imaging, neurology, etc. They must also pass a four part National Board examination (Yeomans 2009).

23.3.7.3 Acupuncture

The Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) was founded in 1982 by the Council of Colleges of Acupuncture and Oriental Medicine and the American Association of Oriental Medicine and is recognized by the U.S. Department of Education as a “specialized and professional” accrediting agency. It now accredits both master’s degree and post-graduate doctoral programs in acupuncture and in Oriental medicine (DAOM) (ACAOM 2012).

Most states grant acupuncturist license although the requirements vary. 43 states plus the District of Columbia require the passage of the NCCAOM examinations or NCCAOM certification as a prerequisite for licensure (NCCAOM 2015).

23.3.7.4 Therapeutic Massage

Most states grant license in therapeutic massage after completion of required training and examination (ABMP 2015).

23.3.7.5 Herbal Medicine, Yoga

There is no official state license for herbalists, and herbology is mostly taught online. There is no official state license for Yoga and there are different certifying bodies for Yoga teaching. The Yoga Alliance, formed in 1997, sets minimum standards for teacher training programs (Hasselink 2015).

23.3.7.6 Homeopathy & Naturopathy

At the turn of the twentieth century there were 22 homeopathic medical schools in the U.S. Perhaps the best known is Hahnemann University, which was established in 1848 as the Homeopathic College of Pennsylvania, but in 1884 it became Hahnemann Medical College of Philadelphia shedding the homeopathic designation, eventually becoming Drexel University Medical School in 2002 (AAUP 2000; drexel.edu 2015).

There are now ten homeopathic schools and five naturopathic schools that also have homeopathic programs. There are also on-line courses on homeopathy (Ullman 2015).

23.3.8 Licensing

23.3.8.1 Physician

Medical license in the United States is granted by the states, but in order to obtain the qualifying degrees of Doctor of Medicine (MD) or Doctor of Osteopathy (DO), the applicant must have graduated from an accredited school of medicine or osteopathic medicine and successfully passed the qualifying examinations.

Students and graduates of accredited U.S. or Canadian medical schools must take Step 1 and Step 2 of the United States Medical Licensing Examinations (USMLE) with the National Board of Medical Examiners (NBME). Students and graduates of medical schools outside the United States or Canada register for Step 1 and Step 2 with the Educational Commission for Foreign Medical Graduates (ECFMG). Graduates of medical schools in and outside the United States and Canada register for Step 3 with the Federation of State Medical Boards (FSMB). Step 1 covers mostly basic sciences, Step 2, clinical medicine, and Step 3, actual simulations of medical practice. The USMLE program recommends that for Step 3 eligibility, licensure authorities require the completion, or near completion, of at least one postgraduate training year in an accredited program.

U.S. osteopathic medical school graduates may take either the USMLE examinations or the multi-part Comprehensive Osteopathic Medical Licensing Examination (COMLEX). Students who have graduated from medical schools outside the US and Canada must pass all three steps of the USMLE to be licensed to practice in the US (FSMD&MBME 2015).

23.3.8.2 Clinical Psychologist

Licensure for clinical psychology in the United States is granted by the states and the requirements differ depending on the state. The common elements include a degree from an approved educational program, a minimum amount of supervised clinical experience, and passing an examination (Dittmann 2015).

The doctorate programs in the U.S. are either PhD programs that have a strong focus on research or PsyD (doctor of psychology) programs that are more clinically oriented.

Some U.S. schools offer accredited programs in clinical psychology resulting in a Masters degree. Many graduates from Masters-level training go on to doctoral programs but a large number also go directly into practice as a Licensed Professional Counselor (LPC), Marriage and Family Therapist (MFT) or Licensed Psychological Associate (LPA).

23.3.8.3 Nurse

Various nursing schools grant different degrees leading to different licensure. Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) may be obtained after 2 years of training in a trade school, community college or technical school. Associate Degree in Nursing (ADN) requires completion of 2 or 3 years of college work and, after passing a national examination (National Council Licensure Examination, NCLEX-RN), leads to the Registered Nurse (RN) designation. Bachelor of Science in Nursing (BSN) degree leads to RN. Master of Science in Nursing (MSN) degree leads to advanced practice in nursing, including Nurse practitioner (NP), Certified nurse anesthetist (CRNA), Clinical nurse specialist (CNS), and Certified nurse midwife (CNM). Some graduate nursing programs lead to doctorates, including Doctor of Nursing Practice (DNP), Doctor of Nursing (DON, ND): Doctor of Nursing Science (DNSc) and Doctor of Nursing Philosophy (PhD) (Directories [2015](#)).

Nursing licenses, granted by the states, entitle the use of nursing titles such as registered nurse (RNs), licensed practical/vocational nurses (LPN/LVNs), advanced practice registered nurses (APRNs).

23.3.8.4 Social Worker

All states and the District of Columbia require that a social worker attain some sort of license, certification, or registration before practicing. Most States require 2 years or a total of 3000 hours of supervised clinical experience for the social worker to be licensed. It is also expected that social workers respond in an emotionally mature, impartial, and delicate manner to people and their difficulties (SREducation [2014](#)). The Association of Social Work Boards (ASWB) is the organization of the social work regulatory boards and colleges, and administers the social work licensing examinations in the United States and Canada (ASWB [2015](#)).

23.3.8.5 CAM Practitioners and Products

In the United States, regulatory controls surrounding complementary/alternative medicine involve six related areas of law: licensing, scope of practice, malpractice, professional discipline, third-party reimbursement, and access to treatments. State laws dominate the first five areas. Federal laws, particularly food and drug laws, largely control the sixth. In each of these areas, legal rules aim to safeguard consumers against fraud and to ensure patient protection against dangerous practices and practitioners (WHO 2001).

State licensing laws provide the requirements for licensing of chiropractors, massage therapists, and naturopaths. Currently, 43 states plus the District of Columbia license acupuncturists after passing a qualifying examination (NCCAOM 2015).

Non-licensed providers of complementary/alternative care (such as homeopaths, herbalists, nutritionists, and spiritualists not practicing within the tenets of a specific recognized religion) who exceed their legislatively authorized scope of practice risk prosecution for unlicensed medical practice.

Medicinal substances used to diagnose, cure, or mitigate disease are classified under federal law as new drugs and are thus subject to extensive premarketing approval to show safety and efficacy before they may be used (WHO 2001). However, “dietary supplements” including a large number of herbal preparations are exempt from FDA regulation (e.g., St. John’s Wort).

According to FDA, a dietary supplement is a product taken by mouth that is intended to supplement the diet and that contains one or more “dietary ingredients.” The “dietary ingredients” in these products may include Vitamins, minerals, herbs or other botanicals, amino acids and other substances found in the human diet, such as enzymes.

Dietary supplement manufacturers and distributors are not required to obtain approval from FDA before marketing dietary supplements. Before a firm markets a dietary supplement, the firm is responsible for ensuring that the products it manufactures or distributes are safe, any claims made about the products are not false or misleading, the products comply with the Federal Food, Drug, and Cosmetic Act and FDA regulations in all other respects (FDA 2015).

FDA held a hearing in April, 2015 on homeopathic product regulation. Invitees representing the scientific and medical community, and various pro-homeopathy stakeholders, gave testimonials on homeopathic products and recommended FDA regulation of homeopathic drugs (Frazier 2015).

23.4 Practice

The practice of psychosomatic medicine in the United States, as in other countries, is not uniform and depends on which definition of psychosomatic medicine is used. In the sense of comprehensive approach to patients, e.g., the biopsychosocial

model, then it is practiced to varying degrees by all health care professionals. Psychosomatic medicine (CL Psychiatry), as a subspecialty of psychiatry, is practiced in various medical settings by psychiatric consultants. As CAM or integrative medicine, certain indigenous techniques, such as meditation, have become medicalized and incorporated to varying degrees in orthodox medical practice. Others are either practiced by specific CAM practitioners in certain subpopulations (e.g., Native Americans, Southeast Asians), or in the general public (e.g., herbal medicine as “dietary supplements” and chiropractics).

23.4.1 Consultation-Liaison Psychiatry

Consultation-liaison (CL) psychiatry is mainly practiced in general hospitals, primary care settings, chronic and palliative care settings, specialized care settings (e.g., HIV/AIDS, oncology), and emergency settings (Blumenfield and Strain 2006; Leigh and Streltzer 2015; Stern 2010).

23.4.1.1 General Hospital Inpatient Setting

Depending on the size and nature of the general hospital, the nature and availability of psychiatric consultation varies greatly. In relatively small hospitals, it is not uncommon to have no psychiatric coverage at all—patients who obviously require psychiatric care, such as severely psychotic or suicidal patients are transferred to a psychiatric hospital or a larger general hospital where psychiatric consultation is available.

Most general hospitals affiliated with a medical school have psychiatric consultation available, either by psychiatrists (who may be full time or more commonly part time) and/or allied professionals such as social workers or nurse clinicians with varying degrees of psychiatric training.

In general hospitals with major affiliation with medical schools, there is usually a psychiatric consultation-liaison service that provides both service and training of psychiatric residents and/or medical students. Such formal CL services usually consist of a director (usually a psychiatrist), other faculty and staff (psychiatrists, psychologists, social workers, nurses, secretary, in varying combinations). Residents of primary care specialties such as internal medicine and/or family practice may also participate (Leigh et al. 2006a, b, 2008).

In CL services with major teaching function, psychiatric consultation is usually requested on-line through the hospital electronic medical record system, and consultation is performed jointly by the team supervised by the attending psychiatrist (Leigh 1987; Leigh and Streltzer 2015; Stern 2010).

Recently, a proactive model of CL in which a psychiatrist attends medical rounds and reviews all patients and identifies those who will require psychiatric care and arranges it, often through non-psychiatrist care managers, has been

shown to be effective (Desan et al. 2011; Sledge et al. 2015). This is somewhat related to old liaison psychiatry model and the new integrated care model in primary care settings.

Psychosomatic medicine practice in specialized care settings exist both in inpatient (e.g., ICUs, CCUs, Stroke Units, Palliative Care, etc.) and outpatient settings (e.g. Hemodialysis, Chemotherapy/Radiation therapy, HIV/AIDS, etc.). Psychiatric consultation in those units may be performed by the general CL Service or by a psychiatrist, usually who is certified in CL Psychiatry (psychosomatic medicine), with a special interest and expertise in these specialized areas. The Academy of Consultation-Liaison Psychiatry, formerly Academy of Psychosomatic Medicine, the major organization of CL psychiatrists, has the following special interest groups for specialized areas as of this writing: Bioethics, Cardiovascular Psychiatry, Emergency Psychiatry, Global Health, HIV/AIDS Psychiatry, Pediatric Psychosomatic Medicine (CL Psychiatry), Telepsychiatry, Transplant Psychiatry, and Women’s Health (APM 2015). Specialized evaluations and treatments may be performed in these settings, e.g., psychiatric evaluation prior to transplant or bariatric surgery, evaluation for capacity to terminate hemodialysis, psychotropic drug interactions with retroviral drugs, etc.

23.4.1.2 Primary Care Setting

CL psychiatry in the primary ambulatory care settings varies depending on the size and nature of the setting. There may be no psychiatrist available in smaller settings and the primary care physician (PMD) may have to refer patients to psychiatrists in the community or to an affiliated outpatient facility. Part-time psychiatrists may be available for certain periods of time in other facilities. In larger integrated care settings, such as the Veterans Administration facilities or Kaiser, and in most medical school affiliated settings, there are usually designated CL services for primary care.

The CL services vary in size and function—there is usually at least one full or part time psychiatrist, and in a teaching setting, trainee(s) such as medical student(s), students of allied professions (e.g., nursing, social work, psychology), resident(s) (e.g., psychiatry, medicine, family practice). There may be a nurse and/or a social worker and/or a psychologist who may be either assigned to or designated as liaison to the CL service. The CL service is usually co-located with the primary care team.

In this model, the CL service responds to consultation requests by the primary care team, and patients are evaluated by the CL service either during the same visit as the primary care or by a separate appointment. Treatment recommendations are made to the primary care physician. Follow-up visits may be arranged with the CL team.

In the Integrated Care model, there is usually a team consisting of a psychiatrist (full or part time) and one or more care managers who are usually nurse practitioners. The care manager is imbedded in the primary care team, and evaluates patients screened for mental health problems such as depression. (See section “[Basic Concepts of Integrated Care](#)” for concepts and description of the integrated care model).

Utilizing the stepped care model, the care manager, under the supervision of the psychiatrist, may recommend medications to the PMD. The care manager may provide mental health education/counseling to the patient either in group or individual sessions, and may refer the patient for psychotherapy. If the patient does not respond to these interventions, the patient is referred to the psychiatrist for specialized treatment, including possible psychiatric hospitalization. The psychiatrist also responds to ad hoc curbside consultations and questions by the PMDs.

23.4.2 Practice of Complementary and Alternative Medicine (CAM)

Certain practices which originated from CAM have been fully integrated with medical/psychiatric practice, such as mindfulness meditation, acupuncture, and relaxation techniques. In the United States, however, CAM is often considered in patients who have “failed” in mainstream medical/surgical treatment, for example, chronic back pain. For such patients, acupuncture, meditation, or even chiropractics may be suggested by the medical establishment. The patient or family/friends may also suggest CAM often out of frustration.

As there is no formal referral mechanism for CAM, and coverage varies depending on insurance status, it is up to the consumer to seek out CAM if desired. Over the counter, “dietary supplements” including herbal medicine, are not usually covered by medical insurance.

There are about 300,000 massage therapists and more than 54,000 licensed chiropractors in the United States. There are about 28,000 licensed professional acupuncturists. There are approximately 3,000 homeopaths, most of them licensed physicians. There are about 7,000 naturopaths, for whom license can be granted in 17 states. There are hundreds of Ayurvedic practitioners (Micozzi 2015).

CAM treatments can be quite harmful as illustrated by a recent case in which a homeopathic physician was reprimanded and fined by the Florida Medical Board. The physician’s patient, a toddler, died soon after being given a dose of amygdalin (also known as laetrile) to treat her advanced eye cancer. Amygdalin, whose active component is believed to be cyanide, is not approved by the US Food and Drug Administration (FDA) (Ault 2015).

The use of over the counter, “dietary supplements”, such as vitamins, minerals, glucosamine, valerian root, etc. is quite common in the general population.

There are also specific indigenous non-Western medical practitioners in subcultures such as of the Hmong (e.g., Shaman) and Native American (e.g., Medicine Man).

23.5 Conclusions

The United States is a diverse country where many different ideas, traditions, and practices are introduced, intermingle, interact, recombine, evolve, and develop. It is where the East and West, North and South, meet, interact, and flourish. Psychosomatic Medicine was introduced into the US from Europe by emigres such as Franz Alexander, giving rise to both psychosomatic research and the practice of psychodynamic principles in the general hospital, the beginnings of Consultation-Liaison Psychiatry. American pioneers such as Flanders Dunbar at Columbia University and George Engel at University of Rochester consolidated the field of psychosomatic medicine/consultation-liaison psychiatry. Adolf Meyer of Johns Hopkins University and Thomas Hackett of Harvard, among others, were early major figures in training medical students and psychiatrists in the principles of comprehensive care, who, in turn, inspired and trained many more. Consultation-Liaison Psychiatry eventually redefined itself as psychiatry practiced in the general hospital setting with emphasis on co-morbidities of psychiatric and other medical conditions and collaborative and integrated care of patients with such patients (Boland et al. 2018; Lipsitt 2016).

In terms of research, psychosomatic research evolved into comprehensive research concerning various social and psychological factors interacting with pathophysiology, biochemistry, genetics, epigenetics, as well as the role of information (memes) in the processes. In a sense, then, “psychosomatic” research is supplanted and replaced by such new fields as psychoneuroendocrinology, psychopharmacology, epigenetics, memetics and information research, and neuroscience in general.

The holistic approach to illness from indigenous cultures including Native American and CAM approaches such as acupuncture and Yoga are undergoing natural selection and evolution, resulting in some widely accepted practices such as Mindfulness training.

Unfortunately, as of this writing, the future of Consultation-Liaison Psychiatry in the US is uncertain, as the Affordable Care Act and its support of the integrated care model are in jeopardy due to the regressive and hostile attitude of the Trump administration toward improved health care and science in general. In spite of this, the outlook for comprehensive research is bright because the rapid pace of development in genetics, epigenetics, neuroscience, and informatics has now reached an unstoppable momentum.

Questionnaire Response

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry in your (or your chapter's) Country.

Please return this as an attachment to your email

Country on which you are reporting:

Your Name: Hoyle Leigh

Institution: UCSF

City & Country (e.g. London, UK): San Francisco, CA

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?
 Yes () No () In some sense ()
 - a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes () No ()
 - b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes () No ()

2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?
 Yes () No ()

Is teaching of psychosomatic medicine in medical schools required by law or health care system in your country? YES () No ()

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?
 Yes () No ()

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No ()
 - a. If YES, which?
 Psychosomatic Medicine () Consultation-Liaison Psychiatry ()
 - b. If YES, the status of such certification is:
 - i. Independent Medical Specialty ()
 - ii. Subspecialty of Internal Medicine ()

iii. Subspecialty of Psychiatry ()

iv. An independent non-medical discipline, as Psychology, Social Work ()

v. Other (Specify): []

5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No ()

If YES, please list names of the organizations and the websites if available:

Academy of Consultation-Liaison Psychiatry

American Psychosomatic Society

6. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:

Psychosomatics

Psychosomatic Medicine

General Hospital Psychiatry

Int'l J of Psychiatry in Medicine

7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in your country? Yes () No ()

a. If YES, where does it occur? Check all that apply:.

b. Medical School () Residency () Fellowship ()

8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes () No ()

9. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)

a. It is insignificant ()

b. Some subgroups (e.g. ethnic, religious) practice it ()

c. A significant part of the general population practice it ()

d. Is the most prevalent healing method used ()

e. It is often used in combination with Western medicine ()

f. More widely used methods are as follows (Please list, e.g., spiritual healing, meditation, herbal, etc):

10. Please add any comments to your response here:

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Chapter 24

Canadian Consultation-Liaison Psychiatry/ Psychosomatic Medicine: A Discipline Still Waiting for Official Recognition and Patient Care Accessibility



Fabien Gagnon

24.1 Psychosomatic Medicine or Consultation-Liaison Psychiatry?

Like in many other countries, there have been numerous discussions about the differences between the terms “psychosomatic medicine” and “consultation-liaison psychiatry”, in Canada. The term consultation-liaison psychiatry is heard more often than psychosomatic medicine. For many Canadian clinicians, psychosomatic medicine is associated with the beginning of C-L psychiatry and its close relationship to the psychoanalytic approach. Consultation-liaison psychiatry is generally used to refer to the more recent type of activities done by psychiatrists working in complex medical-surgical environments (inpatient: general hospital medical-surgical wards, intensive care units, coronary care unit, etc.; outpatient: specialized medical clinics like pain clinics, cystic fibrosis clinics, dialysis units, eating disorders clinics, integrative care units, etc.).

In 2005, Dr. Louis van Zyll (Queen’s University) and I (Dr. Fabien Gagnon, Université Laval) co-founded the Canadian Academy of Psychosomatic Medicine (CAPM). At the time, the Canadian Psychiatric Association (CPA), which was actively supporting the foundation of CAPM, suggested that we use the term “Psychosomatic Medicine” instead of “Consultation-Liaison Psychiatry”. For many of the CPA board members consulted on that question, psychosomatic medicine was the term used by the American Academy of Psychosomatic Medicine to help psychosomatic medicine’s recognition as a specialty in the United States. Accepting their recommendation, the name became the Canadian Academy of Psychosomatic Medicine. Interestingly, almost at the same time, residency programs across Canada essentially offered, and continue to offer, “Consultation-Liaison psychiatry”

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rotations. Also, the Academy of Psychosomatic Medicine (U.S.A.) recently changed its name to the Academy of Consultation-Liaison Psychiatry. I will use the two terms interchangeably, although slight differences in meaning may exist.

24.2 Before and Around World War II/The Period of a Developing “Interest”

At the beginning of the twentieth century, in Canada, medicine was practiced by general practitioners working in community offices/clinics, at patient’s homes, or in general hospitals where “specialists” would also be found. Psychiatric patients were at the time treated in separate hospitals designated for psychiatric care. There was almost no access to mental health care in general hospitals for medical-surgical patients.

Around the time of the second World War, some psychiatrists in major cities like Montreal, Toronto and Vancouver, became “interested in medical patients” who were presenting somatic symptoms which intrigued their medical colleagues. Generally, these psychiatrists had trained as psychoanalysts and worked in Canadian university settings. They had trained in Europe (primarily Germany and Austria, and others from England, Scotland and France) and many came to Canada to flee the evolving political and social situation in Europe. Most of them brought with them an interest to understand the interface between medical symptoms and psychiatry, and how those medically symptomatic patients could be helped by psychiatry. Some of them previously had the opportunity to work at a psychiatric hospital half of their work day, and work at a psychoanalytic institute the rest of the day. Most often, it is at the psychoanalytic institute (not at the psychiatric hospital nor at a general hospital) that they could meet medical patients referred by the treating medical-surgical physicians. There they could try to explore the patient’s somatic symptomatology or complaints influenced by biological factors, but also by psychological and socio-environmental factors.

After being discovered by French explorers, Canada became a colony of France. Following major battles between French and British armies, Canada changed hands to be a British colony. As a result of this history, there are two official languages in Canada: English and French. French Canadians are dispersed across Canada, but there are two major provinces where French is spoken: Quebec and New Brunswick. The Canadian psychiatrists interested by psychosomatic medicine were from these two different backgrounds with the English clinicians more influenced by German and British psychoanalytic movements while the French Canadian psychoanalysts were more influenced by the French psychoanalytic movement.

At this time, Montreal had two major universities, McGill University and Université de Montréal. Both had a faculty of medicine with major departments of psychiatry staffed with dynamic professors. This co-habitation of two cultures was a great opportunity to facilitate exchanges between psychiatrists sharing common interests, mainly psychoanalysis and psychosomatic medicine. During that period,

Montreal became an important milieu for the development of psychosomatic research, scientific writing and teaching on psychosomatic medicine issues, with people like Eric D. Whitkower, Z.J. Lipowski, Maurice Dongier, Henri F. Ellenberger.

The other major site for the development of psychosomatic medicine in Canada was at the University of Toronto where psychiatrists like R.C.A. Hunter, A.B. Stokes, and F.H. Lowy were teaching.

24.3 Psychosomatic Medicine Around the 1970's: Some Illustrious Pioneers and the "Development of the Discipline"

Before the 1970's, some psychosomatic services and psychosomatic research existed but were not easily accessible to patients. I can say that it was a period when the discipline was building its core of knowledge which would make this "field of interest" become a "discipline". Some would prefer to call it the discipline of "psychosomatic medicine", putting the emphasis on the understanding of the mind-body interface and related psychotherapeutic issues. Others would insist the discipline be concerned with the delivery of care to more complex medical-surgical patients and situations. Many Canadian psychiatrists have written on those issues. As mentioned earlier, most Canadian psychiatrists would now currently use the terms interchangeably with a preference for the term C-L psychiatry.

Among the numerous international contributors to the discipline (Streltzer 2016), two Canadians are among the most important to the development of the discipline: Dr. Eric David Wittkower, and Dr. Zbigniew J. Lipowski.

Born in England, Dr. Eric Whitkower (Murphy 1983) studied medicine and psychiatry in Germany, and became a professor in psychosomatic medicine at the University of Berlin. With the changes in Germany in the early 1930's, he moved to Switzerland, and later to England (working at the Maudsley Hospital and at the Tavistock Institute) where he completed his psychoanalytic training. He then moved to Montreal where he taught at McGill University. He was the co-founder of the Canadian Psychoanalytic Society and also contributed to the development of trans-cultural psychiatry. He was the first president (1970–1973) of the International College of Psychosomatic Medicine. He published four books (Whitkower and Warnes 1977), co-edited three books (with Paul Hoerber, Robert Cleghorn, Maurice Dongier, and Hector Warnes), and wrote more than 225 articles. He had a special interest in psycho-dermatology. He also has done many of the early studies on the impact of emotions on physical organ function in normal and neurotic individuals.

Born in Poland, Dr. Zbigniew J. Lipowski taught at McGill University, Dartmouth Medical School in the U.S.A., the Medical College of the University of South Carolina in the U.S.A., and completed his career at the University of Toronto. Very active in the American Psychosomatic Society and the Academy of Psychosomatic Medicine, he was also a prolific writer on many issues such as: psychosomatic medicine (Lipowski 1984), consultation-liaison psychiatry, somatization, reactions to ill-

ness, and many others. His work on the understanding of delirium (e.g. hyperactive vs hypoactive vs mixed delirium) is certainly one of his major contributions (Lipowski 1985). He also published two interesting and inspiring triads on psychosomatic medicine and consultation-psychiatry (Lipowski 1967a, b, 1968, 1986a, b, c).

24.4 1960's and 1970's: A Canadian Universal Health-Care System, and The Royal College of Physicians and Surgeons of Canada

Like the development of the associated core knowledge and research, the practice of clinical psychiatry in Canada seems to follow the evolution of health policies and the organization of health services. Let us have a quick look at a major change in the Canadian health-care system delivery occurring in the 1960's and 1970's.

Canada is located in the northern part of North America, and is a confederation composed of ten provinces and three territories. It extends from east to west from the Atlantic to the Pacific Oceans, and from south to north from the United States of America border to the Arctic Ocean. Canada is sparsely populated with most of its population in urban areas near the southern border. Access to health services, more specifically mental health services, may differ according to the location. The Canadian Constitution (Constitution Act, 1867) specifies that the federal government has responsibilities relevant to health care, but the provinces are responsible for delivering health care to Canadians. Before World War II, health care in Canada was privately delivered and funded. In the Hospital Insurance and Diagnostic Services Act of 1957, the federal government offered to reimburse provincial and territorial governments for half the costs of specified hospital and diagnostic services. The federal Medical Care Act, in 1966, saw the provinces and territories reimbursed or sharing costs of medical services provided by a doctor outside of a hospital. By 1972, all the provinces and territories had universal insurance plans covering physician services. Since then Canada has a universal health-care system with the principle of equal access to care for all Canadians. However, differences exist between the ten provinces and the three territories, but most medical care is free.

The development of this universal health-care system led the provinces to invest a lot of money in the training of physicians. In Canada, a medical school is a faculty or school of a university that trains medical students/doctors and usually offers a three- to five-year Doctor of Medicine (M.D.) or Doctor of Medicine and Master of Surgery (M.D., C.M.) degree. Although presently most students (at least for students from other provinces than the Province of Quebec) enter medicine having previously earned another degree, the M.D. is considered an undergraduate degree in Canada. There are currently 17 medical schools in Canada.

Postgraduate trainees (post-md trainees) are referred to as "residents". The Royal College of Physicians and Surgeons of Canada (RCPSC) is an association of physi-

cians concerned with setting national standards for medical education and continuing professional development for 80 medical specialties. The Royal College is neither a licensing nor a disciplinary body, but has a major influence on the training and recognition of medical specialists across Canada. It is a regulatory authority that helps ensure that the training and evaluation of medical and surgical specialists and the specialty programs maintain certain standards of quality.

All specialists in Canada, except family physicians, must be certified by the RCPSC before they obtain a provincial or territorial licence to practise. The only exception is in the Province of Quebec, where the Royal College technically shares the responsibility for certifying physicians with the Collège des Médecins du Québec (CMQ). So, in certain exceptional situations the CMQ may deliver a licence to candidates who did not pass the RCPSC examination, but most of the time Quebec candidates must take and succeed the RCPSC examination.

To become certified, a physician must pass Royal College examinations in the specific specialty and/or the sub-specialty. Access to these examinations is usually gained by completing a Royal College-accredited residency program at a Canadian university. To become a general psychiatrist, a physician must complete 5 years of post-md training in a recognized residency program in psychiatry and succeed the RCPSC examinations.

In collaboration with the Canadian Psychiatric Association and the Royal College of Physicians and Surgeons of Canada, the federal and provincial governments in Canada have invested most of their efforts in training “general psychiatrists” who could respond to the general needs of the Canadian population in all provinces, from childhood to advanced age. As a result, the question of accessibility to general health services was and is still an important issue and priority.

24.5 From the 1970’s till Today: Canadian Contributions to Advances in C-L Psychiatry and Psychosomatic Medicine

While the system of care was consolidated across Canada, many Canadian scientists and clinicians continued to contribute to the advancement of C-L psychiatry and psychosomatic medicine. The health care system being universal, the C-L services, where available, were free to Canadian citizens.

The contributors already mentioned continued their work, but new Canadian contributors joined the efforts. Among them, Dr. Graham Taylor, (University of Toronto) developed the Toronto Alexithymia Scale (Taylor et al. 2003). Dr. Laurence J. Kirmayer (McGill University) conducted major research and published on somatization issues (Kirmayer and Robbins 1991), and transcultural psychiatry. Dr. Donna E. Stewart (University of Toronto) did very interesting research in psychosomatic medicine and perinatal mental health (Stewart et al. 2017). Dr. François Lespérance, (Université de Montréal) with Dr. Nancy Frasure-Smith (Psychology, McGill University) has made major breakthroughs on depression and coronary

artery disease with its influence on the prevention of post-infarct morbidity and mortality (Frasure-Smith and Lesperance 2003).

More recently, Dr. Gary Rodin (University of Toronto) has done great research and clinical work in psychosocial oncology (Rodin 2018) and palliative care and has authored texts on psychiatric aspects of transplantation. Dr. Susan Abbey (University of Toronto) teaches on consultation-liaison psychiatry (Zhou et al. 2018) and does research with a focus on depression, quality of life and stress management with medical and transplant patients and families. Dr. Glendon R. Tait (first at Dalhousie University, then at University of Toronto) tries to understand patient and health system complexity using qualitative and complex adaptive system lenses (Tait et al. 2015). Dr. Robert Swenson (University of Ottawa) worked on C-L training of psychiatry residents and on the treatment of mental health problems in patients with chronic medical illnesses. Dr. John Davine (McMaster University in Hamilton, Ontario) is a C-L psychiatrist who is a pioneer and major contributor to shared mental health care (integrative care) in Canada (Goldbloom and Davine 2011).

Over the years, psychosomatic/C-L physicians had an important influence on the teaching of psychotherapy for patients with psychosomatic conditions and education to psychiatry residents and family physicians. Among them were Dr. Jacques Monday and Dr. Pierre Verrier (Université de Montréal) (Bouchard and Verrier 2005), Dr. Jean-Pierre Bernatchez (Université Laval) and more recently, Dr. Pierre Gagnon (Université Laval) who also does research on delirium, psycho-oncology and spiritual therapy (Gilbert et al. 2018).

Among our young colleagues, Dr. Sanjeev Sockalingam (University of Toronto) conducts research on the assessment and management of psychosocial issues related to bariatric surgery, managing psychiatric issues in liver disease, delirium, and medical education specifically related to continuing professional development, curriculum development and evaluation (Zhou et al. 2018).

Of course, Canadian contributors were not and are not all from Central Canada. I can think of Dr. Alistair Munro who was at University of Toronto but continued his work on monosymptomatic hypochondriasis (Munro and Mok 1995) while he was at Dalhousie University in Halifax, Nova Scotia. Dr. Michael Butterfield (University of British Columbia /UBC) is working on pain and skill development for psychotherapy techniques such as acceptance and commitment therapy and intensive short-term psychodynamic therapy. Dr. Roger Shick, (UBC) is doing interesting research and training on pain disorders. Dr. Peter Chan (UBC) is working on delirium in the elderly and is teaching C-L and geriatric psychiatry. Dr. David L. Keegan (University of Saskatchewan) wrote on educational aspects of C-L psychiatry. Dr. Nancy Brager (University of Calgary) pursues research and clinical work on cystic fibrosis, renal transplantation, the interface between the mind and body and the management of chronic disease. Dr. Allan Abbass (Dalhousie University, Nova Scotia) does major research in the area of brief psychotherapy with some focus on brief psychotherapy for psychosomatic patients (Abbass 2005).

This overview has put the emphasis on adult C-L psychiatry. However, some child C-L psychiatrists, some geriatric C-L psychiatrists and many multidisciplinary mental health professionals do research on mind-body issues.

Even though psychoanalytical concepts and approach are still considered useful by clinicians in their approach of psychosomatic issues, with the advancement in cognitive therapy, more and more clinicians have integrated behavioral-cognitive strategies, and also motivational strategies, in their approach of psychosomatic patients.

Over the years, more psychologists became interested in behavioral medicine and/or health psychology. Many Canadian psychologists have done, and do, major research on health psychology. For example, Dr. Linda Kwakkenbos, (McGill University) is doing research on rheumatology and the assessment and treatment of psychological well-being in systemic sclerosis (scleroderma). Dr. Gordon J.G. Asmundson (University of Regina) has done research on health anxiety (Asmundson 2001), and hypochondriasis and related conditions. Dr. Donald A. Bakal (University of Calgary) has done major research on somatization, chronic anxiety, headache (Bakal 1983) and other chronic pain disorders. Dr. Patricia Furer (University of Manitoba) has conducted innovative research on the treatment of health anxiety and fear of death (Furer et al. 2007). Dr. Josée Savard (Université Laval) does research in health psychology and psychooncology (Savard et al. 2017). Dr. Steven Taylor (UBC) does research on classification, biopsychosocial etiology, and treatment of health anxiety. Dr. Sonia Lupien (Université de Montréal) is interested in the effects of stress throughout life and has conducted studies in children and young adults. Her studies with young adults led her to demonstrate the acute and chronic effects of stress hormones on memory and emotional regulation (Marin et al. 2010). Finally, her studies on elderly populations have shown the negative effects of chronic stress on the hippocampus, and its impact on learning and memory processes.

24.6 C-L Training in Canada in 2018

In Canada, the Royal College of Physicians and Surgeons of Canada Fellowship is the national standard for specialist medical expertise. As indicated on its website, for the RCPSC a specialty is an area of medicine with a broad-based body of knowledge that is relevant in both community and tertiary settings and is a foundation for additional competencies (such as subspecialties). A subspecialty is an area of medicine with a more focused or advanced scope that builds upon the broad-based body of knowledge defined in a parent specialty. An area of focused competence (Diploma) is a highly focused discipline of specialty medicine that addresses a legitimate societal need, but does not meet the criteria for a specialty, fundamentals program, or subspecialty. Typically, AFC (diploma) programs represent either a) supplemental competencies that enhance the practice of physicians in an existing discipline, or b) a highly specific and narrow scope of practice that does not meet the criteria of a subspecialty. A special interest group for medical activity (SIGMA) is an emerging area of interest in specialty medicine or community of practice that addresses a legitimate societal need without a widespread role in healthcare. SIGMAs serve to provide a forum for individuals with a common area of interest to

come together to discuss the evolution of their discipline. This category is not considered a formally recognized discipline of the Royal College.

For many years, some Canadian residency programs were offering elective rotations in C-L psychiatry. In 2002, the Canadian Psychiatric Association and the RCPSC collaborated on a revision of general psychiatry training. After major discussions from 2002 to 2007, the Canadian Psychiatric Association and the RCPSC has put in place the National Strategy for Postgraduate Education (NSPGE) which proposed a new training program in general psychiatry (Gagnon 2009; Fleming and Gagnon 2009) according to the CanMEDS roles. (Readers are encouraged to access the documents from the RCPSC website at www.rcpsc.medical.org and <http://www.royalcollege.ca/rcsite/specialty-discipline-recognition/categories-discipline-recognition-e>).

A major initiative of the NSPGE involved the development of levels of competency to guide the resident's acquisition of knowledge, skills and attitudes through definition and behavioural anchoring. These would be included in the Objective of Training Requirements document for the specialty. Then, since 2007, general psychiatry residents must complete a minimum of 3 months (mandatory rotations) in C-L psychiatry to achieve basic competencies in C-L psychiatry during their 5 year residency program.

All 17 Canadian university programs currently offer residency training in general psychiatry. Across Canada, programs offer between three and four mandatory rotations (each rotation is 4–6 weeks duration) in C-L psychiatry. Most programs also offer 3–6 months elective rotations in C-L psychiatry for senior residents, and a few offer up to 12 months of an elective rotation in C-L psychiatry for senior residents. At least two programs, McGill University and University of Toronto, offer post-residency fellowships in C-L psychiatry. At McGill University one of the fellowship programs is specifically for psychiatrists trained outside Canada (2 years) and one is for graduates trained in Canada (1 year). Other Canadian programs may offer “university fellowships” on an individual basis, since at this time “fellowships in C-L psychiatry” are not officially part of the RCPSC recognized specialty or sub-specialty programs.

24.7 Canadian C-L Psychiatry: A Discipline Which Is Still Waiting for Official Recognition

Over the last part of the twentieth century, many psychiatrists across Canada have worked hard to have C-L psychiatry not only recognized by university programs but also by credentialing bodies, different academic organizations, federal and provincial governments (funding sources) but with limited success. Even though the societal financial benefits of C-L psychiatry have been well documented in the literature, the Canadian and provincial governments do not seem to understand the long term benefits for them and, of course, for patients and their relatives. A possible factor

appears to be that until 2005, the Canadian Psychiatric Association did not seem to strongly support sub-specialization in psychiatry. It was afraid that it would “fragment” the practice of psychiatry while the Canadian population needs access to general psychiatry.

Following a large survey of Canadian psychiatrists, the CPA finally agreed to support sub-specialization in psychiatry. CPA has Academies which represent and advance the special interests of subspecialty areas of psychiatric practice. In 2007, with the CPA’s commitment to support the RCPSC application process for subspecialty recognition, four academies (including the Academy of Psychosomatic Medicine) prepared their initial submissions to the RCPSC Committee on Specialties (COS) to be heard in the spring of 2008. Three academies were successful in part one of the application process (a two-part process) and proceeded to submit their part two applications in the fall of 2008. The RCPSC COS met in April 2009 and approved the subspecialties of child and adolescent psychiatry, geriatric psychiatry and forensic psychiatry. Unfortunately, the RCPSC did not recognize psychosomatic medicine (consultation-liaison psychiatry) as a sub-specialty. For the COS of the RCPSC, C-L work did not differ sufficiently from general psychiatry.

Interestingly, 25 years ago, in 1993, three C-L colleagues have done a Canadian survey on “Consultation-liaison psychiatry as a subspecialty” (Swenson et al. 1993). At the time the CAPM was not created, but the Canadian psychiatric Association had a Section on Psychosomatic Medicine. The survey showed that 55% of respondents agreed that C-L psychiatry should receive designation as a psychiatric subspecialty, but 35% were opposed and 10% did not give an opinion. The authors concluded that: “Factors unique to Canada that may influence attitudes toward psychiatric subspecialization include the number and geographic distribution of psychiatrists, their educational background, and governmental funding priorities.

At this time, the RCPSC is moving to a model of Competency-Based Medical Education (CBME). As of 2014, the Royal College moved to CBME and Competence by Design which is an outcomes-based approach to the design, implementation, assessment and evaluation of a medical education program using an organizing framework of competencies. (the reader is invited to search the RCPSC website for more details). For residents in training and specialist physicians who pursue lifelong learning under CBME, medical education progresses not according to how much time a resident or certified physician has practised certain skills which was the case in the past. Instead, according to the CBME, it progresses under a system in which residents and certified physicians must achieve and demonstrate core competency levels called “milestones” before they move on, receive credit or are otherwise recognized by the system.

From the information now available, I understand that for C-L psychiatry the CBME will not really differ from the existing basic C-L psychiatry training. Therefore, the discipline of C-L psychiatry will probably not receive the benefits from official recognition that other psychiatric sub-specialties (child-adolescent, geriatric, forensic) have acquired including official university divisions and additional funded training time for fellows.

The RCPSC has already indicated its concern about the number of specialties and sub-specialties but did create Diplomas. The probability that C-L psychiatry will be recognized as a specialty or sub-specialty in Canada is unfortunately low. However, potential for recognition of C-L psychiatry as an Area of Focused Competency (RCPSC Diploma), and its eventual impact on the discipline of C-L psychiatry, has yet to be determined.

24.8 Conclusion

Even if psychosomatic medicine/consultation-liaison psychiatry has been part of clinical psychiatry for more than 80 years in Canada, the discipline of Canadian PM/C-L psychiatry is not yet a recognized specialty or sub-specialty by the Royal College of Physicians and Surgeons of Canada. Basic C-L psychiatric training (3 months) is now offered in 17 university medical programs in cities covering 8 of the 10 provinces. Those programs have members (psychiatrists and/or psychologists) actively teaching and doing research on major C-L issues. So, outside of some major cities across Canada, C-L psychiatry services are usually offered by general psychiatrists doing part-time basic C-L work, which results in limited access to advanced C-L care. With the universal health care system across Canada, compared to the situation in the United States, there was an opportunity to offer free advanced C-L care to the Canada's population but that opportunity still struggles with government financial and political priorities.

With the Royal College of Physicians and Surgeons of Canada not giving sub-specialty recognition a priority, C-L psychiatry may essentially only hope to be recognized as an Area of Focused Competency (Diploma). In Canada, the non-recognition of C-L psychiatry as a sub-specialty may delay the development of the discipline, particularly at times when governments prioritize funding choices. Fortunately, many Canadian clinicians and researchers in C-L psychiatry (and health psychology) continue to believe in the value and the benefits of an eventual recognition of C-L psychiatry as a sub-specialty, in the best interest of the Canadian population.

Questionnaire Response

COMPARATIVE GLOBAL PSYCHOSOMATIC MEDICINE

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry in your (or your chapter's) Country.

Please return this as an attachment to your email

Country on which you are reporting: Canada

Your Name: Dr. Fabien Gagnon

Institution: Université Laval

City & Country (e.g. London, UK): Quebec City, Province of Quebec, Canada.

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?

Yes () No () In some sense (X)

a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes (X) No ()

b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes () No (X)

2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?

Yes (X) No ()

Is teaching of psychosomatic medicine in medical schools required by law or health care system in your country? YES (X) No () Re: 3 months to do during PGY-1 to PGY-5

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?

Yes (X) No ()

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No (X)

- a. If YES, which?

Psychosomatic Medicine () Consultation-Liaison Psychiatry ()

- b. If YES, the status of such certification is:

i. Independent Medical Specialty ()

ii. Subspecialty of Internal Medicine ()

iii. Subspecialty of Psychiatry ()

iv. An independent non-medical discipline, as Psychology, Social Work ()

v. Other (Specify): []

5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes (X) No ()

If YES, please list names of the organizations and the websites if available:

Canadian Academy of Psychosomatic Medicine / www.capm-acpm.org

6. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:
No one.
7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in your country? Yes () No ()
- If YES, where does it occur? Check all that apply:
 - Medical School () Residency () Fellowship ()
- * University of Toronto and Mc Gill University have official “university fellowships”, but other universities may offer university fellowships” on demand.
8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes () No ()
9. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)
- It is insignificant ()
 - Some subgroups (e.g. ethnic, religious) practice it ()
 - A significant part of the general population practice it ()
 - Is the most prevalent healing method used ()
 - It is often used in combination with Western medicine ()
 - More widely used methods are as follows (Please list, e.g., spiritual healing, meditation, herbal, etc): Meditation, Yoga
10. Please add any comments to your response here:
The Royal College of Physicians and Surgeons of Canada did not accept (2007) to recognize C-L / PM for a Diploma by the RCPSC. At this time, many Canadian psychiatrists practice C-L/PM in urban hospitals or Outpatient Clinics. Some efforts are done to try to have C-L/PM recognized for a RCPSC Diploma (which is less than a subspecialty) but it stagnates.

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Chapter 25

Psychosomatic Medicine in Argentina



Roberto Bronstein, Oscar Olego, and Raul Walder

25.1 Introduction

25.1.1 *Geographical and Historical Location: Pre-Columbian and Post-Colonization History*

Argentina is a country located in the southernmost tip of the Americas, surrounded by Chile, Bolivia, Paraguay, Brazil and Uruguay, and has a population of nearly 44 M inhabitants, according to the Department of Economic and Social Affairs of the United Nations. The population is distributed unevenly, since as many as 89% of Argentines inhabit urban areas, whereas rural areas are populated only by the remaining 11% (2001 Argentine National Census). The Metropolitan Area of Buenos Aires, capital city of the Republic, accommodates 31.9% of the population, according to the National Geographical Institute and data collected in the latest population census, conducted in 2010.

Argentina is usually thought of as an “immigration country”, primarily thanks to massive immigration waves from European countries between 1850 and 1955. Most such immigrants came from Spain, Italy, Germany, Poland and Eastern Europe. Subsequent immigrants were predominantly from neighboring countries.

In large Argentine cities, Western medicine is practiced in many fields of specialty, such as psychiatry, to the same quality standards as some first-class centers in the world. However, in certain regions located far away from city centers, pre-His-

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panic medicine is the root of popular medicine, and is still practiced in some areas. Thus, different cultures find a meeting point in several communities located far away from provincial capitals. Here, Western university medical training blends with a predominance of beliefs and a heritage from cultures existing prior to the sixteenth-century Spanish colonization. There is still a spiritual, magical and mystic component to medicine in these regions. An instance of this is the unrelenting use of *coca* leaves in Northeastern Argentina, an ancient tradition dating back to pre-Columbian times.

It should be stressed that Argentine university medical training is based upon the concepts of Western academic medicine. Some historians argue that aboriginal medicine in this area is approximately 10,000 years old, as its origins can be traced back to the arrival of groups from North America. Others believe that these regions were already populated some 30,000 years ago.

Towards the year 1500, when the Spaniards arrived, present-day Northwestern Argentina was inhabited by indigenous peoples influenced by the Peruvian southernmost branch of the Inca Empire. Vestiges of human populations dating back 11,000 years can be found in this region; in Tierra del Fuego, they date back 6,000 years.

The concepts of “disorder” that these peoples had were inevitably constrained by magic, taboo and, afterward, religion. Although such supernatural views did not fully leave out the empirical and the rational, the latter did not prevail.

It was the shaman, otherwise known as healer or sorcerer according to the different religions, that was in charge of all therapeutic processes. Shamans were thought to be capable of finding out the causes of disorders through their communication with spirits, who they often claimed to fight.

More often than not, disorders were attributed to supernatural factors, so their treatment was predominantly magical. The results of such treatment were usually based on such things as beliefs, the impact of rituals or the natural evolution of the disorders. The discovery of burr holes and cranial deformations in archeological excavations does not mean that abscesses and tumors were incised or drained. Rather, such findings can be explained by animist theories.

Toward the south of the country, some tribes put disorders down to certain punishments for actions against deities. Curing a disease was therefore tantamount to appeasing the wrath of the gods through different ceremonies, the consumption of specific herbs or types of meat, the use of talismans, the laying on of hands, and other rituals. Other times, the origin of disorders was not thought to be the wrath of gods, but other magical causes, such as planetary or natural phenomena.

The role of the shaman could not be undertaken by just about anybody. They were usually men with a distinctive physical or spiritual feature that represented the needs, fantasies, desires or expectations of the community he belonged in. In some tribes, there were also women with skill and knowledge who were believed to have these healing powers capable of curing ulcers, wounds, the “evil eye” and other conditions. Apart from their required personal traits, these people were trained to mediate between humans and spirits through rituals, summonings, trances, etc. This transfer of skills from master to apprentice could take years. Much of this wisdom

and knowledge has been transmitted orally, and there are still some areas where some ancient practices are still ongoing.

Early documents about these different conceptualizations of disorders and related therapeutic practices date back to the sixteenth century, with the arrival of Spaniards. Many of them were officials of the Crown, military men, clergymen, or simply travelers or chroniclers. Not only did the Spanish draft these early documents, but they also brought a number of diseases with them that were alien to the natives, who were decimated by war and different epidemics. These sprung up as something mysterious and explosive, without an apparent cause and bringing about sizeable demographic changes.

Only toward the year 1600 was medical training by the Spanish first documented in Northwestern Argentina.

The importance for these communities of the supernatural, of the divine and of truly ancient beliefs related to the ideas of health and disease cannot therefore be overstressed, and nor can their influence on people's daily lives. Premonitions and dreams were thus an inseparable part of life.

25.2 Nineteenth and Twentieth Centuries: Great Migrations and European Cultural Influence

25.2.1 Psychoanalytic Influence

As mentioned above, during the nineteenth and twentieth century a great number of Europeans migrated to South America and, particularly, to Argentina. Thousands of people from different countries and cultures poured into the country, with varying degrees of education and knowledge, and practicing different religions.

From the very beginnings of psychiatry in Argentina, there was a strong influence of biopsychology. Christofredo Jakob, a German physician, was hired in 1899 by Domingo Cabred as a tenured Professor of Psychiatry. Jakob conducted extensive neuropathological research up until 1946, thus laying the scientific groundwork for the development of psychiatric thinking for all the physicians who helped create a local school.

Between 1933 and 1941, there was a large wave of migration to Argentina of European psychoanalysts who were driven out by Nazis. By late 1942, the first society of psychoanalysis was founded, with Angel Garma, Marie Langer, Enrique Pichon Riviere, Celes Cárcamo, Arnaldo Rascovsky and Enrique Ferrari Hardoy as members. Thus began a sound psychoanalytical school, with a strong influence on psychosomatic theories in Argentina. These early Argentine psychoanalysts, who published several works related to different medical fields (including neurology, dermatology, gynecology and obstetrics), did not develop a specific theory of the psychosomatic. Rather, it follows from their work that all pathologies implied a psychosomatic component, but no difference was made between psychosomatic and non-psychosomatic disorders.

For Spanish physician Laín Entralgo, the idea of “psychosomatic pathology” has been around since the origin of psychoanalysis—although “psychosomatic medicine” has always existed, it is thanks to Freud that emotional, personal and psychological factors were first thought of as etiopathogenic.

From the 1950s onward, other Argentine psychoanalysts gained prominence, such as David Liberman, Arminda Aberastury and José Bleger. These paved the way for many researchers of psychoanalysis, who made important theoretical-clinical contributions about patients with somatic conditions.

Liberman refers to a certain type of person whose conflicts are stored in their autonomic nervous systems, which functions as a gateway for pathological symptoms to arise. These people are described as childish on account of their mode of communication lacking symbolic capacity. They are able to express themselves verbally in concrete, objective situations but they have difficulty conveying their emotions. They tend to replace emotion by rationalization, the somatic symptom being the manifestation of these mechanisms. Rather than seeking psychotherapy of their own accord, they are usually referred to a therapist by their primary care physician. The therapist, in turn, must be flexible enough during treatment until the patient becomes aware of the nature of his/her symptom.

From the 1960s onward, a new school for the development of Argentine psychoanalytic psychosomatic concepts arose, headed by Luis A. Chiozza. Chiozza developed a psychotherapeutic clinical method for treating the type of psychosomatic disorders which he referred to as “pathobiographical study.” For this author, who relies heavily on several writers including Freud, Groddeck, Weizsäcker and Racker, organic disorders are a kind of language that masks a history whose meaning would prove intolerable to the subject. Chiozza does not necessarily point to a cause-effect relationship in psychosomatic disorders; rather, the psychic and somatic components are the two sides of a coin where the patient’s physical and biographical history is expressed not through words but through organs. This somatic model of understanding disorders implies a particular representation of the affect related to the conflict, which Chiozza describes as “pathosomatic destructuring of the affect.” This particular way of representing the affect to prevent it from reaching consciousness as such facilitates its manifestation as a “somatic condition,” i.e. a medical disorder. Chiozza’s starting point is Freud’s metapsychology of affects, and he argues that “the choice of which organ to express a disorder through is governed by the same principles that determine the choice of any other representation.” He states that every affect has an unconscious memory trace that determines the quality of the somatic discharge; for each disorder, there is a specific unconscious fantasy connected with language. Through their psychosomatic research, Raquel and Rubén Zukerfeld introduced the concept of “vulnerability.” This concept allows for the study of predisposing or triggering factors, as well as factors that exacerbate psychopathological and somatic disorders. They represent a tendency to angst and extreme emotions while the patient adjusts to crisis, stress or tragedies which may predispose them to vegetative reactions and somatic injuries. From a metapsychological point of view, this implies an insufficient representational organization, a lack of mental resources and a tendency to discharge.

Back then, psychoanalysis began to have considerable influence over psychiatry and psychopathology services in general hospitals, which resulted in the creation of important consultation teams together with other areas of medical specialty. Such a strong influence over hospitals was simultaneous to its major impact on Argentine culture, particularly in large cities. In 1957, the National Institute of Mental Health was founded, and in 1958, the Goldemberg plan was implemented in Buenos Aires, creating mental health services in general hospitals in opposition to existing psychiatric hospitals. The aim of this was to promote the prevention and treatment of mental disorders within the healthcare community and not in isolation, as was done in strictly psychiatric hospitals. The idea behind this movement was that psychiatry should consider social and environmental factors as disorder triggers.

Medical training in Argentina was marked by the influence of psychoanalysis in the first half of the twentieth century, with an avid interest in European developments. Afterward, the growing presence of the United States in all areas of culture was also felt in sciences in general and medicine in particular. Thus began a movement toward a conception rooted in hard sciences, with an introduction of statistical methods and comparable experiences.

In the 1990s, the decade of the brain and the influence of globalization, together with the appearance of new therapeutic drugs in the market and the great momentum of the pharmaceutical industry, there was a turn in the way psychiatry was taught. Thus workshops, courses and postgraduate programs in neurosciences were gradually implemented.

25.3 Current Practice

Currently, there are numerous academic programs in psychoneuroendocrinology, stress medicine and psychosomatic disorders. The diversity of names itself shows that there is still not a clear definition in our field.

In public hospitals, mental health services are run by physicians and psychologists working jointly. Liaison and psychiatry consultation teams are part of these services. There is no agreement on a criterion for handling a consultation, just like there are multiple views of psychosomatic medicine. There are, however, multiple groups with a psychoanalytical and psychoneuroendocrinological orientation, with many research studies completed and publications issued.

As a result of this diversity of views, there are different treatment options, from the prescription of therapeutic drugs to a wide array of psychotherapeutic treatments, with different orientations (Freudian, Lacanian or Kleinian psychoanalysis, cognitive behavioral therapy, systemic therapy, gestaltism, etc.). The development of interdisciplinary treatments including both psychotherapy and medication is commonplace in our country. It should be stressed that alternative medicine is frequently used, often as a complement to the treatment of pathologies deemed psychosomatic.

25.4 Consultation-Liaison Psychiatry in Argentina

25.4.1 Primary Healthcare: Family and Community Medicine

In Argentina there is a medical subspecialty called psychosomatic medicine, which deals with clinical and research activities within family and community medicine or primary healthcare, as it is called in other countries.

It is a known fact that this specialty is based on a theoretical construct which considers that the appropriate reason for a visit is not symptoms but the patient's context in terms of family, community and society. It is characterized by providing medical support for patients over time, as opposed to the model of permanent intervention by a specialist.

This branch of specialty arose in Argentina and in other countries out of the need to reform the public healthcare system under the General Public Health Laws, with a view to clearly strengthening primary healthcare for patients making use of the healthcare system.

25.4.2 Profile of Family Physicians in Argentina

Family physicians are doctors that whose role is to be the first link between patients and the healthcare system. They possess clinical experience and are skillful at manual or some surgical procedures (minor surgery or invasive procedures). They are experts in consultation, be it outside, at the patient's home or at the community, in hospital or for emergencies. They provide continuous care from childhood to old age. They can work with population groups with or without risk factors, regardless of age, sex, organic systems and diseases. They can also apply their knowledge of different areas, such as biology, social sciences and behavioral sciences, thus developing a type of Comprehensive Community Medicine. Comprehensive medicine includes education, prevention and healing; it can provide cost-effective solutions (cost-effective medicine); and it can deal with 95% of healthcare problems (from isolated signs and symptoms to complex cases involving multiple conditions).

Primary healthcare and family medicine are intimately related, the former being the main area of work for family physicians and the latter being a key tool for a full development of primary healthcare.

Family physicians arose in Argentina out of the need to consult an expert in clinical situations with real healthcare problem-solving capabilities for patients and their families. This also makes the healthcare system more effective, as most healthcare problems can be solved at this level, and only those cases requiring further resources, be it due to their complexity or technological requirements, are referred to specialists.

The primary healthcare physicians' view of the ill is holistic and comprehensive, and it encompasses biological, psychological and social aspects. Healthcare is patient-based and not disorder-based; a patient's health is governed by his/her context and family situation, and the prevailing view of medicine is community-centered. By analyzing the community, which can either trigger the disorder or help treat it, different actions can be taken, such as preventive treatments or health promotion.

Patients are treated throughout their lives, which includes both consultations and visits at home or at different social settings (such as schools, retirement homes, etc.).

This professional profile requires a thorough understanding of medicine, including practically all medical and surgical areas, as well as psychiatry and health management. Physicians' ability to solve a certain health problem is therefore only limited by their own knowledge and skill, and the structural and technical resources they possess.

Training in family and community medicine is provided through graduate internship and residency programs, with a duration of 3–4 years, depending on the country.

The underlying principles of the specialty have been clearly laid out by several authors. The theoretical basis provided by many researchers has helped consolidate a body of knowledge, an epistemological framework of its own, forging an identity and allowing the specialty to be considered as such.

The name of the specialty itself is subject to controversy, even if training programs are similar but not exactly equivalent, from "General Practitioners" in Sweden or the UK to "Comprehensive General Medicine," which covers primary healthcare in Cuba and Venezuela.

25.4.3 Professional Practice of Family Medicine in Argentina

In keeping with a global trend, family medicine has gained momentum in Argentina in the last few years. It has been proven that health systems with the greatest inclusiveness, efficiency and quality are based on a system of primary healthcare. In such systems, family physicians and their activities are highly valued; they develop a healthcare model for patients throughout their lives and they work jointly with all other clinical and surgical specialties.

In Argentina, there is a great demand for physicians specializing in family medicine. This need for qualified human resources can be appreciated in the different subsectors (public and private healthcare, social security, mutualism), which are redirecting their systems toward strengthening primary healthcare.

In Argentina, there are currently 10 Family Medicine Services in public hospitals and about 150 Family Medicine Residencies in general hospitals, which take 4 years to complete.

Moreover, there have been successful family medicine programs in every sub-sector. In social security, the Public Aid Scheme for Construction Workers (in Spanish, OSPECOM) has been implementing a Family Medicine program at the federal level for over a decade.

In the City of Buenos Aires, experiences in the private subsector at the Centro de Estudios Médicos e Investigaciones Clínicas (CEMIC), Hospital Italiano and the former Hospital Francés (currently, Hospital Cesar Milstein) have become role models for other health organizations.

25.4.4 Clinical Practice in Argentina

Family physicians work in primary healthcare centers together with other colleagues and members of the healthcare team. They also work in private practices that are part of the healthcare network. Ideally, they should be working within the community and jointly with other specialists. Community-oriented primary healthcare is a key activity for family physicians. This helps promote health and develop pre-emptive activities strengthening the ties with the community, generally through group work.

As mentioned before, family medicine is a predominantly clinical cross-cutting specialty that applies knowledge and skills from other specialties and encompasses biomedical, behavioral and social sciences. Unlike other specialties, it is directed toward all ages, genders and disorders, focusing on humanitarian medicine, the relationship between physicians, patients and families, as well as educational and preventive aspects.

In Argentina, there is a professional movement within family medicine seeking to change the prevailing paradigm that favors constant check-ups. This is called “quaternary prevention” and it seeks to avoid, reduce and alleviate the harm caused by medical intervention. This is achieved through avoiding unnecessary procedures, as it is often the case that scientifically proven tests are used unnecessarily for asymptomatic patients. This harmful overuse of medicine, i.e. systematically using tests or treatments that are more harmful than beneficial, is called “overdiagnosis,” “overtreatment” or “medicalization.”

According to these professionals, there is sound evidence about problems caused by false positives and false negatives, and how these unnecessarily expose the patient to tests that may do more harm than good. They claim that regular check-ups should be based on thorough questionnaires assessing personal and family backgrounds and taking into consideration factors such as age, diet, physical activity and other circumstances.

Lastly, they point out that asymptomatic patients should be required to take tests only when it has been proven that, if used systematically in large populations, such tests reduce the risk of death or after effects. These include HIV tests, Pap smears (every 3 years between the ages of 21 and 65) and blood pressure tests.

25.5 Conclusions

Argentina's geographical location, its historical factors and its relationship with global culture have determined Argentine healthcare theories, concepts, beliefs and practices. This includes so-called "psychosomatic medicine." On account of Argentina's great size and geographical diversity, its culture and society are likewise diverse, with an uneven distribution of the population (urban vs. rural), with different histories, identities and degrees of development (including economic development), and different levels of access to healthcare resources.

This has resulted in the coexistence of ancient theories and worldviews, dating back thousands of years; the development of important theoretical models, such as the psychoanalytic model (particularly in large cities) with all its influence on different schools; and clinical practices with the latest breakthroughs of psychoneuroendocrinology, molecular biology, neurosciences, etc.

In the clinical practice, different models coexist and have completely different approaches: the highest degree of specialty vs. the family doctor's clinical practice; the use of home-made remedies vs. cutting-edge molecules.

In Buenos Aires and other important cities in Argentina, meaningful scientific activities are carried out in terms of healthcare, research and teaching of the different intervention models, both inside and outside university settings (public and private), with publications that sometimes have international impact.

Nowadays, the globalization of communication through the Internet, e-mail, social networking, etc. allows for a greater sharing of information and medical updates, as well as details about certain countries and regions. This great interchange also facilitates access to conferences, courses, written material, updates, concepts, different views and versions of what is known as "psychosomatic medicine," a wide and controversial concept in itself which has different shades of meaning, even in Argentina.

Questionnaire Response

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry in your (or your chapter's) Country.

Please return this as an attachment to your email

Country on which you are reporting: Argentine

Your Name: Oscar Olego -Roberto Bronstein – Raul Walder

Institution:

City & Country (e.g. London, UK) CABA - Argentina:

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?
 Yes (X) No () In some sense ()
 - a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes (X) No ()
 - b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes (X) No ()

2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?
 Yes (X) No ()

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?
 Yes (x) No ()

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No (X)
 - a. If YES, which?
 Psychosomatic Medicine () Consultation-Liaison Psychiatry ()

 - b. If YES, the status of such certification is:
 - i. Independent Medical Specialty ()
 - ii. Subspecialty of Internal Medicine ()
 - iii. Subspecialty of Psychiatry ()
 - iv. An independent non-medical discipline, as Psychology, Social Work ()

 - v. Other (Specify): []

5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No (X)
 If YES, please list names of the organizations and the websites if available:
 There are some small groups studying and working in Psychosomatic Medicine and Consultation-Liaison Psychiatry inside the Psychiatric Associations. Not website available.
6. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry: NO ONE
7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in your country? Yes () No (X)
 a. If YES, where does it occur? Check all that apply:
 Medical School () Residency () Fellowship ()
8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes () No (X)
9. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)
- It is insignificant (X)
 - Some subgroups (e.g. ethnic, religious) practice it (x)
 - A significant part of the general population practice it ()
 - Is the most prevalent healing method used ()
 - It is often used in combination with Western medicine ()
 - More widely used methods are as follows (Please list,e.g., spiritual healing, meditation, herbal, etc):
10. Please add any comments to your response here:

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Part VI
Contemporary Psychosomatic Medicine
and Consultation-Liaison Psychiatry in
Australia: Development, Research,
Education, and Practice

Chapter 26

Australia: Consultation-Liaison Psychiatry not Psychosomatic Medicine



Robert Gribble

26.1 Introduction

The terms “psychosomatics” and “psychosomatic medicine” have multiple intertwined associations. Lipowski (1968) defined the “science of psychosomatics” as the study of how biological, psychological and social factors influence the cause, course and outcome of every human disease. Fava et al. (2012) conceived a broad concept of Psychosomatic Medicine (PSM) based on this. In the US, Consultation-Liaison Psychiatry (CLP), the subspecialty of clinical psychiatry was rebadged as Psychosomatic Medicine for more than a decade when it was recognised as a subspecialty in 2003. Psychosomatics is also associated with two very different intellectual products of American psychosomatic psychoanalytic traditions: the reductionist idea of psychogenesis wherein psychological conflict leads to physical illness, and Engel’s integrative biopsychosocial approach which underpins Lipowski’s definition.

In Australia, while Engel’s bio-psych-social approach to illness has been part of the scaffolding of Australian medical education since the 1970’s (Orchard 2003), the term “psychosomatic” is too strongly and negatively associated with the idea of “psychogenesis” to be treated with anything but suspicion and hostility. This was the case in the 1950s (Lafferty 2003) and remains so today. General hospital patients ‘know’ that if their doctors use the term it means that their symptoms, distress, and probably they themselves, are likely to be dismissed as “all in the head”.

Fava’s (2012) notion of Psychosomatic Medicine, like the biopsychosocial approach, appears a conceptual discipline, applicable throughout medicine, rather than a definable clinical field with a separate and identifiable population of patients. From a CLP perspective Fava’s (Fava et al. 2012) suggestion of PSM as a

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“comprehensive, interdisciplinary framework” seems distant from the practicalities of most CLP workplaces where medical specialists retain the final say about the management of the patients they refer and the specialist medical clinics they head, and “comprehensive” psychosocial care is achieved through interdisciplinary and inter-professional collaborations, based on relationships and networks.

Consultation-Liaison Psychiatry (CLP) in Australia is a subspecialty of clinical psychiatry and does have a defined patient population for which it provides a clinical service through the processes of referral, consultation and liaison. The 1995 Bylaws that saw the formation of the Section of Consultation-Liaison within the Royal Australian and New Zealand College of Psychiatrists (RANZCP) described that population as those who are physically ill or who somatise and who are in medical settings of care, particularly the general hospital.

When it emerged in the 1970's CLP in Australia was largely on its own in providing access to psychiatric expertise for general hospital medical patients. The unique combination of medical and psychiatric training, the authority of being doctors within a medical system, and the ability to clinically assume some ‘medical’ responsibility- albeit a delegated authority from the referring medical specialist – and to negotiate at this “medical” level with the mental health system, mean that CLP retains a necessary role at both clinical and organisational interfaces. Clinically it is usually and appropriately the default option, the place where the psychosocial ‘buck’ ultimately stops.

Other psychosocial professional disciplines, largely nascent at that time, have developed and evolved over the years and are increasingly developing roles in the psychosocial care of patients in the general hospital, in particular Social Work, Psychology and Mental Health Consultation [Liaison] Nursing (MHLN). MHLN and psychologists in particular may be members of multidisciplinary CLP or they may be Mental Health funded and work in the general hospital but be administratively independent of CLP. However CLP Psychiatrists also work in interdisciplinary arrangements with non-mental health funded psychologists and social workers and with specialist nurses in areas such as cancer services, Pain Clinics, Antenatal Clinics, Emergency Departments (EDs) as well as in more established liaison attachments in general hospitals.

Models of engagement have also extended beyond the core of acute problem-based referrals as, within general hospital medical and surgical specialties, there has been an increased awareness and preparedness to address the level of psychosocial and psychiatric morbidity and its impact on care and outcome. There are routine assessments for complex procedures (e.g. dorsal column stimulators for pain, living related transplant donor/ recipient pairs, epileptic surgery), standard-of-care psychological interventions in pain, chronic fatigue, obesity and metabolism clinics, and screening (e.g. nursing screens for delirium, screening for depression in Cystic Fibrosis and strokes, or interdisciplinary antenatal psychosocial screening).

Australian CLP was enormously advantaged by its inclusion as a required component of psychiatric training in the first RANZCP Guidelines for Training in 1978, by its retention in the 2003 RANZCP Guidelines, and then again in 2012. Aitkins et al. (2016) suggest that the development of CLP in Britain has been driven by academic psychiatry, in Australia it might be said to have been driven and main-

tained by College training requirements. The development of formal professional structures within the College and subspecialty recognition followed rather than led the process. An RANZCP Consultation-Liaison Interest Group was only formed in 1992, a decade and a half after the first Guidelines, the Section for Consultation-Liaison Psychiatry in 1995, and CLP did not become a RANZCP Faculty till 2016.

Following a brief discussion of Indigenous health beliefs, this chapter will focus primarily on CLP, its context in Australia, the development of the all-important 1978 Training guidelines and later development and challenges, on the clinical practice and on training and research. However although the group of patients specifically referred to CLP are a particularly important subgroup of “the physically ill and those who somatise”, they do not constitute all those who receive, need or might benefit from input from psychosocial or mental health professionals, and there will also be discussion of the other professional groups that have developed and are also part of the informal interdisciplinary psychosocial network in general hospitals.

26.2 Indigenous Health Beliefs

Indigenous Health in Australia is an important, politicised and contested arena. The life expectancy of Australia’s first people is 10 years less than that of the remainder of the population and 10 years of government policies to “Close the Gap” have made limited headway.

Traditional health beliefs are described as “holistic” but extend well beyond what that term implies in the frame of western health-service perspective (e.g. Maher 1999). They are embedded in a world view that is described in terms of “Aboriginal Spirituality” in an Indigenously-authored discussion paper, “Spirituality and Aboriginal People’s Social and Emotional Well Being” (Poroch et al. 2009), to which the reader is directed.

Despite the colonial frontier’s slow passage across the country from the south-east to the centre and north over 250 years, these authors report persisting commonalities of belief about the interconnectedness with land, kinship, community, spirit and the ways these contribute to aboriginal well-being albeit with the outward expression of this aboriginal spirituality affected by place and the length of exposure to colonial influence (Poroch et al. 2009).

Poroch et al. (2009) also reflect on the “Bringing them Home” report of the 1995 Australian Human Rights and equal Opportunities Commission into the previous policies of child removal and they reference the finding that in addition to the loss of identity, culture, family and community these individuals experienced profound and lasting physical and emotional problems. They invoke the First People’s concept of a “soul [spirit] wound” and suggest that the accumulated intergenerational trauma and its impacts on social and emotional well-being need to be considered as distinct from mental illness even if the two interact. Quoting from the National Strategic Framework (2004) it is suggested that effective care needs to “build on community strengths and capacity and include counselling and social support”.

The more recent general appreciation and understanding of the impacts of complex trauma and its intergenerational transmission perhaps mean that not only may non-Indigenous Australia have much to learn from the underpinnings of Aboriginal Spirituality as Poroch et al. suggest, but also from their historical experience and its sequelae.

There is no doubt that Aboriginal people often experience difficulty negotiating the general hospital system (Wand et al. 2009; Rose et al. 1993), as do patients with mental illness (Rose et al. 1993). The fear, distrust and experience-based negative expectations of mainstream services did lead to the development of Aboriginal Community Controlled Medical Services over two decades ago but interaction with mainstream services are still necessary to optimise medical care and there are still many challenges in trying to develop relationships, partnerships and trust (Taylor and Thompson 2011; Taylor et al. 2013; Haynes et al. 2014)

26.3 Theoretical Issues in Australian CLP

The predominant influence on the development of CLP in the country from the 1970s has undoubtedly been the conceptualisation of CLP that evolved in the US at that time. In the early years Lipowski's writings were significant theoretical points of reference, as well as the source for the initial definition of the subspecialty (RANZCP 1995), and the early editions of the Massachusetts General Hospital Handbook of General Hospital Psychiatry were held in near reverence. However a review of visiting CLP speakers at RANZCP and Section/Faculty events suggests that recent influences may be more aligned with British Liaison Psychiatry: Goldberg, Wesley, Guthrie, Creed, House, Mayer have all visited whereas the roll-call from US CLP is limited and there have also been few to reflect the European Psychosomatic traditions.

The cumbersome title "consultation-liaison psychiatry" remains conceptually relevant as it still captures some of the dynamic tensions in the field in relation to patients, practice, perspective and objectives.

"Consultation" might be seen as one pole of a continuum. It involves assessment and the provision of prompt, practical advice to referrers about their patients and of management and follow-up for identified psychiatric disorder in the medical setting or until transposed into a psychiatric one. Liaison, the other pole of the continuum, involves regular engagement with the members of a medical or surgical team with the objectives of consulting, case-finding, assisting the non-psychiatric staff in conflict resolution and management of patients (Lipowski 1967a, 1983, 1986), that is working "systemically" within a medical or surgical team (Smith 2009; Lipowski 1967a, 1983). In an era when biopsychosocial sensibility was not as much a part of medicine or medical education as it is today much of this was considered under the rubric of "teaching". Today this seems dated and self-absorbed and it might be better reframed as "collaboration", or "interdisciplinary collaboration".

Although risking oversimplification, the poles of the continuum might also be seen to reflect differing goals. At one end consultation can be seen as being about

the identification, diagnosis and management of co-morbid psychiatric conditions which are, and whose treatment is, in many respects parallel and separate from treatment of the medical condition responsible for general hospital admission. Good psychiatric care is the goal. The other pole involves clinical engagement in situations where the patients' psychopathology, their reactions to illness, their behaviour and interaction with the immediate system of care, may challenge that system's capacity to provide "good-enough" overall medical care for the presenting condition. The groundings of CLP in psychodynamic understanding of the patient (another legacy of the US heritage), in systems theory, and in formulation rather than just diagnosis (Smith and Strain 2002; Smith 2003, 2009) – the "liaison" skills – come to the fore in this context. The goal is collaboration with, and support of, the treating team to achieve, in the first place, "good-enough" medical care for the patient .

An old, but still useful conceptualisation of the referral process also emphasises this second group (Lipowski 1967a, b; Meyer and Mendelson 1961; Caplan 1970). It suggests that two conditions need to be met for referral to occur. Firstly the consulting specialist needs to be confronted with a problem that puzzles them and which they do not know how to approach, and secondly that it is a problem that they need to address in order to proceed with their own management of the patient's primary [medical] condition. The implication is that referral to CLP is likely when a problem perceived to be in the psychiatric domain interferes with, rather than just co-exists with, the progress of the patient's medical management and potentially jeopardises it. In this context the particular skill of the C-L psychiatrist, collaborating at the level of a 'medical' specialist are probably critical, and certainly in Australia there is a predominance of psychiatrist and psychiatric trainee in CLP services.

The positions are not mutually exclusive, and the simple dichotomy between consultation and liaison is inadequate. Lipowski's dialectic synthesis of the argument between the two early in CLP history may still be apt: that while consultation is the cornerstone of CLP practice as CLP is a service based on referral, as much liaison should inform and be injected into this practice as time and resources permit and, in this way, all consultations should be "comprehensive" (Lipowski 1967a, b, 1983) .

In Australia as elsewhere CLP services are seldom referred more than 2–3% of admitted patients in general hospitals (Holmes et al. 2011; Chen et al. 2016; Ellen et al. 2006; Smith 1993). The epidemiology of medical psychiatric comorbidity in general hospital patients is however significantly higher, of the order to 20–50% or more (Smith 1998; Royal College of Psychiatrists 2013). The process just described suggests that the referred group are not a random selection of those with comorbidity but an important subgroup whose overall medical care may be at risk. Liaison attachments can lead to improved identification and access for patients with referral rates of 10–17% in established services to oncology (Kissane and Smith 1996), renal medicine (Rustomjee and Smith 1996) and HIV/AIDS (Judd et al. 1997).

Looked at from the 'consultation' end of the continuum the aim of advancing the psychosocial care of medically ill patients would be population based and concerned with identification and providing, and supporting the provision of care, for high prevalence conditions within this gap: screening for depression and anxiety, stepped and collaborative care models for identified disorders, psychoeducation about managing with chronic illness, survivorship and so on. Clinical processes that will

be importantly contributed to by a range of mental health and psychosocial professionals as well as by specialist nurses in medical services (e.g., Sharpe et al. 2014; Turner et al. 2017).

Contrasting, but ultimately complimenting, this, Graeme Smith (Smith and Strain 2002, Smith 2009) highlights the potential roles of CLP in the care of those with chronic and complex illnesses and multi-morbidity, arguing that because of its grounding in psychodynamics, systems theory and because it “welcomes” complexity, CLP is particularly well placed to contribute clinically.

These ideas are also relevant in the context of the new paradigm, emergent in Australian Health policy in the last 10 years, of Patient Centred Care (Luxford et al. 2011). Its premise is that fostering partnerships with patients by fully involving them and being respectful and responsive to their preferences, needs and values, will result in improving the quality and safety of health care. (Luxford et al. 2011). It has clear links to ideas of individualised health care and patient self-management.

Smith & Strain (2002) have gone as far as suggesting ‘patient centred care’ as the successor to the biopsychosocial model as it subsumes that approach but extends it to take into account the patient’s experience of illness, their narrative of self-understanding and issues of autonomy and “patient as partner”. They point out that the biopsychosocial model, while a valuable concept, can be criticised as an explanatory model as it is without rules or pathways (Smith and Strain 2002; McHugh 1992; McLaren 1998) and that by contrast patient centred care lends itself to empirical study of what matters to patients. This approach is likely to be particularly relevant in chronic and complex illness and multi-morbidity when the confidence in the “best medical treatment”, an excellent goal for a single acute illness, is no longer easy to determine. This sort of illness is progressively becoming the norm (Smith and Strain 2002; Fava et al. 2012; Tinetti and Fried 2003; Tinetti et al. 2004; Fava et al. 2016).

In an environment where medicine can be perceived as paternalistic and focused on professional priorities, patient centred care could be misconstrued as an assertion of consumer rights over professional judgements which would be unhelpful. It might be more usefully seen in terms used by Salmon as the negotiation between the medical expertise of the doctor and the patient’s expertise in what they feel and think. (Marchant-Haycox and Salmon 1997; Salmon and May 1995; Peters et al. 1998). This is potentially a complex negotiation that can certainly result in the positive outcomes envisaged by the new paradigm but may also be challenging and lead to situations in which both parties are at “loggerheads” to use a word that Pilowsky (1975) uses in the context of the doctor-patient interaction in *Abnormal Illness Behaviour*.

Another historical dichotomy that has been central to CLP is the mind-body “problem”. Australian CLP’s links to North American have also tied it to the psychoanalytic psychosomatic tradition. In the US early enthusiasm for the psychogenic causation of illness evolved into Engel’s bio-psycho-social perspective and an integrative, rather than reductionist, view. The psychogenic view did however persist in the more popular conceptualisation of somatisation which saw somatic

symptoms as an alternative expression of psychological distress (Lipowski 1968; De Gucht and Fischer 2002).

Australian Psychiatry did not share either this psychosomatic heritage, or the mitigating popular fascination in psychoanalysis that had emerged in the US after Freud's visit in the first decade of the 1900s. In fact the linkage of psychiatry to the idea of psychological factors being causative in physical disease is suggested to be one of the reasons for suspicion and hostility toward the profession from within the medical establishment as far back as the 1950's (Lafferty 2003). Kalucy's (1979) review of Psychosomatics, the only eponymously named one in the Australia literature, was careful to avoid even the suggestion of such claims.

Medline searches of the important Medical Journal of Australia (MJA) and the journal of the Royal Australian College of General Practitioners, the Australian Family Physician, returned no hits for Psychosomatics or Psychosomatic Medicine, and in the journals of the RANZCP there were just over 20, nearly all prior to 2000.

At a popular level the idea of psychogenesis also has strong links to the politically and socially contested and divisive area of workplace compensation: compensation neurosis in the 1970s (e.g. Rubinstein 1982; Lloyd and Stagoll 1979; Mendelson 1982; Cole 1970), RSI (Repetition Strain Injury) in the 1980's (e.g. Quintner 1995; Hocking 1987; Lucire 1986) the controversies over Agent Orange in the 1990 (e.g. Hall and McPhee 1985).

In 1985 Pilowsky wrote a playful but pointed article in the MJA in which he entreated doctors and health services not to become subject to "Malingeringophobia": an irrational and maladaptive fear of being tricked into providing health care to individuals who masquerade as sick but either have no illness at all or have a much less severe one than they claim (Pilowsky 1985).

The problem of patients who present with somatic symptoms that are either not explained, or are inadequately explained, by demonstrable organic disease, has been and is a core theoretical and clinical challenge for CLP. In Australia Pilowsky's concept of Abnormal Illness Behaviour (AIB) (Pilowsky 1969, 1975, 1997) has been an important anchor in dealing with this group of patients.

The idea emerged at the same time as Lipowski's (1968) revival of the idea of somatisation although it never received the same level of prominence outside Australia. However as somatisation fades from the nomenclature and the somatic syndromes are reappropriated by medical disciplines AIB retains some utility both clinically and heuristically. Fava has even suggested that Illness Behaviour, one of the progenitors of AIB, may provide a unifying framework for understanding the variation of presentation and outcomes of disease, and by extension, of somatic symptoms, that are unrelated to the disease itself (Fava and Sonino 2013).

Issy Pilowsky was one of the émigré psychiatrists who enriched Australian psychiatry. He arrived in the late 1960's after time studying hypochondriasis in South Africa and UK to work with David Madison's Department at the University of Sydney and in its teaching hospital Royal Prince Alfred (RPA). His first paper outlining AIB (Pilowsky 1969) was published in his years there prior to taking the academic chair in Adelaide and further developing the idea in the context of working with patients in a chronic pain clinic. Significantly it rested on two sociological

concepts, the idea of Illness Behaviour introduced by Mechanic (Mechanic and Volkart 1960; Mechanic 1962), and Talcott Parsons (Parson 1964, 1978) earlier delineation of the “sick role”, and it was interactional in that “doctors were central to the process” (Pilowsky 1997 p.15; Singh et al. 1981). From a clinician’s perspective, faced with the frustrated and loaded referral-demand to determine whether particular symptoms were “organic or functional”, it allowed some thought in the space between the dichotomous alternatives and helped provide the option of things being “both one thing and the other”.

It is now apparent that far from being unusual the experience of symptoms in the absence of organic disease is the norm, although most people do not act on these symptoms by seeing doctors (Mayou et al. 1995; Hannay 1978; Verbrugge and Ascione 1987; McAteer et al. 2011). Lipowski’s final definition of somatisation (Lipowski 1988; DeGrucht and Fischer 2002) as the tendency to experience physical symptoms, attribute them to illness and seek medical attention identified the group who did, and it took them to the doctor’s door. AIB can be defined as the persistence of an inappropriate or maladaptive mode of experiencing, evaluating or acting in relation to one’s own state of health despite a doctor’s reasonably accurate and lucid explanation (Pilowsky 1997, p 25). This conceptually takes the patient into the doctor’s consultation and finds them unable to reach common ground about the nature of the condition and appropriate course of action, and potentially be at “loggerheads” (Pilowsky 1975).

Pilowsky (Pilowsky 1975; Pilowsky and Spence 1976a, b) described the cognitive set of his pain clinic patients as involving a conviction about the presence of illness, a focus and preoccupation about physical concerns, and a minimising or dismissal any psychological contribution. Clinical experience suggests that doctors not infrequently develop an opposing cognitive outlook, a conviction that there is nothing physically wrong and that the problem is psychological, somatic complaints are trivialised or dismissed and psychological issues focused on and emphasised. This pattern of polarised, oppositely mirrored views is also described in other models of chronic dysfunctional relationship (White 1984).

The interactional element of the AIB concept then allows question to be asked about the role of dysfunctional doctor-patient interactions in the presentation and phenomenology of these conditions (Gribble 2002) and about factors that might contribute in a group of patients who so often have difficulty with multiple doctors, and who not infrequently have personality vulnerabilities and histories of abuse..

26.4 History: An Australian Context for Consultation-Liaison Psychiatry

There has been universal health cover (Medicare) in Australia provided though the Commonwealth government since the 1970s. The Australian Constitution however determines a division of powers, and the States retain responsibility for public

general hospitals and public Mental Health Services, albeit significantly underwritten by Commonwealth grants. This funding stream means that the Commonwealth retains leverage. Increasing concern about the variation and quality of Mental Health Services across the country led to it facilitating the development of a series of National Mental Health Plans (NMHP) through the, sometimes fraught, Federal Commonwealth-State partnership from the early 1990s.

Within States there are usually separate funding streams for public Mental Health Services (MHS) and for [non-psychiatric] General Hospital Services. State health departments provide funding to local, now mainly geographical area-based, Mental Health Services which allocate and manage this budget and provide for the public inpatient and community mental health facilities as well as the baseline funding of CLP services. In financially straightened times the responsibility for funding services for general hospital patients can be the source of tension in non-CL Mental Health circles notwithstanding either the reality of the psychiatric morbidity or principles of equity of access to appropriate service not being delimited by general hospital perimeters.

Psychiatric training occurs almost exclusively within the public mental health system. The trainees provide the essential junior medical workforce for that system and recruitment has been something of a challenge for many MHS in the last decades.

Funding and allocation decisions about CLP services can then be affected by policies and priorities at all these levels. In the last decades these priorities have increasingly focused on the needs of the traditional, mainly psychotic, mental health patient populations – sometimes labelled the “seriously mentally ill” - along an axis of care encompassing psychiatric inpatient and community mental health (including Early Intervention) facilities. It has been argued for some time that this has been associated with significant “marginalisation” of the mental health needs of those with physical illness – a group Smith has referred to as the “otherwise seriously mentally ill” in view of their established psychiatric morbidity (Smith 1998; Shrader 1998).

Data has become increasingly important at State and National levels as a potential tool to improve efficiency and manage costs and develop funding models. Case-Mix Funding, based on Diagnosis-Related Groups (DRG) was introduced, with various modifications, across many State in the 1990s for inpatients (Ducket 1998). Then from 2010 Activity Based Funding (ABF) has been progressively phased in Australia wide (Solomon 2014; Eagar 2010). Both systems rely on accurate and valid data and the complex process of establishing costings based on diagnoses, activity and interventions to create what, in the ABF system, is termed a “National Efficient Price” as a basis for determining public hospital payment. Both approaches initially struggled to adequately deal with Mental Health. Both continue to struggle to address consultation activity as payment models direct reimbursement to the clinical stream responsible for the management of the patient’s primary condition, not to the services that provide consultations. When a National Australian Mental Health Care Classification was developed to establish mental health costing it only included inpatient and community activities (Solomon 2014). Perhaps this reflects

the dominance of the inpatient-community axis of care and the focus on the traditional mental health patients, but it leaves CLP, and its patients, in an unsatisfactory and potentially vulnerable situation. Currently at least in some States consultation activity is recorded as if it were occurring in a community mental health setting and as if patients were primarily clients of the Mental Health system, neither of which are accurate or valid descriptions. In a publicly funded system the importance of a funding stream accurately based on the particular nature of CLP work is apparent even if a mechanism remains to be established.

Within this context the RANZCP training requirements have been pragmatically very important in maintaining access to mental health expertise for clinical population CLP serves as well as for the development of the subspecialty. In addition to the mandatory basic training experience, from the time of the 2003 Guidelines the possibility has also existed for trainees to do a 2 year Advanced Training in CLP to gain a RANZCP Certificate of Advanced Training. This is a great opportunity for the subspecialty but has also presented challenges. The most frequently heard concerns expressed by general hospital CLP psychiatrists are about the adequacy of funding to meet the service demands, the maintenance of existing funding and the availability of adequate training positions to meet both service needs and the training requirements.

CLP services have developed very unevenly across general hospitals within and across the Australian States and New Zealand. Services in neighbouring hospitals may have different structures, approaches, clinical scope and different staffing numbers and profile. However they are usually small and busy. Service development in each setting is likely to reflect the accidents and advantages of the local history of that general hospital's psychiatry department and of the engagement of psychiatry and CLP clinicians with general hospital services. It is affected by support and prioritisation (or lack of it) within local MHS, by medical and surgical services, by Health Department directions and, by the serendipity of unexpected funding opportunities and the energy of individual clinicians to chase them, and the timing of staffing and trainee shortages, restrictions and freezes. The current overview might then be significantly different if viewed from the perspectives of different services or services in different states.

The author is a part of the Consultation-Liaison Service at Royal Prince Alfred Hospital (RPA) in NSW. This was the premier teaching hospital of the University of Sydney in the late 1960s and 1970's when CLP was emerging in Australia. At the time the Academic Department was led by Professor David Maddison, an RPA trained physician-psychiatrist, an educationalist and something of a force of nature. He had a profound influence on the development of the RANZCP, the vision of psychiatry in Australia at the time, and on the training of psychiatrists and of medical students (Mellor 2008; Rubinstein and Rubinstein 1996; RANZCP 2017a). He didn't identify himself as a Consultation-Liaison psychiatrist but his vision of psychiatry as a part of medicine made him a facilitator of CLP at RPA and the hospital was an early hub of CLP activity in Sydney. The clinicians he employed and introduced into the general hospital had a major impact on CLP's subsequent standing and the historical advantages enjoyed by the Service at RPA.

In Melbourne in the same period, Wallace Ironside had an even greater impact on the local and subsequent bi-national (Australia and New Zealand) development of CLP (Orchard 2001; RANZCP 2017b). He became the inaugural Professor of Psychiatry at Monash University in Melbourne in 1969. He identified as a C-L Psychiatrist and was a strong advocate of the liaison model and he developed a large and significant CL service presence within the teaching hospitals associated with Monash Medical School. His advocacy and influence on the development of CLP in these hospitals, in Victoria, and consequently in the RANZCP and in the country, has been very significant.

The major figures in development of psychiatry in South Australia and Queensland during this period, Cramond (Dibden 1992) and Whitelock (Lawrence et al. 2013), did not have the same focus on psychiatry in the general hospital, although Cramond published early work about psychiatry and renal transplantation. (e.g. Cramond et al. 1968)

While Maddison's colleagues and trainees took his broad view of psychiatry to chairs in Newcastle, Brisbane and Adelaide, the evolution and consolidation of CLP as a subspecialty in the College can be traced to its development in Melbourne under Ironside's influence. As a consequence CLP has historically been most strongly represented in that state.

In 1995, when the Section of C-L Psychiatry was established it had with 225 members. A third of members were from Victoria, a quarter from NSW, and then progressively smaller numbers in Queensland, South Australia, New Zealand and the other states. In 2018 the Faculty has 364 members, 8% of RANZCP Fellows. Victoria still has most (101), NSW has 92, Queensland runs a much closer third with 76 but the other states and New Zealand still struggle to maintain a critical mass with 30 members or less.

In the years after its foundation the Section worked to create a national focus and concentrated initially on a series of successful Scientific Meetings. These were run in association with the annual RANZCP Congress. Their success, and the success of other similar sub-specialty satellite meetings, was seen as detracting from the success of the main Congress and the College withdrew the necessary support and the subspecialty meetings were unfortunately reabsorbed into Congress. Subsequently semiregular 1 or 2 day meetings have however been held in Victoria, NSW, Queensland and New Zealand. In most states, State Branches of the Faculty sponsor RANZCP Continuous Professional Development (CPD) activities.

26.4.1 The 1978 RANZCP Training Guidelines

It seems anomalous that in 1978 a small College of Psychiatry in Australia, a long way from the birthplace of modern CLP in the northeast of the US, should have led the English speaking world by mandating a 6 month training in CLP for all trainee psychiatrists. The requirement is still notable for both its length and mandatory status (Smith et al. 1993).

The genesis of the 1978 RANZCP Guidelines for Training is not detailed in the official history of the RANZCP (Rubinstein and Rubinstein 1996), but from this distance in time they seem to reflect a broad and aspirational view of the role and relevance of psychiatry, and of psychiatry in medicine. Innovation was not restricted to the inclusion of CLP training. A similar 6 month experience in Child Psychiatry was also mandated as was the completion and write up of a supervised 40 session psychodynamic psychotherapy case.

The explanation for the Guidelines composition and successful passage is probably multifactorial: the enthusiasm, drive and influence of key academic figures in both Sydney and Melbourne and the impact they could have in a small College, the resurgence of Australian psychiatry from the doldrums of the asylums, the emergence and influence of academic general hospital psychiatric units, the enthusiasm then abroad in psychiatry in the English speaking world that saw it on the verge of changing the practice of medicine (Lipsitt 2016), and a somewhat matching spirit of change and optimism in Australia in the 1970s.

Mental Health or “Mental Hygiene” as it was often termed (Dibden 1992) in the 1950 and early 1960’s has been characterised as “asylum based psychiatry languishing in forlorn decrepitude” (Lafferty 2003). A series of damning reports had highlighted problems of the large state-run mental institutions from the mid 1950’s to the early 1960s (the Stoler Report to the Commonwealth Government in 1955, the Royal Commission of Inquiry into the Callan Park Mental Hospital in 1961 and the Cramond Report in South Australia in 1963).

Community attitudes to those with mental illness, and those who treated them, were of hostility and suspicion, and these attitudes were largely shared by the medical profession (Lafferty 2003). The ambivalence toward psychiatry is recounted by Maddison, “These were the days of the dumping syndrome - when it was almost unheard of for a psychiatrist to be invited by a non-psychiatrist to collaborate ... in patient management but when, after every conceivable type of treatment had been tried by the physicians (plus a few inconceivable ones), the hapless psychiatrist would arrive on his ward in the morning to find that one or more patients had been unceremoniously ‘dumped’ into his ward during the night by a conspiracy of registrars” Maddison 1981, p212).

Psychiatry was poorly represented in medical education (Maddison 1981; Cramond 1981), the limited number of academics came largely from the UK (Cramond 1981) and post graduate training was desultory. The intrigue and interest in psychodynamics which leavened community and professional attitudes in the US (Lipsitt 2016) was limited as, with exceptions such as Ironside and Maddison, the academic focus in Australia was on somatic treatment (Lafferty 2003). Perhaps things could only get better.

The historian Blainey (1966) described the post-colonial apprehension and pre-occupation about isolation from the centres of power, learning and culture in England and America as a “Tyranny of Distance” and saw it as dominating the Australian national identity prior to the 1970’s. It infected medicine and psychiatry as well. Aspiring doctors and psychiatrists had little option but to pack their belongings, work their passage, often as ships’ doctors (White RT – personal

communication) and make their way to the UK or, increasingly, to the US to gain experience or qualifications. Many future leaders in Australian psychiatry made this return journey. Some spent time with Arthur Crisp in London and brought back an abiding interest in anorexia nervosa which was the archetypal psychosomatic condition in that country at the time. Other beat a path to the northeast of the US and particularly to George Engel's unit in Rochester (Orchard 2003), from there they brought back, the bio-psycho-social model, the beginnings of C-L Psychiatry and abiding interests in grief and trauma.

Lipsitt (2016) described the sense of excitement in US psychiatry in those decades about its connections and potential contributions to medicine. This was built on the legacy of 30 years of general hospital psychiatric units in the US, the wartime developments in psychodynamics that focused on crisis intervention and reactions to stress, and on the ideas of people like Engel. The Australians also brought back this excitement and the optimistic vision of the scope of psychiatry.

David Maddison, whose enthusiasm for psychiatry owed something to a "fascination with psychodynamics" (Mellor 2008; RACP 2017) made return trips both to the UK and the US and worked with Gerald Caplan at Harvard while he was formulating the principles of mental health consultation for community psychiatry (RANZCP 2017a). Down the road at the Massachusetts General Hospital those patient- and consultee-focussed consultation would soon be utilised in the theoretical development of CLP.

Wallace Ironside, a Scot and another of the overseas academics who enriched Australian psychiatry, came on a one-way multi-city ticket, from a psychodynamically oriented training in Scotland, to a fellowship with Engel and a training-analysis at Alexander's Chicago Institute, before foundation professorships first in Otago in New Zealand and then at Monash (Orchard 2001; RANZCP 2017b; Muir 2001) He brought commitment to CLP and the Liaison model and arrived at Monash and with the stated aim of creating a training for psychiatrists outside the psychiatric institutions of the day (Orchard 2001).

Like Maddison, and like Engel he was a physician-psychiatrist. Many of the early leaders of Australian psychiatry were, or had a background in general practice: Kalucy, Raphael, and Orchard. Ellard, who chaired the Accreditations Committee of the College during the period of development of the 1978 Guidelines (Rubinstein and Rubinstein 1996) was another and he suggested that, as an emerging psychiatrist in that era, it was 'what you did' (Ellard 1989).

Until the mid- 1960's Maddison's RPA had been the only general hospital in the country with a co-located psychiatric inpatient unit. The Princess Alexandra Hospital in Brisbane (1965) and then Ironside's major teaching hospital, Prince Henrys Hospital (1969) followed and were the harbingers of a wave of general hospitals with inpatient units and Academic Departments of Psychiatry. Initially largely independent of the stand-alone psychiatric hospitals, these general hospital departments, particularly those affiliated with the Universities of Monash and Sydney developed broadly psychosomatic interests from anorexia to the neurobiology of personality and its psychotherapeutic treatment. They provided fertile ground for CLP. However CLP academics were largely restricted to

Melbourne, and later Brisbane. Despite major changes to general hospital psychiatric units in the mid -1990s, many of those hospitals remain important CLP sites: Monash, the Alfred and St Vincent's in Melbourne, RPA, Westmead, Royal North Shore, Prince of Wales Hospitals in Sydney, the John Hunter Hospital in Newcastle, and Princess Alexandra in Brisbane.

The training of psychiatrists has been a core concern of the college, and its immediate predecessor, from its earliest days and training has often led the way and driven developments. The transformation of the Australian Association of Psychiatrists (AAP) into the Australian and New Zealand College of Psychiatrists (ANZCP) in 1964 (it became the Royal Australian and New Zealand college of Psychiatrists in 1978) was propelled by training needs. In the previous years the AAP had determined to improve local training of psychiatrists and consolidate a scattering of uneven theory-based university Diplomas of Psychological Medicine (DPM) into a single nationally recognised one under the its own auspices. Legal opinion that its qualification would not be recognised as the AAP was not a legally constituted body provided the main impetus to the formation of the College (Rubinstein and Rubinstein 1996).

As Chief Censor of both the AAP and the new College of Psychiatrists, Maddison was a key player in these processes. He initially used the University of Sydney DPM as the prototype for the ANZCP, and then transforming the entire assessment and examination approach with a focus on the development of broad clinical competencies (Rubinstein and Rubinstein 1996).

The innovative exam and assessment structure he designed was in place by 1970, but a trainee's actual training experiences were not stipulated and needed to be arranged either by the individual trainees or by their parent institutions which was unsatisfactory (Smith 2000). In the mid-1970's the Victorian Branch of the College established a Training Committee to regularise and coordinate this process in the state. The model was subsequently adopted nationally (Smith 2000). Training Guidelines were a logical extension of these processes and the College established a Board of Accreditation in 1975, under Dr. John Ellard to deal with accreditation and training matters, separate from examinations (Rubinstein and Rubinstein 1996).

The Training Guidelines of a College of Psychiatrists are not a matter of national political interest, but the political spirit of the times may have an influence in the other direction. The 1970s had seen the country break the shackles of its post-colonial identity and, in 1972, vote in a reforming government under the election slogan of "Its Time". It changed Australian society: the involvement in the US Vietnam War ceased on election night, the voting age was lowered to 18, universal health care and free tertiary education were introduced, multiculturalism emerged and indigenous land rights were recognised for the first time. The years also marked the peak of the anti-psychiatry movement in Australia and saw the idea of community management of the traditional mental health patients become government policy (Lafferty 2003; Wilson 2012).

It is unclear where, between the RANZCP Executive, the Committee for Accreditation and the Committee for Exams the Training Guidelines took form but

the conditions were right for a statement that would shape the development of psychiatry rather than reflect institutional psychiatry and the status quo.

The people were also in the right place: Maddison in Sydney and Ironside in Melbourne were probably the most influential psychiatrists in those cities around, they were both educationalists and concerned about psychiatric training and about psychiatry as a part of medicine, they were both involved in the development to the RANZCP and influential in it, serving as President in 1972 and 1974 respectively. Ironside's successor as Professor in Otago, Basil James, was College President when the important 1978 Training Guidelines were ratified and psychiatrists who had trained under Maddison or worked with him were influential across the country. Ellard, another close associate, chaired the committee that would develop the guidelines. In retrospect there is almost a sense of inevitability.

While the new training demands placed pressure on hospitals to create terms or placements to accommodate the new training needs, neither the terms in CLP, nor in Child Psychiatry, were without precedent in the country. Maddison had initiated a 6 month attachment in Child Psychiatry for at least some of his trainees (Adler and Lonie 2001). Ironside had by 1974 amassed 11 trainee psychiatrists at Prince Henrys Hospital (Smith 2000; Orchard 2003), five of whom worked in the CLP Unit. Graeme Smith recalled that there was virtually a liaison service to every unit in the hospital (Smith 2000). The trainee experience at Maddison's RPA was not as extensive but the infrastructure was in place as through the 1970s he had appointed 4 or 5 psychiatrists to medical units within the hospital including the melanoma and the renal units. Issy Pilowsky was the first of a line of psychiatrists to the renal unit at RPA prior to taking the Chair in Adelaide in the early 1970s.

26.4.2 RANZCP Sub-Specialty Recognition

During the 1980s clinical CLP developed quietly if unevenly in Australia and New Zealand. Identified CLP services gradually emerged within general hospital departments of psychiatry with dedicated CLP clinicians replacing those who had carried out the general hospital consults on an on-call or ad hoc basis but who had primary roles elsewhere. In NSW the Department of Psychiatry at RPA was the first to have a designated CLP Consultation-Liaison Service in 1980, however this didn't happen in some other major hospitals, now important CLP centres, till the end of the decade (Snars J – personal communication).

The process leading to formal recognition of CLP in the RANZCP structure also started slowly.

In Victoria an informal interest group, the Liaison Group, had coalesced around Ironside and the Monash CLP clinicians in 1975. The group prospered and grew and its evening meetings, involving good Melbourne restaurants, have been a focus for CLP in that state since. It provided the impetus and leadership for a number of initiatives in CLP, including the move to gain subspecialty recognition in the College (Smith 2000).

In NSW a group of clinicians had also formed in the mid 1970s, mainly from RPA, the Prince of Wales and Sydney Hospitals, but didn't persist into the 1980's (White RT – personal communication). Allegiances in NSW tended to be aligned with local hospital departments of psychiatry rather than a CLP community. An interest group re-emerged in the early 1990s following a series of annual one-day seminars convened by the RPA CL Service from 1991. This was to form the basis for a NSW Branch of the CLP Section a few years later. Nonetheless a cohort of remarkable clinicians – Vickery, White, Jennings, Streimer, Wilton, Vamos and others - established psychiatry's presence in the hospitals where they worked, set the foundations of persisting liaison services, and trained and inspired a generation of trainees.

Professor Graeme Smith, from Monash and the Victorian Liaison Group provided the assertive leadership that was necessary to draw together the scattered representation of CLP from all Australian States and New Zealand. In the early 1990s he initially gathered a Workgroup of CLP clinicians from both countries to survey CLP activity and staffing (Smith et al. 1994) and then in 1992, at the year's major RANZCP event the College Congress in Canberra, he convened a special meeting of CLP clinicians and the RANZCP Consultation-Liaison Psychiatry Interest Group was established. In 1995 at one of the first national CLP Scientific Meetings organised by the Interest Group, at Port Douglas in North Queensland, the RANZCP By-Laws for a Section of C-L Psychiatry were presented, supported, subsequently ratified by the College Council (RANZCP 1995) and the Section formed.

The timing of the formation of the Section was opportune as in the late 1990s the College undertook a major review of the 1978 Training Guidelines. More subspecialties had emerged in the intervening years and the CLP Basic Training requirement was a under threat. Advocacy from the Section and from the National Association of Psychiatrists-in-Training, who argued that CLP provided their only significant training experience of consultation work, saw the CLP mandatory term retained in the subsequent 2003 Guidelines and, now established, it was again maintained in the subsequent 2012 revision of Guidelines.

26.4.3 *Changing Times*

As this pathway to subspecialty recognition was being pursued through the 1990's the Mental Health environment was changing, and along with it, Mental Health's relationships with the general hospital. These relationships had been important in the development of CLP and now changes would also affect the subspecialty.

The roots of the changes were in the aggressive de-institutionalisation and inadequate reinvestment in community mental health services, let alone general hospital services, from the early 80s which had been highlighted by the National Inquiry into the Human Rights of People with Mental Illness, known as the "Burdekin Report" (Rose et al. 1993). Public and political concern about mental health care also led to the joint development of the first National Mental Health Plan (NMHP) (1993) by

Commonwealth and State governments. These 5 yearly NMHPs are now a feature of Mental Health policy in the country and have led to significant improvements in mental health care funding, coordination and resourcing but they have also been narrowly focused on those with primary mental illness, the traditional group of mental health patients, and contributed to a marginalisation of the CLP patient population in Mental Health priorities (Smith 1998; Shrader 1998).

The first NMHP defined its target patient population for Mental Health Services as those with “serious mental illness”, a term that in resource-poor Mental Health Services was eagerly interpreted to mean those with psychosis. CLP were particularly disadvantaged in Victoria. NSW fared a little better under a State framework called, “Caring for Mental Health” (NSW Health 1998), designed by Beverley Raphael, a Maddison protégé, which retained CLP as a core element.

The 2nd NMHP in 1998 acknowledged the unintentional impact of this narrow interpretation of “serious mental illness”, highlighting its effect on CLP and the population it served. It also set out, amongst others, a principle of Equality of Access to appropriate specialist mental care when and where it was needed (with no exclusion zone around non-psychiatric settings of general hospitals!). This recognition was important but did not change the overall reorientation of policy direction in subsequent NMHP and while CLP is certainly not excluded, it is also clearly low on the policy agenda. In the current, 5th NMHP the focus is on those with “severe and complex mental illness” albeit perhaps no longer quite so narrowly interpreted.

Deinstitutionalisation and the associated loss of institutional psychiatric beds also resulted in the inpatient wards of general hospital departments of psychiatry being taken over by catchment-area responsibilities for the acute, often involuntary, patients previously managed in the large psychiatric hospitals. They effectively became part of a now decentralised system to manage this group of patients and their character changed (Smith 2000), and with it much of the clinical and academic orientation toward the general hospital and the psychosomatic interfaces.

Equally significantly the reduction in the assessment and reception capacity of the downsized mental health institutions, along with limited community psychiatric resourcing, changing pattern of illicit drug use, and the early NMHP policy of “mainstreaming” mental health patients into general health facilities, ostensibly to reduce stigma, led to a very changed and increased MH utilisation of general hospital “EDs” (Emergency Departments) (Tankel et al. 2011; Kalucy et al. 2005; Knott et al. 2007; Frank et al. 2005). In addition and at the same time, the overall utilisation of EDs by the general population was increasing quite dramatically. Moreover within this upsurge, the upsurge of so called “mental health patients” - those with discharge diagnoses within the broad spectrum of ICD-9 “Mental Disorders” or ICD-10 “Mental and Behavioural Disorders” - was disproportionate (Tankel et al. 2011). The changes within MHS also meant that this increase also, and particularly, involved those with the most severe mental health presentations - the involuntary patients who were now being brought in increasing numbers to EDs. In the face of inadequate bed numbers and availability in inpatient mental health settings this led to extended ED stays, what EDs labelled, “Mental Health bed-block” and MHS called “access block”. In NSW the existing Mental Health Act had to be amended

in 2007 in large part so that EDs could be designated as “Declared Mental Health Facilities” and the transport of involuntary patients to EDs could be legally facilitated as it had not been envisaged in the previous legislation. By 2009 just under 70% of patients in general hospital inpatient psychiatric wards were being admitted through EDs (InforMH 2010).

This situation evolved into a significant medico-political crisis, initially in the early 2000s. It led to a number of state government and local MHS initiatives to try to manage the pressures building in the EDs in relation to mental health patients: new configurations of service provision, the introduction of a wave of MHLN into EDs, the introduction of Psychiatric Emergency Care Centres (Frank et al. 2005). While some of these changes have aided patient care in the ED, and provided support to the EDs, the changed underlying dynamic has remained and the issues are again emerging and raising concern (e.g. the Australasian College of Emergency Medicine report on “Waiting times in Emergency Departments for People with Acute Mental Health and Behavioural Conditions” (2018) available at www.acem.org.au, Alison et al. 2019). It is not clear if the problem will prove to be delimited to a problem of ‘mental health patients in ED’ or if the underlying shifts in presentation will require more substantial structural changes to existing mental health service paradigm, patterns of care, and collaborations with the general hospital.

In 2002 80% of CLP services (Section of CLP, 2002 – unpublished) had clinical roles in EDs so these changes have had significant impacts on CLP services and have resulted in consequent concern about trainee’s experience. EDs had almost become offsite psychiatric assessment and admission facilities and threatened to undermine experience with general hospital patients with medical-psychiatric co-morbidity. The Section initiated College processes that resulted in a caveat in the College training guidelines that limited to 30% the time spent in ED work during the CLP training experience. There had previously been similar potential incursion into the CLP training experience by the rebadging of admittedly valuable trainee clinics in primary care as CLP instead of Community Psychiatry despite the patient not having medical-psychiatric comorbidity (Carr et al. 1997a, b; Gribble 1998).

The reorientation of mental health priorities has put pressure on CLP services and has reduced the likelihood of opportunities for Mental Health Service supported development. However medical and surgical services are increasingly aware and concerned about the psychosocial needs of their patients, national guidelines including psychosocial care have been developed for a number of conditions (e.g. NHMRC). State Health Departments may require psychosocial assessment or screening (e.g. in NSW Perinatal Clinics and for Living related Renal Transplants). In public general hospitals, medical and surgical services are seldom more flushed with funds than are Mental Health Services, however opportunities to secure funding through applications for enhancements or under particular government of hospital targeted initiatives, often in an interdisciplinary framework, can arise. While the MHS funding for baseline consultation services for patients in the general hospital is vital, development into other areas of need still often requires this sort of serendipity. In the 2002 CLP survey, just over half the services to significant hospitals reported some, albeit limited, non-mental health funding contribution.

26.5 Clinical Practice and Interdisciplinary Roles

Larger public general hospitals in Australia are likely to have access to at least basic CLP cover, and the major teaching hospitals, particularly those with inpatient psychiatric units and associated psychiatric training programs will probably have an identified CLP services. Nonetheless an internal survey conducted by the RANZCP Section of CLP (unpublished) in 2002 found only two thirds of such services in hospitals with over 300 beds had a designated director and less than half reported any administrative support.

The survey also demonstrated that the majority of CLP work relates to providing a general consultation service for patients referred by medical/surgical teams in inpatient wards but most also provide support for the Emergency Department. Less than half provided outpatient availability, and anecdotally most of this is in the context of liaison attachments to particular specialist medical clinics and few services have the resources to provide a general service for ambulant referrals from their hospitals or follow-up for significant numbers of patients seen as general consultations. In this context involvement with Primary Care, beyond clinical communication about patients, is not frequent (Blashki et al. 2005) although at least one CLP service in Sydney is involved with Balint style groups for General Practitioners. (Wilhelm K. – Personal communication).

In the 2002 CLP survey, in hospitals with 300–1300 beds (median: 500 beds), the median C-L Service had 4.2 staff with 1.6 Full-time Equivalent (FTE) C-L Psychiatrists, 1.8 FTE psychiatric trainees and 1.0 FTE MHLN (Mental Health Liaison Nurse). Fewer than half included a psychologist. Only 14% of services had university supported academic positions although many clinicians had conjoint appointments to facilitate medical student teaching.

Holmes et al. (2011) used data from 3 Melbourne teaching hospitals to determine the minimum staffing levels necessary to provide the basic consultation component of a CLP service. Their suggestion was 1.0 FTE clinician /100 beds and they note the need for higher staffing levels if the service was to undertake liaison activities and to provide education or conduct research. In their survey hospitals the actual rate was 0.84 FTE/100 beds, and, using the data from C-L Section Survey, the calculated median Australian staffing level is identical.

There are few international comparisons, but the British Royal College of Psychiatrist's report "Liaison psychiatry for every acute hospital" (2013), suggested clinical staffing for a 650 bed hospital equivalent to 3.3 FTE/100 beds, with nearly 50% more psychiatrist time (consultant and trainee) but much greater nursing representation. The exiguous overall staffing probably explains the predominance of medical (ie psychiatric) staffing in the small, busy Australian services that respond predominantly to consultations from medical staff in the usual manner of general hospital medical consultation.

All training hospitals will provide some Liaison experience, as it is a required element of the training. This may be part of an established attachment with engagement across inpatient, outpatient settings with interdisciplinary meetings and sig-

nificant CLP consultant commitment, or it may be more limited. Most larger, established CLP services will have at least some longstanding liaison attachments – cancer, transplantation and HIV/AIDS figuring strongly (Judd et al. 1997; Rustomjee and Smith 1996; Kissane and Smith 1996). The viability even of these established services increasingly seems to hinge on at least limited specific funding support from the medical or surgical teams, or from specified MH funding streams (e.g. for Perinatal Psychiatry) or other sources. Some “single purpose” services have also developed separate to the general hospital CLP units in specialist hospitals or specialised unit within hospitals as in some maternity hospitals (Philips et al. 1996; Judd et al. 2010; Dunsis and Smith 1996) and in stand-alone Cancer Centres.

Geriatric Medicine may have services provided from the general CL Psychiatry, or, as is often the case in the UK, from area based Old Age Psychiatry services (Draper 2001). A pioneering text book on Geriatric CLP boasts both Australian and New Zealand Editors (Melding and Draper 2001). Child and Adolescent Psychiatry generally provide CLP in specific larger Children’s Hospitals and may provide secondary consultation in general hospital with children’s wards.

The gap between CLP referral rates and the prevalence of mental health disorder in general hospitals has been discussed previously. The literature (Huffman et al. 2014) describes models of collaborative and stepped care for depression, usually underpinned by screening and involving primary care, but also extended to patients with physical illness such as diabetes and to outpatient oncology patients. In Australia Turner et al. (2017) reported a tiered multidisciplinary approach integrated into routine care in an oncology setting.

All these formal, structured approaches are substantial undertakings and outside the scope of the small, busy Australian CLP services. A few large cancer centres or pain clinics may fund and coordinate the necessary personnel but in the CLP setting, interdisciplinary clinical collaboration developed over time and based on locally built relationships in the context of liaison attachments is more likely to lead to comprehensive responses – examples exist albeit usually unsung (e.g. Helou 2009).

In NSW expectant mothers have psychosocial screening at their first antenatal clinic visits. At the author’s hospital there are over 5000 live births annually. An application for 2nd NMHP funding some years ago secured a part-time CLP consultant. Close working relationships were established with the Obstetric Social Work team and with midwives and a joint intake, triage and assessment meeting established. Externally funding was ultimately accessed to support firstly a MHLN and then a commonwealth funded Specialist Training (Psychiatric) Registrar. An effective interdisciplinary service has been established despite administrative diversity but based on collaborative relationships but involving limited direct MHS funding (although they subsequently assumed the funding of the MHLN).

One of the opportunities, and some of the challenges, for Australian CLP come from the emergence of other psychosocial and mental health professionals in general hospital work. If the ultimate goal of CLP is to advocate for, and contribute to, improving the psychosocial care of physically ill patient in the general hospital (Lipowski 1968) then this is to be welcomed and supported. CLP services now often

include Mental Health Liaison Nurses and Clinical Psychologists but CLP also work with structurally separate MHLN practitioners or teams and with clinical psychologists, psychologists and social workers linked with medical teams or clinics. The challenge is often to facilitate interdisciplinary collaborations that respect the particular skills and contributions of all these professional groups but also recalls that access to CL psychiatry skills is necessary.

A comprehensive clinical psychosocial response for patients in general hospitals cannot omit access to CLP skills as it will be essential not for every patient but for a very important minority. In complex areas within medicine this is best managed by CLP engaged with the team, knowing the trajectories of care, and aware of the patients experience. Smith (2009) has pointed out the importance of liaison skills and the potential contribution CLP can make in interdisciplinary endeavours but he also reflects on the difficulties and challenges of the interdisciplinary space.

Social Work, often now a part of the allied health infrastructure of general hospitals, has developed roles in counselling, particularly in areas of grief and loss, and in assisting patient to negotiate the social and medical systems that extend far beyond being the “welfare officers” or “almoners” they started as in the 1930s (Miller 2006). Training in Australia started in the 1940 but it is now an established university trained profession, with increasing numbers of graduates particularly since the 1990s (Miller 2006).

Academic Psychology has a long history in Australian Universities, but the clinical roles, particularly in the general hospital are more recent. The Australian Psychological Society was formed in 1966. Its first and major specialist college, that of Clinical Psychology, was established in 1979 (APS website www.groups.psychology.org.au), and that group of Masters level specialist clinicians have gradually but increasingly been represented in medical units in general hospitals, sometimes in CLP services and, less frequently, as part of hospital clinical infrastructure. The APS College of Health Psychology formed in the late 1990 (APS website www.groups.psychology.org.au). The sub-discipline had been established in the US in the mid 70’s in response to the ascendancy of the biopsychosocial model and specialises in understanding the relationships between psychological factors and health and illness. It has a focus both on health promotion and clinical work. By 2000 Masters Level training in the sub-discipline was well established in Universities round the country, but for various reasons has now contracted (Buchanon 2016; Martin et al. 2014) although there are spirited arguments for its retention and inclusion of compulsory units in undergraduate training as well (Martin et al. 2014). An Australian-adapted text-book appeared recently (Morrison et al. 2012).

During the 1980s there were growing links between senior medical staff and psychologists at Sydney and Melbourne Universities at least and productive research partnerships in psychosocial aspects of endocrinology, cancer, anorexia and in neurosciences. In Melbourne the Department of Psychology shifted into the Faculty of Medicine in 1991 (Buchanon 2016). Psychologists are often valued because of their strengths in clinical research as well as their clinical capabilities. The numbers employed clinically has increased in recent years. In the hospital in which the author

works, from a situation of relative scarcity a decade ago, the number has grown to nearly 30, significantly outnumbering what is a large CLP service. Although they may be represented in CLP teams, and in other roles in mental health, psychologists are perhaps more often linked to medical services. Again, at the author's institution one Clinical Psychologist works in CLP but is funded from a medical service. Elsewhere psychologists have roles Chronic Pain settings, Metabolism and Obesity Clinics, HIV/AIDS services, Advanced GI Surgery, Psycho-oncology etc.

Today Psychologists provide a very major psychosocial contribution in a number of interdisciplinary organisations that have grown up around particular clinical populations, like COSA (The Clinical Oncology Society or Australia) and the APS (The Australian Pain Society, the Australian Chapter of the International Association for the Study of Pain). The large interdisciplinary Psycho-oncology Co-operative research Group (PoCoG), funded through Cancer Australia, and operates out of the School of Psychology at the University of Sydney (www.pocog.org.au).

The professional workplace changed significantly in 2006 when a specified group of psychological services were, for the first time, made rebate-able under Medicare, providing increased opportunities for psychologists in the private mental health arena. Notably one of those items involves assistance in adapting to chronic illness. Furthermore, in 2016 the Mental Health workforce in Australia comprised just over 3,000 psychiatrists, 21,000 mental health nurses and nearly 25,000 registered psychologists (AIHW 2016). Increased interdisciplinary arrangements are likely to be part of future CLP developments.

Lipowski (1983) advocated that Liaison nurses to be part of CL services to liaise with medical and surgical nurses as, he argued, this offered significant benefits for the psychosocial care of patients. The earliest reports of Mental Health [Consultation] Liaison Nurses (MHLN) in Australia appear in the 1980's, when nursing training was hospital, not university, based and mental health and general nurses trained independently (Happell 2007). Some were administratively part of general hospital nursing structures rather than mental health, engaged dual trained senior nurses and offered "consultee-focused" engagement with ward nursing staff (Meredith and Weatherhead 1980), others were part of CLP multidisciplinary teams having roles parallel to trainees (Hicks 1989; Gribble et al. 1989). The different governance models, either as part of multidisciplinary CLP teams or as separate clinical services (usually within Mental Health Services now) in interdisciplinary arrangements with CLP, still exist and are a source of discussion.

The development of university based nursing education through the 1990s contributed to increased academic interest in MHLN. The crisis of mental health patients in ED provided a clinical opportunity, and MHLN roles in CLP but more particularly in the ED increased significantly after 2000 (Sharrock and Happell 2001). Additionally the introduction of "mainstreaming" in the 1st NMHP resulted in nurses in non-psychiatric settings often feeling inadequately prepared to meet the mental health needs of patients and MHLN could provide expertise to help in patients' care and support nurses (Sharrock et al. 2006). MHLN referrals came from a range of health professionals but predominantly from nursing staff (Sharrock et al. 2008). A number of reports attest to the value MHLN in the general hospital but

particularly in ED (Sharrock and Happell 2002; Wand 2004; Wand and Fisher 2006; Wand and White 2007; Wand et al. 2015), and their role in the mental health response in ED has been significant.

MHLN is a growing Advanced Nursing sub-specialty and has a recognised Special Interest Group within the Australian College of Mental Health Nursing, there is an annual scientific meeting and a body of local literature, with some emphasis on MHLN roles in the ED.

26.6 Education and Training

While there has been no applicable review of medical school curricula, experiential and anecdotal evidence indicate that medical students are exposed to at least some didactic input about the problems of medical-psychiatric co-morbidity and somatisation during psychiatric teaching and that they may get at least some clinical exposure to psychiatry in non-psychiatric general hospital settings. Specific training in communication skills is increasingly common and significant component of their training.

Engel's biopsychosocial approach has been a ubiquitous part of medical school education in Australia since the 1970s, and his thinking had a major impact on the new and re-energised medical schools of that period: Monash, Flinders, Newcastle, and Melbourne Universities (Smith and Strain 2002; Orchard 2003). Nonetheless the biopsychosocial model is not referenced in recent Australian Medical Council's Standards for Primary Medical Education (2012). The new paradigm, Patient Centred Care (Luxford et al. 2011), discussed previously, is however repeatedly referenced.

Post-graduate RANZCP psychiatric training includes a required 6 month full-time training term in a College accredited Consultation-Liaison post during the second or third year of training (Stage 2). This includes experience of a Liaison Attachment. Trainees need to demonstrate competence in two Entrustable Professional Activities (EPAs) that target delirium and the management of significant psychological distress in the context of a patient's medical illness in a general hospital. Trainees also attend a College accredited Formal Education Course (FEC), usually in the form of a University-run Masters level courses, which will characteristically include at least a semester in which CLP is part of the subject matter. (Further details on RANZCP website www.ranzcp.org).

The last 2 years of RANZCP training, Stage 3 (Advanced) Training, provides the opportunity for Trainees to gain Certificates of Advanced Training in Consultation-Liaison Psychiatry, or other subspecialties. The CLP Advanced Training requires 12 months attached to a C-L Service offering consultation across an entire general hospital and including emergency work, 12 months involvement in one or more Liaison attachments and 12 months outpatient experience including the longitudinal follow up of patients with chronic physical illness. The trainee can also spend up to 12 months in "non-core" training terms approved by State (CLP) Advanced Training

Committees. A Formal Education Course (FEC) is also required as are a series of EPA, Case summaries and a research or scholarly project (Further details on RANZCP website (www.ranzcp.org)).

Basic (Stage 1 & 2) RANZCP training is, at least in NSW, organised by Training Networks and coordinated by Directors of Training employed by the local Mental Health Services (MHS). Mandatory training terms (including CLP) are supported by the MHS. Advanced CLP Training is more complicated as it, and the necessary FECs, are managed by volunteer-based State Faculty of CL Psychiatry Branch Committees and their individual State Directors of Advanced Training (SDAT). Additional and appropriate CLP Advanced Training experiences do not have to be provided by local MHS and the existing ones also need to cater for Basic Trainees' requirements. Despite these challenges CLP is a popular choice for Advanced Trainees, and the flexibility designed into the CLP AT requirements, the work of SDATs and the support of the membership are such that at the time of writing there are well over 50 trainees and Fellows working toward the Certificate of Advanced Training in CLP across the country (S. Ghali NSW SDAT 2018 – personal communication).

26.7 Research

Ilchef (2006), an Australian CLP, reflected that resource constraints and service requirements led to CLP performing below its weight in academic and research terms despite it being a fascinating and under-researched field. Graeme Smith, the 3 time Chair of the Section for CL Psychiatry, was particularly acknowledged for promoting the academic base of the subspecialty in the commendation for his 2004 RANZCP Medal of Honour (RANZCP 2004), which perhaps reinforces the point. A Medline search of the two major RANZCP journals using the key phrase “Consultation-Liaison Psychiatry” identified 40 of 5342 listings since 1996.

CLP staff roles tend to be narrowly service driven. Similar position in major teaching hospitals in other areas of medicine might generally require higher research degrees, but this is not the case in psychiatry where generally positions can be hard to fill. The short-fall Ilchef (2006) identifies may be at least partially addressed by the inclusion of research and scholarly projects in the CLP Advanced Training requirement. The absence of a national CLP meeting remains a gap that will hopefully be filled soon with the reconvening of a national CL meeting in 2019.

Publications focused on CLP practice and theory may be limited, but there is a considerable amount of world class research in the clinical fields CLP also inhabits, the intersection of physical and psychological medicine.

Psycho-oncology deserves particular mention. There is a network of academics from Psychiatry and Health Psychology who have provided the focus for work on psychosocial care in cancer, amongst them Professor David Kissane (<https://research.monash.edu/en/persons/david-kissane>) from Monash in Melbourne, who was a onetime Chair of the Section of CLP and also sojourned

as Chairman of the Psychiatry at the Memorial Sloan-Kettering Cancer Centre in New York, Phyllis Butow (<http://sydney.deu.au/science/people/phyllis.butow.php>) who is Professor in the School of Psychology at the University of Sydney, Professors Jane Turner (<http://researchers.up.edu.au/researchers/85>) and Brian Kelly (<https://www.newcastle.edu.au/profile/brian-kelly>). Their research “threads” include work on psychosocial interventions for group, couples and family in the context of cancer and palliative care, discussion of euthanasia and substantial work on doctor patient communication, with spin offs into skills training and its incorporation into medical school curricula. Turner chaired working groups that collated early, important NH&MRC (National Health and Medical Research Council) guidelines for health professionals: e.g. Clinical Practice Guidelines for the Psychosocial Care of Adults with Cancer (Turner et al. 2005).

Psychosocial research in Cancer has been advantaged by both the presence of not-for-profit organisations, particularly the Cancer Council (Australia) and its state branches, but also a variety of other benefactors of cancer research, including some government agencies (e.g. The NSW Cancer Institute) which promote and fund research. The unique existence of a single, integrated and centralised cancer hospital in Victoria, the Peter McCullum Cancer (now the Victorian Comprehensive Cancer Centre but affectionately known as the Peter Mac), associated with the University Melbourne also assisted in that state.

Another significant research and academic ‘thread’ in the Australian research, one that overlaps at times with psycho-oncology, is the concept of “Demoralisation” (e.g. Clarke and Kissane 2002; Robinson et al. 2017; Kissane et al. 2001; Kissane and Kelly 2000).

CLP psychiatrists have also contributed to important work that has gone some way to challenging the dominant Risk Assessment paradigm of managing suicidal and violent behaviour (Large et al. 2014, 2017; Paton et al. 2014)

CLP works, as the UK definition of Liaison Psychiatry emphasises, at the interface of medicine and psychiatry (RCPsych website). As it does not “own” patients, who remain under the care of their primary specialist, CLP is at heart collaborative – albeit sometimes from a “one down” position. Research in some important clinical areas has something of the same construction, and significant collaborative research contributions in the areas such as chronic pain, chronic fatigue syndrome (e.g. Hickie et al. 2009; Vollmer-Conna et al. 2007; Wilson et al. 2001), functional bowel disorders (Boyce et al. 2000; Talley et al. 1998a, b) and clinical work with fibromyalgia and non-epileptic seizures etc. – areas that may initially have frustrated medical colleagues but which ultimately were not shunted to psychiatry and are now being reappropriated into mainstream medicine.

26.8 Conclusion

There is ample evidence of the psychosocial and psychiatric morbidity associated with major medical illnesses and their often demanding treatment within the various settings of general hospitals, and of the new challenges associated with chronic and complex illness, survivorship and patient centred care. There is also little doubt about the difficulty that patients with pre-existing mental health issues have in negotiating general hospital medical care, or of the increased utilisation of general health facilities in the assessment, admission and initial care of patient presenting with primary or comorbid mental health issues. However in recent decades the public Mental Health System, and academic psychiatry, have increasingly been based in and focused on the “new” mental health institutional settings and on those with primary mental health issues seen in mental health settings of care. There is increasing, and appropriate, concern for the physical comorbidities of this segment of the population with mental health issues, but not for those whose psychiatric issues are in the context of either primary medical illness or whose care is primarily within non-psychiatric general hospital settings and involving such illnesses. The Australian “Mental Health statement of rights and responsibilities” (Commonwealth of Australia 2012) implicitly identifies its target as “mental health consumers”, and while this does not exclude the medically ill from rights of access to appropriate care, like the older notion of the “seriously mentally ill” their intended or implicit inclusion may be overlooked. There appears to be a persisting service dichotomy and as yet no reports that might mirror some in the UK in recent years: “No health without mental health” (Academy of Medical Royal Colleges 2010) or “Liaison psychiatry for every acute hospital: integrated mental and physical healthcare” (Royal College of Psychiatry 2013).

In Australia, Consultation-Liaison Psychiatrists were in the vanguard when it came to providing psychiatric services within the general hospitals and advocating for those with medical-psychiatric comorbidity. The subspecialty, and its patient population, were greatly advantaged by the foresight and belief in psychiatry as a part of medicine that saw CLP introduced as a required part of the RANZCP training of all psychiatrists, and while only a small minority may identify and work primarily at the interface of medicine and psychiatry, there is consequently a broader level of awareness and skill. The subspecialty also owes a great deal to those who, in the 1990s, mustered the limited and dispersed representation of CLP from the States of Australia and from New Zealand into a cohesive group that could successfully pursue recognition within the RANZCP and protect those gains and advocate for the patients as times became harder.

CLP is a part of psychiatry and of mental health services and it is also inevitably linked to general hospital services. At times it is valued by both and at others not fully accepted by either. In the final analysis its goal is to improve the access and availability of psychiatric and psychosocial care for patients with primary medical conditions, and/or managed in non-psychiatric general hospital settings. Not with-

standing the advantages CLP has enjoyed in Australia compared to some countries, there remain major challenges: advocacy for the legitimate needs of its patient population for mental health care, responding to the increased awareness of the importance of psychosocial care in medicine, the adequacy and mechanisms of funding, the opportunities of interdisciplinary/inter-professional models of care in specialised clinics, liaison services and general hospital wards, contributing to both the complexity of individualised patient centred care and to “population-based” interventions for common comorbidities such as depression and delirium. In addition to advocating for its patient population the subspecialty must also continue to develop its professional identity and cohesion notwithstanding small, busy and dispersed services and advocate for the particular and essential role of CLP in any comprehensive response to the psychiatric and psychosocial needs of the medically ill. The maintenance of training requirements and opportunities of, and demands for, advanced training remain positive omens in an uncertain environment.

Appendix

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry in your (or your chapter's) Country.

Please return this as an attachment to your email

Country on which you are reporting: Australia

Your Name: Dr Robert Gribble

Institution: Consultation-Liaison Psychiatry, Dept. of Psychiatry Royal Prince Alfred Hospital,

City & Country (e.g. London, UK): Sydney, NSW, Australia

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?

Yes (X) No () In some sense ()

- a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes () No (X)

- b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes (X) No ()

2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?

Yes () No (X)

Is teaching of psychosomatic medicine in medical schools required by law or health care system in your country? YES () No (X)

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?

Yes (X) No ()

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes (X) No ()

a. If YES, which?

Psychosomatic Medicine () Consultation-Liaison Psychiatry (X)

b. If YES, the status of such certification is:

i. Independent Medical Specialty ()

ii.Subspecialty of Internal Medicine ()

iii Subspecialty of Psychiatry (X)

iv. An independent non-medical discipline, as Psychology, Social Work ()

v. Other (Specify):[]

5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes (X) No ()

If YES, please list names of the organizations and the websites if available:

RANZCP Binational (Australia and New Zealand) Faculty of Consultation-Liaison Psychiatry (with active State branches in at least NSW, Victoria, Queensland and New Zealand)

6. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:

Nil. However the two RANZCP College Journals (The Australian and New Zealand Journal of Psychiatry and Australasian Psychiatry) publish a limited number of articles related to C-L Psychiatry. Similarly the Australian Journal of Psychology and Australian Journal of Clinical Psychology publish article about Health Psychology.

There are in addition Australian Journals of Herbal Medicine, Music Therapy and a Journal of the Traditional-Medicine Society noted on the NSW government Clinical Information Access Program (CIAP) website

7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in your country? Yes () No ()

a. If YES, where does it occur? Check all that apply:.

b. Medical School () Residency () Fellowship ()

8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes and No

There are National Boards that, in conjunction with the Australian Health Practitioners Regulation Board (AHPRA) keep public registers of all registered health professionals. There are such Boards for Chinese medicine, Chiropractic, Osteopathy but not Naturopathy.

9. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)

- a. It is insignificant ()
- b. Some subgroups (e.g. ethnic, religious) practice it (X)
- c. A significant part of the general population practice it ()
- d. Is the most prevalent healing method used ()
- e. It is often used in combination with Western medicine (X)
- f. More widely used methods are as follows (Please list, e.g., spiritual healing, meditation, herbal, etc):

10. Please add any comments to your response here:

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Part VII
Where We Are and Where Do We
Go from Here?

Chapter 27

Striving for Salutogenesis: “The History of Psychosomatics in Europe” and “Psychosomatics in Germany Today”



Wolfram Dieter Schüffel and Ernst Richard Petzold

*Somewhere in my brain
Each laugh, tear and lullaby*

Becomes memory. (J. Woodson 2014:20)

27.1 Introduction

We, the two authors, were directors of the university hospital wards and polyclinics for psychosomatic medicine for many years: WS was director of Psychosomatics in the Center for Internal Medicine at the University Clinic of Philipp’s University of Marburg in the German Federal State of Hesse, whose largest city is Frankfurt. ERP was director of the University Psychosomatics at the University of Aachen in the German Federal State of North Rhine-Westphalia with its largest cities Cologne, and Aix-la-Chapelle (Aachen). We are both professors, born shortly before the second world war, and have been involved with establishing psychosomatic medicine in Germany all our professional lives up to today, 2019. This section is based on the two chapters of this book “History of Psychosomatics in Europe” and “Psychosomatics in Germany Today”. Here we will pursue the

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horizons presented and phenomenologically defined in them, in the form of seven stations or perspectives. In Donn Welton's (Welton 2003) terminology we will pursue "horizons" as value concepts of (1) everyday language, (2) professional (technical) jargon, (3) context, before a (4) background, in a (5) rhythm, as (6) democracy, as (7) culture. To clarify these stations from a medical-humanistic perspective, we use pictures (in a metaphorical and in the original sense). They will be accompanied by spoken commentaries or attributions in modern lyrical form to convey an individual-personal manner of listening, a way to become a writer and ultimately a revolutionary, as in the *Brown Girl Dreaming* (Woodson 2014). All of this comes with our thanks to Ms. Judith Whittaker-Stemmler who has translated this chapter into English within a very short time frame.

27.2 Striving for Self-Determination and Belonging: What Defines our Culture and Thus our Medicine?

Sola fide, sola scriptura, sola gratia (faith alone, scripture alone, grace alone)—that was the position Martin Luther held as a devout Christian, which nevertheless ultimately led to Church's schism in his day: Only through belief, the Bible's scriptures, and God's forgiveness can a human find the way to faith. Luther received essential support from Philipp Melanchton, named Praeceptor Germaniae, although we cannot go into his history here. – However, Luther was by no means the instigator of the schism, as I (WS) stressed in Chap. 3 of this book; instead, it was an **interaction** with the new ideas of autonomy, individual self-determination, which emerged in that age of humanism, represented most notably by Erasmus of Rotterdam, namesake for the best-known academic exchange program within the European Union today. That is the basic message of the contributions to "History of Psychosomatics in Europe". The related quotes from Georg Büchner on two schools of medicine in Europe, a French-English and a German, are underlined by an observation from the German poet Heinrich Heine (1997). He wrote in 1834:

The French have lately believed they come to understand Germany when they have acquainted themselves with the products of our fine literature. In this way, however, they have only just lifted themselves from the condition of complete ignorance to one of superficiality. For the products of our fine literature are but silent flowers; the full German mentality remains an illusive riddle as long as they do not comprehend the meaning of religion and philosophy in Germany

It was postulated that an individual studies the Bible based on his belief, his inherent convictions, and this way finds his path to God autonomously and steadily, thus determining his own life. In this respect, Luther agreed with the Swiss Protestants led by Zwingli in Zurich, later by Calvin in Geneva. – The Catholic Church, on the other hand, insisted the individual fate is determined exclusively through **the Church's** continual mediation. Whoever conducted himself otherwise was persecuted with grim brutality, that is, ostracized and burned alive. That happened 100 years before to the Czech Jan Huss who Luther saw as one of his spiritual

forebears. A second one was the mystic Meister Eckhardt of Erfurt/Germany (deceased 1328), who was convicted of heresy (!) – What do such fundamental cultural values mean for life today, and for both doctor and patient, who live in a world thus defined?

The Reformation’s followers in Central and South Germany asserted their goals through two methods that were particular to the times and demonstrate their cultural self-conception up to today. Both performed existentially, put their very existence at risk. The Central German Reformers relied on the written message, on the word; the contemporary Southern Germans, the Swiss today, relied on the deed. In 1517 Luther sensationally publicized a text of 95 points by hammering it onto the portal of his home church in Wittenberg (Saxony), and presented the “theses” with utmost effect. The *impact* on the previously sacrosanct church door serves as a **first** picture (Fig. 27.1).

During the fasting season, southern Germans prepared and ate not fish but sausage. This is a **second** picture we will return to again later with education, which from our viewpoint plays a critical part. Both could be interpreted in academic didactics in the sense of cognitive versus pragmatic approaches, drawn together through an affective approach. The affective is the pivotal approach, almost identical to the value-centered.

Fig. 27.1 Door of Church in Wittenberg. (Public domain, <https://pixabay.com/en/luther-wittenberg-castle-church-1821498/>)



The latter, the “sausage-eaters”, had such an immediate effect that at the (World!) Council (comparable to the UN today) being held at the same time the participants reacted with agitation and sent delegates to Zurich with the strict decree to desist with the sausage consumption. Refusal to do so would be sentenced to the stake. In Central Germany the regional lords, ultimately the Elector Prince of Saxony (Frederick the Wise) and his ally, the Landgrave of Hesse, Philipp the Magnanimous, practiced a kind of secret diplomacy. That was not at all necessary among the southern Germans, in fact impossible, because they were able to bring up their positions directly in the townships and act accordingly. The central German regions were more agrarian, where the nobility had the final word.

Completely different social-cultural conditions existed in England under Henry VIII and France under Henri IV, where the Reformation was also taking place with lasting effects; in England with the formal separation from the Church in Rome, in France with the brutal persecution of the Huguenots. This point will not be delved into further.

The Protestant-humanistic break with clerical mediation between man and God: the Protestants take wine at the Eucharist; the Catholics watch as their *priests* drink the wine. An aptitude for introspection in most primal physical-spiritual oneness was encouraged, for contemplation by abandoning the superficial. The Calvinist position that material success demonstrates God’s approval does not contradict this. The Calvinists believed success was achieved through devotion to God, material success ultimately followed and was considered *gratia*, God’s grace.

What do these three fundamental values of autonomy mean for the field of medicine? – In medicine, the need for autonomy led to question what causes the human in the literal sense, the anatomic-physical in a figurative-primal sense, to comprehend, move and breathe? What is the inherent power (of breath)? Exactly 110 years after Luther’s theses of 1517, William Harvey presented his groundbreaking research findings on human AND animal blood circulation (suddenly mankind was not a unique creation!): That was the beginning of modern medicine during the process of a unifying European body, published in Frankfurt a.M., Germany, 1627 (Harvey 1627). – It is not divine powers, as Harvey indirectly put it, that allow humans to breathe but those from his organs, powers regulated by the heart and circulatory systems.

The heart became a **third** picture, within science no longer to be ignored by mind or feelings. These insights originated in a progressive region in Upper Italy, in Padua. They were tested in decades of research in London, specifically Oxford, but published in Frankfurt. The enclosed, revolutionary space of Padua was thus expanded to a great revolutionary range Padua-Oxford-Frankfurt. – The reason: Harvey’s understanding of circulation was contrary to Church teachings; in short, they were *blasphemous*, which was severely punished. As a student Harvey was forced to learn that in 1600 the scholar and humanist Giordano Bruno was publicly burned at the stake in Rome. Bruno had recently taught at the Protestant Leucorea, the university in Luther’s home town of Wittenberg, and was therefore a fellow of Luther who had taught there a generation before. At the time, this university was world-renown, even the Danish Prince Hamlet was educated there. A brief historic background: As a university the Leucorea existed for over three centuries until after

the Battle of Leipzig (Völkerschlacht) in 1813 and the Congress of Vienna when the entire surrounding Saxon region was taken by the victor Prussia. The Leucorea was then assigned the University of Halle, also under Prussian control. – To return to Harvey: Interesting to note is that Harvey was personal physician to Charles I, who as British monarch was beheaded in 1649 and was blamed for not being supportive to the protestants, but too friendly to the catholics. It is possible Harvey wanted to spare his royal patient a conflict by publishing in Frankfurt rather than in London. The constant background threat of the pyre must be seen as the **fourth** picture.

The progression toward autonomy and human self-determination in medicine continued in the protestant Netherlands. Taking the organ-based (!) pathology, meaning pathology isolated first from the environment, of the Englishman Sydenham into consideration, Boorhave in Leiden developed a medical education system that spread within his lifetime like a network over all of Europe, including the British Isles. The Netherlands still were enjoying their Golden Age in this period. They had become an influential naval power and also a colonial power and were spreading their values, their culture. From a distance a **fifth** picture emerges, Caspar David Friedrich: *Two Men Contemplating the Moon* (*Zwei Männer in Betrachtung des Mondes*), 1819/20 (Fig. 27.2).

Boorhave came from a tolerant, Calvinist household and was able to address a variety of knowledgeable representatives of his time and beyond. I (WS) can



Fig. 27.2 Two men contemplating the moon. Artist: Caspar David Friedrich (German, Greifswald 1774–1840 Dresden), Date: ca. 1825–30. Metropolitan Museum, NY, Public Domain

remember the lively reports from Prof. Dr. J. J. Groen of Amsterdam/Jerusalem/Leiden (himself an ardent admirer of Spinoza) in the 1970s and '80s on Boorhave's achievements. If I follow the phantasies of the *Dreaming Girl*, (Woodson, op.cit.) I can literally recognize JJ Groen (Groen 1982) as the discussant with Boorhave in the fifth picture. What Boorhave accomplished was organizing the medical education and training (!) at the advent of emerging natural sciences. As a general clinician (referred today as internist) he divided the six-year education into a natural science/preclinical (2 years) and a general-practical and clinically oriented phase (4 years).

This system exists worldwide up to today and only now is gradually being replaced by a modernized one (cf. McMaster, Hamilton/Canada and Maastricht/NL). The entire medical education system of Europe profited from Boorhave's reform. His students created the afore mentioned educational network in West and Central Europe with individual emphases, for example, in Vienna the humoral medicine (corresponding best today to endocrinology) and in Germany the so-called romantic medicine emphasizing the psychosocial components. These were (among others): Carus on the unconscious; Heinroth on aspects of personality; Hufeland on macrobiotic-salutogenetic (!!!) aspects; Müller on sensory perceptions. The greatest figure of science in this epoch was Alexander von Humboldt highly praised "(He) is the true discoverer of South America". ... "One of the wonders of the world, like Aristotele, like Julius Caesar..., who appear from time to time as if to show us the possibilities of the human mind" (Watson 2010: 177). Even Darwin considered him to be his predecessor, Wulf 2015). In Germany his holistic view of the world was well transported into the early 20th Century by physicians like L. Krehl, R. Siebeck of Heidelberg and E. Wittkower of Berlin. – And as we continue to follow the *Dreaming Girl* and contemplate Friedrich's painting: A sixth picture appears, two painters stand in a room: the painter-physician Carl Gustav Carus, a prominent medical doctor in his time, personal physician to the Saxon king, and a close friend of Caspar David Friedrich's. In commemoration of this physician from German Romantic Medicine, the annual German Psychosomatic Convention in Berlin is always accompanied by a Carus Lecture (Newen 2019).

Parallel to this holistic-personal medicine the natural scientific approach also developed in connection with the early industrial period, particularly in the rapidly emerging political power of Prussia as an industrial power. It was a phase of medicine that disregarded the individual's intrinsic transformations yet enjoyed international acclaim: It seemed to promise unlimited applicability within the living environment. Accordingly, a *de-individualized* perspective took hold. In retrospect the predominant attitude in this period of European Restoration must be seen as an enthusiastic and uncritical acceptance of medical progress. This soon gave way to medical pseudo-advancements that neglected the individual (used here as a synonym for the subject).

Prominent figures of medicine of the times supported the position as commented by Bernfeld, Cassirer-Bernfeld (1981). In 1842 Dubois wrote (Bernfeld 1981) (quoted by Uexküll, T. and Wesiack, W., 1988:622): "The astonishing history of this natural scientific school's success began in the early 40's (of the nineteenth century) with the friendship between Emil Dubois-Reymond (1818–1895) and Ernst von Brücke

(1819–1892), joined shortly thereafter by Hermann von Helmholtz (1821–1894) and Karl Ludwig (1816–1895). From the start this group was inspired with a true sense of crusade. Du Bois wrote in 1842: ‘Brücke and I, we have vowed to assert that there are no other powers that affect the organism than the common physical-chemical.’

Typical for this period were two breakthroughs in medicine that are cornerstones of medical history: the first description of what is referred to today as posttraumatic syndrome (PTSD) and the tetanus vaccination. – In 1889 Oppenheim in Berlin used the term “traumatic neurosis” to describe what is currently known as PTSD in its various symptomatic, somatic forms (Oppenheim 1889a, b, 1916). In the twentieth century and into the present it became *THE* popular epidemic (Weber et al. 2006). The psycho-social effects are comparable to the effects the tetanus vaccination had in its time. Just how significant the tetanus vaccination was, was acknowledged in 1902 when the first Nobel Prize for Medicine was awarded to Emil von Behring in Marburg. Both the first description of PTSD and the potential control of tetanus were accomplishments from the German-speaking regions of the medical field that then became models internationally and were adopted by Japan’s Meiji Regime in the 1880s and in the USA in 1910 by the Flexner council.

Then World War I raged 1914 to 1918; shortly thereafter educational subjects in Germany and Austria were drastically stripped of ethical values, which after WWII at once became unequivocally and internationally evident (Mitscherlich and Mielke 1949, 1962). In 1915 the traumatic neurosis was labeled a “Jewish ailment” because its discoverer Oppenheim was a Jew; in contrast, Emil von Behring was knighted by the German Emperor himself. – The **seventh** picture appear in *Guernica* by Picasso (Fig. 27.3). Following the *Dreaming Girl* further, my focus switches back and forth between *Guernica* and the *Trauernden Mutter* (*Mother with her Dead Son*) by Käthe Kollwitz (today in the Neue Wache in Berlin), henceforth illustrations 7 + 1 (see below).

After 1945, and to some extent starting with 1870 the term “Romantic Medicine” became an insult and this remained so until the 1990s.

Fortunately, the excellent figures of this medical discipline survived, who saw people as individuals, with values set in their organs, in other words, determined by



Fig. 27.3 *Guernica*, (wikiarts.org Public domain). (https://www.google.com/search?q=guernica+public+domain&rlz=1C1SQJL_enUS787US788&tbn=isch&tbo=u&source=univ&sa=X&ved=2ahUKewjtn4qe5pLdAhUE3lQKHW15DYQQsAR6BAgDEAE&biw=1536&bih=811)

the seven value concepts mentioned above, namely, the phenomenologically defined “horizons” (Welton 2003, 2012) of a value system. These were, among others, Ritter von Bayer, P. Christian (both of Heidelberg), Groen (who as a Jewish Dutchman survived the German Wehrmacht’s occupation of the Netherlands), P. Hahn, D. Janz, A. Jores (Hamburg; himself in a Gestapo prison), P. Vogel (like Hahn and Janz, of Heidelberg), Thure von Uexküll (Ulm) and his father Jacob von Uexküll (as an ethologist, Hamburg), Viktor von Weizsäcker (Heidelberg) et al.

We return now to the 7 + 1 pictures and understand them in the context of the introductory quote by Woodson on the origin of memory. Yet Woodson’s words go far beyond these pictures in that they speak of “laughs and lullabies” not found in them. Only gradually can the values connected with this idea be retrieved and projected onto the modern age. The persons named above and many not mentioned here made it possible to innovate medicine with a double emphasis:

- Psychosomatic medicine is an intellectual-attitudinal position inherent to each doctor.
- Psychosomatic medicine is a special discipline with its own methods of treatment, research and teaching, including post-graduate and life-long further education.

27.3 Michael Balint and His Team: The New Pictures

But at the end of the day, I was alone with Brown Girl Dreaming – walking through these memories and making sense out of myself as a writer in a way I had never done before.
(J. Woodson 2014:325)

One cannot overstate the relevance the British-Hungarian-Jewish physician Michael Balint and his team have had for the development of psychosomatic medicine in the German-speaking regions including Switzerland and Austria. It stems from the first of the two aspects, the *inherent* attitude. One scene might illustrate this when the German internist Walter Crodel, director of the regional hospital in Halle (East Germany) asked Michael Balint, who was visiting at the end of the 50’s shortly before the Wall would be built, whether he should flee to West Germany or remain in Halle. Michael Balint returned the question with, “Where will you be needed more?” – Crodel didn’t need to answer; he stayed in East Germany, in his hometown Halle where his family had been held in high regard for generations for their artistic abilities. He remained with HIS *Dreaming Girl* at the psychosomatic medicine in Halle.

Michael Balint was a physician’s son in a German-Hungarian-Jewish family during the imperial monarchy of Austria-Hungary. He studied medicine like his father and underwent a training psychoanalysis under Sandor Ferenczi in Budapest, a highly gifted and favorite student of Freud’s with an affinity for psychosomatic thought and conduct. He fled to England from the Nazis. After the sudden death of his first wife Alice he married the British social worker (!) Enid Balint there. They were, in metaphoric sense, another couple of admirers of the *Dreaming Girl*. Not only that, they also became WRITERS, as Woodson refers to herself and those who

seem congenial, thus signifying an original development. This was the process by which these continental REFUGEES (!!!) together with like-minded NATIVES of the British Empire of those times developed a modern view of medicine. This happened before and during the implementation of NHS and again in a looming crisis with NHS during the Thatcher era.

Two important books stem from the couple’s team that should be emphasized here (Balint 1957; Balint et al. 1993):

Balint, Michael (1957): The Doctor, his Patient and the Illness, revised 2nd ed., London: Pitman Paperbacks, 1968.

Balint, Enid; Courtenay, Michael; Elder, Andrew; Hull, Sally and Julian, Paul (1993): The Doctor, the Patient and the Group – Balint Revisited, Routledge, London and New York.

The first title is Michael Balint’s first publication on relation-based medicine. The second was written by the team in an intensive, year-long cooperative effort led by Balint’s widow Enid Balint, herself a social worker and psychoanalyst. The first title is internationally renowned. The second title is considered an insider’s tip.

The first book serviced the school of thought that led and leads to in-depth changes to the curriculum in Germany, which hadn’t undergone such since Boorhave, and in neighboring regions. Balint’s central thesis from 1957 and 1968, respectively, read: Medicine that does not take human relationships into consideration threatens to lose sight of its purpose; not until relationships between two individuals (doctor and patient) are consciously formed will medicine be effective.

The followers of his relationship-based medicine succeeded in establishing a post-graduate study requirement that facilitates interactive abilities and skills. Only those physicians who have participated in this kind of post-graduate extension program will be acknowledged financially. For general practitioners, gynecologists and obstetricians this program is required by law. The program was made possible as of 1970 through initial, cautious changes to the curriculum in medical schools in West Germany (in all Germany after 1990) by adding so-called psychosocial requirements: medical psychology, medical sociology, psychosomatic medicine, and psychotherapy.

After the Berlin Wall fell in 1989 it became possible to blend the contents of the two books. (Petzold and Schüffel 2018). This occurred within a 25-year-long annual seminar of two and a half days each called Wartburg dialogues (Schüffel 2009, 2012; Schüffel et al. 1998). At first only patients and doctors met who felt connected to relationship-based medicine. They agreed to open their work to observation by personally (!) taking part with their patients in a group situation, a live encounter (Deter 2018). In the presence of his (silent and observing) doctor, the patient would then speak with a doctor from the Wartburg dialogue circle. These were the predecessors to what was later termed the MOVING SEMINAR (MOSE; see below) with the core exchange of feeling, touching (i.e. both sensing and moving/being moved) and bestowing meaning.

The Wartburg dialogues showed that contrary to tradition, doctor and patient can and should go public with all their individual feelings (Fenner 2012; Köllner

and Loew 1998; Merkle 2012; Speidel et al. 2012; Spies 2012; Schulz-Asche 2012; Weil 2012). Here it is possible to speak completely openly even in a large group about reciprocal problems. That cannot at all be taken for granted: The doctor-patient dialogue is of course treated as an intimate conversation. The participants are bound to secrecy. The doctor-patient dialogue, however, also takes place in a political territory, which naturally was different in East and West Germany (see next section, “the niche”).

Later on, and by including the salutogenetic principle (Antonovsky 1987, 1996; Antonovsky et al. 1971) which had just been published, it became possible to conduct a dialogue on health *within the familiar, body-centered self-experience group* with the goal of maintaining health during the present month, present semester, and present year (Schueffel et al. 1998). From this, the annual Wartburg Dialogues 1992–2017 (Adam et al. 2012; Bender 2012; Düsing 2012; Heidler 2012; Leydenbach 2012; Merkle 2012; Müller 2012; Petzold 2012; Schüffel 2012; Schüffel and Schüffel 2012) and consequently the Moving Seminar (MOSE) emerged, a method sought by both health providers and medical laypersons (Brucks et al. 1998; Deter 2018).

Two persons allowing for this were Boris Luban-Plozza in Ascona and Benyamin Maoz (Beer Sheva). Luban-Plozza because he introduced the originally Hungarian idea to undergo supervision together, in person, with the patient in treatment. Maoz (this chapter is dedicated to him and to his widow Elly) because he, an ethnic Yekke born in Kassel, represented the German culture in its glory and in its horror: In Israel his family performed German theater pieces in their home; in Kassel they had lived next door to the family of the Nazi judge Roland Freisler, President of the People’s Court in Berlin. Their children tried to teach little, innocent “Benjamin” to lift and lower the Thora before Family Mauersberger escaped in time to Palestine; they have since lived well distributed across Israel. Later Benyamin Maoz studied medicine in Leiden under Groen (see above), among others.

“Benjamin” told his mother about the Thora games. She had a dizzy spell. Not until years later, almost a lifetime later, he realized: He, the nine-year-old, had put the family’s life in jeopardy. – Even in the year 2009 (Schüffel 2009) neither Benyamin nor I (WS) had the heart to mention this bitter truth. Even a few days ago, August 11, 2018, I myself (WS) could not speak out loud, much less write about this reality. Not until the next morning and while writing this section, on August 12, 2018, did this happen. What took place? I (WS) found it chilling.

The Moving Seminar developed over a quarter century in the Wartburg dialogues and was incorporated into psychosomatic primary care, here within the Hessian State Chamber of Medicine and its educational center in Bad Nauheim (Frevert and Merkle 2019). Finally, the Moving Seminar is offered at the above mentioned annual German Psychosomatics Convention in Berlin each March as a transcultural event in the English Track with the English title “Moving Seminar (MOSE)” (Schüffel, Leydenbach, and Hashizume 2018, 2019). Within the students’ curriculum in Marburg a further academic-didactic course has taken shape: “Relationship-based, trans-generational Medicine – Clinic Requirement for Pre-clinical Medicine”.

The most recent development is connecting this requirement with the Marburg Health Dialogues (Ehrhardt et al. 2018, 2019, 2020).

Woodson’s “Author’s note” (2014:325) serves to remind the reader that at first silhouettes emerge only gradually that allow the 7 + 1 pictures sketched above to gradually form a continuum, allow **coherence to emerge**, which forms “memory” and ultimately the significant **NOW** to a source of past, present and future. Each moment of laughter, each tear and each lullaby, “somewhere in [the] brain,” becomes a part of memory without anyone being able to say why this happens.

27.4 Two Different Cultures: Or Two Different Reflections of the Same Culture?

*“If your story’s true,
our grandmother reminds us,
you’ll remember it
how to listen. (Woodson 2014: 346)*

Starting from the relationship we can approach the future. This occurs in the following way:

- With the help of a correspondence between Michael Geyer and Wolfram Schüffel. Here the question how the East and West Germans can communicate with each other is dealt with:
- By at any time remembering the feeling the word “**unfreedom**” induces;
- By re-approaching their 50-year history and their 500-year history across 2000 years of German history;
- By addressing the male/female relationship, the gender issue. The result: The story becomes true. Trauma will be overcome with the help of the narrative.

27.4.1 *Michael Geyer: An East German Does Not Understand the West German – and Vice Versa*

In a correspondence between Michael Geyer and the lead author WS, Michael Geyer said, “*A West German cannot understand an East German.*” – This is the gist of a comment on a West German’s behavior from an East German’s perspective, and it is thought-provoking.

How should this statement be understood?

Michael Geyer was President of the Society for Psychotherapy, Psychosomatics and Medical Psychology in the GDR (East Germany), therefore before and after the Berlin Wall fell. Until his retirement he was the director of Psychosomatic Medicine and Psychotherapy at the University Hospital in Leipzig. – He is the editor of the book:

Michael Geyer (Ed.) *Psychotherapie in Ostdeutschland – Geschichte und Geschichten 1945–1995*; 2011. (Psychotherapy in East Germany – History and Stories 1945–1995; 951 pages).

This is an extensive study on the history of psychotherapy in the GDR. It has quickly become a standard text. It received a friendly review from a sociologist of West German socialization, but in my opinion (WS) insufficient and superficial. There was no mention of the four questions I posed (see below).

Leipzig, May 5, 2017

“Dear Wolfram,

(...)

“[Y]our mail to the sociologist in Erfurt, whose express opinion you requested to

- Questions on trauma
- Man/woman relationship
- Child rearing (child care centers and their effects)
- Holocaust

in the GDR. **As a West German he cannot answer that** [*author’s bold print, underscore and italic alteration here and elsewhere below*], and I fear he wouldn’t be able to read the book I’ve edited to the extent that he could evaluate the unmistakable references to these topics given there.

“In principle, I would hazard that so far we have come to terms with the GDR period as little as we comprehend it, just as with the Nazi dictatorship 25 years after it ended. Apparently it takes longer.

“First the principles:

The book had to be written

1. because the people who experienced the period themselves, the witnesses, will not be around much longer.
2. I am one of the few who has personally experienced all the developments since about 1967 and as last president of the association had access to all the documents available since around 1960.
3. There were facts that had to be published without evaluation. These are contained in the chronicles of psychotherapy since 1945, and perhaps the book’s most important achievement.
4. My personal motive to take on this colossal task was the observation that people were writing about East German psychotherapy who had absolutely no idea about the true processes. In the meantime no one can overlook this book who wishes to write on the subject.

“Our book of course suffers the following problems:

There’s still no master narrative of the GDR of the kind that undoubtedly exist on the Third Reich (see my preface to this book!). Therefore it’s still too early.

1. It was written just 20 years after the end of the GDR, actually too soon, but still just in time before some contemporaries’ memory failed.

2. About one-fifth of the authors are people with whom I would never have exchanged thoughts about the GDR period because I felt they had been too close to both regime and party. Nevertheless, I needed their views of the times for the book.
3. All of the authors described their subjective view as the ‘truth’. We very well know that memories most often serve to verify the present and author’s opinion.

“Now to your topics:

I could say something to all of these topics, although not always in breadth or depth. For us, these topics were less predominant than the general theme of ***unfreedom in the GDR.***

“What the relationship between ***man and woman*** in the GDR was like is obviously still an incomplete picture. It’s interesting that a great number of East German women have become important figures in Germany today. This is true of both culture and politics. So, there was a special kind of equal opportunity that’s undoubtedly still innate to the ‘East German women’, but is still far from what’s considered feminism today. That would take a special study.

“In the GDR ***the holocaust*** was treated much sooner than in the West as a singular German crime and as a component to the culture of remembrance and was discussed everywhere as such. In the FRG (West Germany), it has been treated more as a current problem the Nazis hadn’t prosecuted. Many Eastern psychotherapists were complicit to this denial, but my friends and I repeatedly tried to make an issue of the evil within us.

“The ***child-rearing*** in daycare centers was not criticized much in public in East Germany, but among psychotherapists it definitely was. However, it was always judged in connection with the actual situation in a given daycare center: At what age did the children begin, how much staff was there and with what kind of degrees, etc.? There is a highly differentiated discussion of this in my book by A. Israel.

“From the start, psychotherapy in East Germany had for myself and my friends two functions:

1. ***It was a niche that at latest by 1971 was a sector of medicine relatively free of state-imposed political-ideological demands.*** (Of course this always depended on the directors within institutions. But there was no abuse, that is, no state-prescribed directive to turn medicine – as had happened in the Soviet Union – into a politically influential institution.)
2. Psychotherapy was one possibility to act subversively by influencing other individuals, which means psychotherapy should establish an individual’s freedom in an unfree society (which we later recognized as false strategy, but which enabled us to hold up our heads at all in this illegitimate state).

“I’ve found the draft of a lecture from the GDR period that also from today’s perspective pretty clearly presents the opposite position to the GDR regime’s. In the keynote address on ‘Special Psychotherapy’ (Geyer et al. 1989) for the 12th Annual Meeting of the Society for Medical Psychotherapy I stated the following: ‘[...] the

therapist's function itself lies primarily in enabling the patient to build new forms of interpersonal relationships, that is, more freedom within relationships. As I understand it, this applies in a special way to the therapeutic relationship itself [...]. "That means a pathogenetically significant form of interaction must first be identified; second, its own role be reflected so that, third, an agreement on the form of relationship be met and, fourth, this relationship be restructured in that the therapist successively modifies the positions. The therapist should be capable

- of at least temporarily assuming the position or role given him by the patient. This is concerned with accepting complementarity. This includes reflecting his preferences and limits in assuming such roles.
- of looking objectively at his own and his patient's or a group's roles from a higher stance, an ability Piaget called 'decentering'. This includes the ability to switch fairly flexibly between an active and a reflective position.
- of enduring tensions that arise as the relationship progresses. This is concerned with partnership skills.

"During his training, meaning under supervision and self-experience, a psychotherapist should be confronted with general and personal fundamental problems inherent to the role of helper:

- help as a measure to avoid one's own vulnerability,
- help as a protection against one's own guilt feelings,
- help to unconsciously satisfy one's own needs,
- help as an anti-emancipating act.

"The last problem I would like to illuminate briefly with respect to unconscious anti-emancipatory tendencies, especially those therapeutic attitudes that express a therapist's unreflecting adaptation to the society he lives and works in. A psychotherapist should acquire a discerning eye not only for his own personal power- and dominance needs, but also for anti-emancipatory pressure from groups and institutions. The psychotherapist must side with the individual's need to develop and exercise rights to freedom. This means a psychotherapist also requires courage to maintain critical distance from more or less subtle extra-therapeutic power mechanisms. From this I personally derive the necessity to enable self-experience not only in the intimate pair relationship but also within greater social structures; this allows experiencing how power structures emerge within groups of various sizes and how one should confront them. Without this kind of training, the psychotherapist can easily lose sight of society's reality and withdraw to the closed quarters that society has bestowed his profession [...].

"That's it for today.

"Best Wishes,
Michael"

About one month later, Michael wrote a second letter.

Leipzig, June 5, 2017

"Dear Wolfram

Some time ago I started to reply to your last mail and never got around to completing it. After a very relaxing week of vacation on the Rhône river I’ll give it another try. I’ll leave the incomplete response as is, although – and this is the reason why I didn’t finish back then – I was speaking in fundamental terms because I had understood you in fundamental terms: Apparently you were occupied with the question of our (that is, of psychosomatic doctors’ or psychotherapists’) present-day concrete political activity or the responsibility to do so.

“If I understand correctly, you see – as I do, too – a psychotherapist’s actions (actually those of any doctor’s) (also) as political action because our way of influencing people’s lives depends on whether or not we choose to accept the individual’s rights to freedom [author’s italics and underscore alteration here elsewhere below]. If “illness [is] a life inhibited in its freedom” (As Marx writes, who ‘borrowed’ this idea from philosophers and practitioners before him), then at least some thought should be invested on whether our actions in some way resist the politically induced ‘inhibitions’ upon the lives of our fellows.

“I have attempted this at various levels and come to the conclusion that

1. I as a doctor in the context of therapy must be humble and as an expert on health politics should together with my colleagues in all fields strive for the best conditions to work in, and.
2. I as a politically-minded person shouldn’t be too shy to strive for the power that allows me to truly transform society.

“The first task I’ve tried to accomplish my entire life (perhaps the climax was my activity as prorector for development at the University of Leipzig in the 1990s when the rectorate reorganized the Karl-Marx-University to a standard institution, which cost about 10,000 former employees their jobs).

“For the second task there was not enough time. (In younger years I would have had to become a dissident, which I didn’t want to do. For today’s society I wasn’t well enough socialized to make a great breakthrough. Now I’m too old to try again.)

“With that I believe I’ve answered to your request [both author’s alteration].

“In the following a few comments: As someone who experienced and suffered the extremes from the right and left fundamentalisms in the twentieth Century in different ways, I uphold a deep suspicion against left- and right-winged ideas of how to save the world that would supposedly place society’s interests above the individual.

“Neither do I believe that there is a better form of society than what exists in Western democracies; in other words, a more or less controlled capitalism. However, this societal structure has the tendency to slip in one or the other direction when citizens cease to actively participate in shaping their society, as happened some to extent in the past.

“In this respect I fall into a dilemma, as does everyone, that forces a compromise: If one pole in human society represents liberality and the other pole the opposite of liberality marked by all these *-isms* like socialism, communism, fascism and all those other fundamental ideologies to which most religions also belong, then it’s clear that the right to individual freedom is threatened more the more the idea of

society drifts away from liberality to the *-isms*. Likewise, a society cannot allow itself only liberties, that is, to exist with no rules imposed on the individual. At the same time, our societal form automatically allows individuals to be manipulated by certain social groups (and their ideologies) that represent “supra-individual interests”. (At present we are being indoctrinated by ecological-leftist ideologies falsely disguised as liberal.) We remain caught in this dilemma.

“The only solution is to make it clear that there are limits to what the individual can endure, that is, that humans are not endlessly capable of adapting to conditions that ignore basic needs. This however is only indirectly related to our work as physicians. Here we must act as political individuals who also perform on a political level. In the GDR some of my friends and I ran the risk of confusing psychotherapy with political action. In overcoming the therapist’s position of power in therapy groups we believed we had accomplished something against the unfreedom in society. At the same time we were too cowardly (or too smart) to directly battle the regime and end up in prison. (Adapted from Che Guevara, and not just in a humorous sense, our slogan was: With our therapies we create ‘liberated zones’.)

“However, ‘should the doctor wish to cure the misery of his day in the little tales of suffering from those he serves, then he is working like a barber who talks politics with his customer and accidentally cuts his throat’ (Kisker 1970).

“By the end of the GDR it was clear to me that things could not go on this way and I joined the demonstrations in Leipzig while it was still really dangerous to do.

“Nevertheless, it was easier then to estimate and define political action. Today we feel so free that we can’t even imagine we have to do something for our freedom. When I pointed out to colleagues forms of non-freedom that exist, too, in our liberal Western societies, the reaction was more surprise than any awareness.

“In short: We are treading a narrow path. On the one hand we should help the individual entrusted us to recognize and perceive his (developmental) potential without dogma or coercion in a direction that discomforts or stresses him; on the other had we have to deal with the greater issues and try to project our expertise onto the political level and, in the best case, with a political effect.

“The criticism is perhaps justified that statements coming from our field are modest. Most of us have no interest at all in engaging ourselves politically (not even in political action directly related to our field). However, even those who do try are found more in the feature section than the political section of media.

“Why that is would be worth another round of discussions.

“That’s it for today.

“Best Wishes,

Michael”

On May 14, 2017 I (WS) wrote to Michael. I argued that as I saw it, I hadn’t at all addressed the “wrong person”. As a psychosomatic physician I understood in the four topics listed the four main problems of a psychosomatic and psychotherapeutic kind in Germany today.

I had criticized the review of his book because the reviewer hadn’t mentioned the four topics and I couldn’t find them. Whether he could comment on this opinion of

mine. The reviewer had replied in the negative and advised instead me to write directly to the editor of the book reviewed, which was Michael Geyer. This event had been the content of a longer letter to M.G. that I as a citizen of our common nation where he had received his education and continued education as sociologist could very well expect an answer.

To this M.G. wrote to me on June 5, 2017 and declared, a West German couldn't understand an East German. We, the West German authors (WS and ERP), have perceived what East Germans consider to be West Germans' non-understanding of East Germans as a **RECIPROCAL ATTRIBUTION**. The East German experienced “unfreedom” from 1945 to 1989. After 1949, the West German lived in a democratic state. In the years since 1989 up to today (2018) there has been no significant exchange, at least in the field of medicine, about how these different preconditions have affected democratic living. In this sense, reciprocal non-understanding continues to take place in Germany. The question at the beginning of this section must be plainly answered: It is not a matter of two different German cultures but of two different forms of reflection – acquired over time from 1945 to 1989, partially intensified and persisting since 1990 to the present. In medicine and within a bio-psycho-social-relational understanding it may help to go back to the Brown Girl's saying: We live through grandma's experience, i. e. *transgenerationally*. This means it is *pre-Natal and peri-Natal* experience that forms our life's fundament (Janus 2019a, b, c; Verny 2019a, b, c).

27.5 The Space of NOW (Here): Our Space, My Space

Write down what I think
I know. The knowing will come
Just keep listening ...
How to listen #10. (J. Woodson 2014:310)

This last section serves to understand the seven stations along a phenomenological path we have been following, that is, the horizons 6 and 7, our democracies and cultures as sites or spaces that help us deal with rhythm or time. How then are the stations 1 to 5 connected to democracy and culture? – This will be concerned with how we shape the ever-existent space. We consider it a success when the Minister of Justice of the Federal Republic of Germany visits the memorial sites at the concentration camps in Auschwitz and Birkenau and spends 80 minutes at each (Nico Fried: *Das so etwas nicht mehr passieren kann* [That something like that may never happen again]; SZ 08/21/2018). – Foreign Secretary Heiko Maas said at Auschwitz, it is “the most horrifying place in the world”. Also that “I entered politics because of Auschwitz in order to help prevent something of the type from ever happening again” (Fried 2018).

A survivor of Theresienstadt, who as a 12-year-old with her mother and siblings expected each day for over a year to be sent to Auschwitz, told me about how she was freed. The adolescent girl had to march through the still smoking ruins of

Dresden and remembered feeling exceedingly pleased in the thought, “How wonderful, now it’s hit them, too.” – When I heard those words, as a “native” of Dresden I (WS) was stunned. I did not feel capable of seizing upon them. – I felt something similar with the story described above of Benyamin playing with the children of the Freisler Family. It is the *own* traumatic experience referred to here and it must be dealt with. It’s not about pursuing the injured parts or even the sources of injury inside myself or the other person, but about finding where the healthy parts are, tracing them, tracing the sense of coherence. This concept ultimately stems from a meticulously conducted research work within a so-called “We-Project” carried out by Antonovsky and his assistants (Antonovsky 1987, 1996; Antonovsky et al. 1971). At this point (before becoming professor and directing physician for psychiatry in the Medical School of the Ben Gurion University in Beer Sheva) Benyamin Maoz was one of the team members. As general practitioner in the region of Beer Sheba he was in a position enabling him to engage female patients of his to participate in the We-Project (Maoz 1998a, b). These papers aroused protest and outrage and the researchers were furiously criticized (Maoz 1998a, b). *This work was achieved under the leadership of M. Prywes, Founding Director and Dean of the Medical School of Beer Sheva (Prywes 1994). The researchers had broken a taboo. At the time people in Israel considered anyone who had once been in a concentration camp to be ill for the rest of their lives. Actually it was found that over 30% of the women examined were healthy in the usual sense of the word. Benyamin Maoz encouraged us in Balint work and especially as a FOUNDED MEMBER of the Wartburg dialogues not to look at just the patient’s part, but at **our own**. In the Wartburg dialogues we tried to delve deeply into our own part by making a topic of our own feelings, to then assess the symptom for what it means and recognize it as a valuable act of the organism’s. Again, we could follow the *Dreaming Girl* and her certainty: “*The knowing will come. Just keep listening*”

27.6 Twenty Years of the Balint-Journal: Dreamers in Medicine

You’re a writer, Ms. Vivo says,
Her gray eyes bright behind
thin wire frames. Her smile bigger than anything. (J. Woodson 2014:312)

The Balint-Journal has become a cultural pillar of the German-language relationship-based medicine (Bergmann 2018). In the second number of the current year 2018, a dreamer (Trenkel 2018) describes how in 1998 he was observing an elegant female colleague, a dermatologist, as she dealt with a sweating male patient who was showing her the irritating and troubling eczema in his groins and anal area (Trenkel 2018:43). The doctor is a participant of the dreamer’s, a psychiatric colleague’s, Balint group. In this report from 1998 there is still no mention of the fan-

tasies between man and woman although one can definitely imagine them under the heading “The Subjective Reality of Relationships – a *conditio humana* – a Dream.” – It is remarkable that this report from the dreamer from 1998 (the year the German-language Society for Psychotraumatology was founded!), was presented only orally, not in written form. Twenty years later exactly this occurs: The dream has been noticed, commended in the medical field. In other words and in Woodson’s sense: The representatives of Balint work identify with the dream a part of reality, a reality that requires scientific analysis.

The acknowledgement is reflected in a paper that is a text analysis. It deals with the “**moment of crisis**”, which is referred to as symptomatic of an “**ailing system**” and simultaneously connected to the “so often experienced, touching and possibly transformative learning effects of the Balint group.” The text analysis is performed by a male/female miniteam (Koch and Preiser 2018).

What is remarkable is that a male/female team of authors understands the narrative analysis altogether as a method of investigating a central topic between doctor and patient: How do I handle problems between man and woman? The question opens a broad, transcultural field for Balint work that Trenkel had already foreseen by alluding to Penelope and Odysseus, parents to Telemach who grew up as a half-orphan in the chaotic aftermath of the Trojan War. This topic has been handled recently in the context of *Mimesis* (Auerbach 2013, 2015) by Mary Beard (2017, 2018) who analyzes the relationship between Penelope and Telemach. The son is under age, yet dictates to the mother, the ruler of Thebes, what she must do. This he does by the power of his MASCULINE gender; she submits to his orders because of her FEMININE gender. Beard identifies through Homer’s work a European relationship that has persisted for over 3000 years (an altogether Western “me-too” gender relationship) and is only gradually beginning to change. How can and will this change, what can “writers” say about this?

27.7 Occurrences in Motion in Space: Significant Occurrences in Balint-Group Work

Equal rights, a boy named Andrew yells out.

For women.

My hands freeze on the thin white pages.

Like Blacks, Ms. Vivo, too, is part of a revolution. (J. Woodson 2014:312)

In the same number of the Balint-Journal the issue of crisis continues and records how it is dealt with in group work. This takes place during a meeting of Balint group-leaders in Sils, Switzerland (Langewitz et al. 2018). The fundamentals, the conclusion, can be summarized so: It is essential to have the courage to experience one’s own breathing, meaning to move about and breathe while doing so, or, to breathe and *experience* while doing so. The mixed-gender group of participants registers four processes:

1. trance-induction to open oneself to non-categorical perception (p. 59), somewhat in the sense of *functional relaxation*;
2. recording the atmosphere within the group and its reflection;
3. reconciling oneself to what is occurring, and,
4. supporting the own (still) weak position in the face of a strong counterpart in the group.

The intention would be to transfer the insights gained over several decades at first in Switzerland to the German situation. Geyer describes this in detail for East Germany. For West Germany the developments based on understanding the situation for all of Germany have been outlined (Schüffel, Geyer, and Petzold 2019). An overview of psychosomatic care facilities and their opportunities to develop has been presented (Kruse 2018). The issue now is how health care workers and those entering the field in the future will find their paths under the newly created conditions. Main topics will be the two major migrations within Germany: the displacement of 15 million people, and the escapes or relocations of another 3 million from East to West Germany. In other words: 18 million people who have had the most diverse experiences with the critical event “displacement”. With a current total population of approximately 80 million German people, changes of immense significance transpire in both political and cultural respect (Hawes 2017). Another author ventilates the concept of regarding the former German Democratic Republic (GDR) to be the Trojan Horse of present Germany. Es wird sogar von dem Trojanischen Pferd DDR auf dem Gelände der Bundesrepublik gesprochen (Bach 2017, 2019).

27.8 Arriving in the Space of Every-Day Life: The Sausage-Eaters of Zürich in 1522 and Bern in 1960; the Master Plan of 2020

This moment, this *here*, this *right now* is my teacher saying,
You're a writer, as she holds the poem I am just beginning. (J. Woodson 2014:311)

Draft of a letter to Michael Geyer

25th of August 2019

Dear Michael,

Let us return to our correspondence. Let's try to understand how these two Germans either do not understand each other or do so only with difficulty. They can indeed speak and write to each other, which we are doing. The poet Jacqueline Woodson quoted throughout this book describes this same phenomenon among the residents of Ohio who live between the North and South of the United States. We would suggest practicing the East-West communication. This means we do without “master narratives” that in our opinion don't exist. – From a pathogenetic viewpoint the issue is the traumatic neurosis denied for 110 years in Germany; however, it is essential that we discover a **sense of coherence**, establish reason as the basis for our health. The NOW (here) opens itself to the past, present and future.

With this basic attitude we can imagine ourselves back in 1521 when the citizens of Zürich with their sausage consumption (see above) became representatives of global-minded democracy and culture and how centuries later a new sausage club was opened in Bern in the 1960s (Wiedersheim 1989). Wiedersheim was founding president of the University of Herdecke. Out of this emerged the Institut für Ausbildungs- und Examensforschung (IAE; Institute for Research in Medical Educational and Evaluation) of the Medical School of the University of Bern, headed by Hannes Pauli (Peter Salazin et al. 1989). Today this facility is internationally known by the name “Institut für Medizinische Lehre” of University of Bern (IME; Institute of Medical Education).

As in Harvey’s time, it is a matter of mustering the will to compare and contrast Guernica (a kind of pyre) and the contemplative men in Caspar David Friedrich’s work. Each individual can do this with firm confidence in oneself and others (*sola fide*, faith alone) to support one’s own master narrative. The individual takes on the attitude of the “writer” and now presents the own individual script (*sola scriptura*, scripture alone). In this way continuity and a sense of coherence will develop as a basis. This base is a web of belonging we can ultimately build upon (*sola gratia*, grace alone). Nothing other than this is what we strive for in our democracies and cultures.

Contemplating this, we can return to the image of refugees and British “natives”. The latter had just survived the fight for survival of W-W-II (Kershaw 2015). They developed the National Health System (NHS), also in cooperation with the refugees. It was a battle where many had to perish; but also where many had lived on, similar to Penelope and Telemach (cf. Mary Beard), as (presumed or true) widows and orphans. One must *respect their injuries* not by (transferred) wishes of retaliation but by grace (Leigh 2017) – this is nothing more than the work with traumatized persons.

Within a relatively short time from 1989 to 2018, medical educators have traversed the Bern institute (IME), among them a great number from the German-speaking regions. It can be expected they will greatly influence the so-called “master plan” (Jünger 2018; Jünger and Köllner 2003) of 2020 which will lead to lasting changes in medical curriculum. Thus a half-century later, after the first cautious attempts at reform in 1970, a long-term reformation to medical education will take place in Germany. It is expected that occupational reforms based on the Balint approach will receive stronger backing than as yet in German medical faculties and medical schools.

Beginning in 1970, a definite transformation has taken place. A great number of psychosomatic-psychotherapeutically trained doctors have entered the field (Jansen 2018). Now it is vital to adapt oneself to the space created for the newly-acquired skills which have been carefully and compassionately pursued in the recent past (Zipfel et al. 2016). Trenkel’s dreams no longer have to be dreamt today, they can be lived. – This much as a letter draft to Michael.

27.9 NOW (Here) in Germany: Transcultural Medicine Live

And standing in front of the class

Taking my poem from her

My voice shakes as I recite the first line:

Black brothers, black sisters, all of them were great ... (J. Woodson 2014:312)

Modern medicine began in the intellectual freedom of Padua with the picture of an autonomously beating heart and the circulatory system sustaining the bodies of humans and animals. The interplay between the Renaissance and Protestantism has allowed us to pursue the idea of human autonomy in the concept of modern medicine. Now it is time to remember the heart's role in human medicine. Therefore two psychocardiologists will be cited here in conclusion, "namely Volker Köllner and Christoph Herrmann-Lingen": The first psychocardiologist states that in the German-speaking regions about 30,000 medical students have gone through case history groups since 1969/70 (Köllner and Loew 1998). He is the medical director of a psychosomatic rehabilitation clinic of the German Federal Pension Fund (Psychosomatic Medicine in Germany, cf. Chap. 11) and President Elect of the German Congress of Psychosomatic Medicine, Berlin, 2020 (Köllner 2020). – The other psychocardiologist describes how at this time there is great variety within institutionalized psychosomatics that is becoming feasible (Hermann-Lingen 2011, 2017). He is the current President of the German College of Psychosomatic Medicine (DKPM) and is Past President of the American Association for Psychosomatic Medicine. Both physicians emphasize what a great role the conscious secondary socialization of consciously conducted academic didactics plays. We need to refer to both (cf. Chap. 3) the narrative and the evidence based elements of health care delivery. This implies we should foster a culture which allows members of health groups (cf. Ehrhardt et al. 2018, 2019, 2020) to make use of their **individual** (which is not identical with "personal") sensing. The sensing is geared towards the Own Self and therefore towards the Other. The Self and the Other are striving to move and to breath *freely*.

With that we have honored in retrospect what was established in Ascona, with extensive efforts from the couple Luban and Plozza, that is, the Students' International Balint Award 2019 (German Balint Society, 2018; Petzold and Otten 2010; Stubbe and Petzold 1996) which is being advertised as follows and has flowed into this contribution as the acronym:

ERAP: Namely

Exposition: The paper should include a presentation of a truly personal experience of a student-patient relationship. (Manuscripts of former medical theses or diplomas cannot be accepted.)

Reflection: A description of how the student experienced this relationship, either individually or as part of the medical team.

Action: The student's own perception of the demands to which s/he felt exposed and an illustration of how s/he responded.

Progression: A discussion of both ways in which the student’s own approach might change in the future, and also possible ways in which future medical training might enhance the state of awareness for individual students.

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Prof. Dr. med. Ernst Richard Petzold, professor emeritus, academic chair for Psychosomatics and Psychotherapeutic Medicine at the University Clinic of the RWTH Aachen. He became acquainted with this group work in Switzerland (1969/1970) and was fascinated by it (1970). Many years later, Wolfram Schüffel invited him to the first Wartburg Dialogues. From 1992 to 2017 he was a regular participant at these extraordinary meetings. From 1997 to 2009 he was the chairman of the German Balint Society; from 1995 to the present he has been a member of the Viktor v. Weizsäcker Society and the DKPM. Since retiring he has been living in Kusterdingen near Tübingen.

Chapter 28

Consultation-Liaison Psychiatry and Psychosomatic Medicine: Where Do We Go from Here?



Hoyle Leigh

28.1 Introduction

When this volume was planned more than 3 years ago, the title was *Comparative Global Psychosomatic Medicine*. At that time, “psychosomatic medicine” was newly established as a subspecialty of psychiatry in the United States, and there were many professional organizations and publications in the world with *psychosomatic* in their titles. It was not clear, however, what was meant by “psychosomatic.” Under its rubric could be found such diverse fields as psychoanalysis, yoga, meditation, autogenic training, psychoneuroendocrinology, biofeedback, psychopharmacology, somatization, psychooncology, psychopharmacology, hypnosis, psychiatric consultation to the medically ill, etc. etc. As the book progressed, it became clear that there was indeed a line of cleavage between *consultation-liaison psychiatry* and *psychosomatic medicine* (whatever its meaning), and in fact, the subspecialty of “psychosomatic medicine” in the United States changed its name to “consultation-liaison psychiatry” and, ditto, the *Academy of Consultation-liaison Psychiatry*. Consultation-liaison psychiatry emphasizes the role of psychiatry in general medical settings and psychiatric co-morbidities in patients with medical diseases rather than *psychogenesis* of medical diseases.

Complementary and Alternative Medicine (CAM), often based on traditional and indigenous healing practices, also has claims of being *holistic* and thus *psychosomatic*. Certain CAM-derived practices such as Mindfulness, Relaxation Techniques, and Yoga, have been researched and integrated into mainstream (psychosomatic) medicine and psychiatry. Others may have certain effects mostly

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through the placebo mechanism- which may be considered to be an excellent example of *psychosomatic intervention* in the sense that placebo, in the form of beliefs and symbols and thus information causes brain changes resulting in physiologic and genetic changes, which in turn may result in pathology or recovery. Taking a placebo pill has an effect not because of the chemical composition of the pill, but the idea and act of *taking a pill*. Psychological stress, e.g., an upcoming test, may have an effect on the body not because of the content of the test but the *idea* that it is approaching. Psychological stress *is information* just as placebo is. So is, of course, knowledge gained through education. I'll discuss this further later in this chapter.

28.2 Consultation-Liaison Psychiatry and the English-speaking Countries (UK, US, Canada, Australia, South Africa, Sub-Saharan Africa)

As Gribble points out in the Australia chapter, there is a certain aversion to the term *psychosomatic* among our medical colleagues and the population at large, as the term implies *psychogenesis* or “all in the mind” to them. Clearly, the scope of *consultation-liaison psychiatry* is far broader than “conversion” or “somatization” as it includes the diagnosis and treatment of psychiatric disorders co-morbid with medical/surgical disorders as well as of illness behavior, coping with and adaptation to disease, death, rehabilitation, and recovery. Thus, *consultation-liaison psychiatry* is defined largely by the location (general hospital and medical clinics) rather than by diagnoses. This is in a sense ironic because *psychosomatic medicine* began in medical settings studying the role of psychological conflicts (Alexander), personality traits (Dunbar), stress (Cannon, Selye), interaction of illness with personality types (Kahana & Bibring), and biopsychosocial factors in disease (Engel), etc. (Alexander and Benedek 1950; Cannon 1932; Dunbar 1947; Engel 1977; Kahana and Bibring 1964; Selye 1985).

Parallel to the general trends in medicine and particularly in psychiatry in the United States, Consultation-liaison psychiatry was heavily influenced by psychoanalytic thinking in the early days, but became progressively more biologically oriented, especially with the advent of psychoneuroendocrinology and the rapid advances in neuroscience and genetic/molecular biology. In spite of the wide acceptance of Engel's *Biopsychosocial Model*, the actual integration of the psychological and social dimensions of the patient with biology remains a challenge. Leigh, Feinstein, and Reiser attempted to operationalize the biological, psychological, and social dimensions of the patient with the *Patient Evaluation Grid (PEG)* with limited success, which was incorporated in the *Intermed* program by Huyse, de Jonge et al. in the Netherlands (de Jonge et al. 2004; Leigh et al. 1980; Leigh and Reiser 1980, 1985, 1992). With the advent of cost-conscious *managed care*, the *liaison* part of Consultation-liaison withered as medical departments and insurance companies did not provide funds for such “non-billable” services. With

the advent of the Affordable Care Act (“Obamacare”), it seemed likely that the *Integrated Care Model*, having shown to be cost-saving in the long run, might be widely adopted. However, in the light of the regressive policies of the current administration, the future of integrated care is at best uncertain (See Chap. 23).

In general, it seems clear that *Consultation-liaison Psychiatry* is widely accepted and vibrant in the English-speaking countries including UK, Australia, South Africa, Canada and the United States. In addition to C-L psychiatry based in Western medical institutions, however, there seem to be, in indigenous populations, significant utilization of traditional CAM practices which may or may not be used in conjunction with modern medicine. Chapter 9 on Sub-Saharan Africa by Rensburg and Tema provides insight into ideas on mind-body interaction and the development of consultation-liaison psychiatry in an often neglected region.

28.3 Psychosomatic Medicine and Consultation-Liaison Psychiatry in Continental Europe

Psychosomatic Medicine, rather than Consultation-liaison Psychiatry, seems dominant in continental Europe, especially in Germany and France. It is of note that in Germany, *the law requires* the teaching of *psychosomatic medicine* and establishes departments of psychosomatic medicine which are independent of departments of Psychiatry. Perhaps this represents the post World War II revival of humanism and psychoanalytic approaches in Germany. There is clearly a strong philosophical and humanistic orientation in German and French psychosomatic medicine. Thus, the orientation and approaches of the psychosomatic departments seem to be clearly psychodynamic in contrast to traditional biologically oriented psychiatry departments. There is a vibrant mix of consultation-liaison and psychosomatic medicine approaches in the Netherlands as well as in Italy, though not represented in this volume. Of note is that Balint Groups, founded in the 1950’s in Britain, seem to be widely accepted in Europe, especially in Germany and German-influenced countries, but it is almost non-existent in the United States.

In countries that emerged recently from totalitarian Communist rule (Poland, Baltic States), *psychosomatic medicine* seems heavily influenced by the German school, though there seems to be also extensive *consultation-liaison activity*. It is unfortunate that Russia is not represented in this volume. It seems psychiatry in Russia is mostly focused on the needs of severely mentally ill patients, though there are a few published articles concerning “psychosomatic” disorders of late (Morozov 2017; Myznikov et al. 2005; Savenko and Perekhov 2014).

Southern European countries, especially Spain and Greece as represented in this volume, seem to be influenced by American approaches embracing *consultation-liaison psychiatry*. Chapter 4 by Deter et al. in this volume provides a valuable overview of the development, and attempts at integration through the interaction of various professional organizations of psychosomatic medicine and consultation-liaison psychiatry in Europe.

28.4 Consultation-Liaison Psychiatry and Psychosomatic Medicine in Asia – (Partial) Incorporation of Traditional Medicine

There are long histories of holistic traditional medicine in Asian countries, mainly arising from two traditions – Chinese Traditional Medicine (TCM) and Hindu/Vedic Medicine, with unique subsequent developments in Japan and Korea. With the introduction of Western medicine and particularly *psychosomatic medicine*, there ensued significant research and treatment of *psychosomatic disorders* such as functional digestive disorders, bronchial asthma, and *Hwa-Byung*, a uniquely Korean anger disorder. Roughly paralleling the changes in concepts and emphasis in the West from “psychosomatic disorders” and “psychogenesis” to an emphasis on the whole person utilizing the *Biopsychosocial* approaches, the Asian countries represented in this volume seem to place increasing importance in *consultation-liaison psychiatry*.

A number of traditional Asian “psychosomatic” practices, on the other hand, have evolved and adapted to modern times, gaining world-wide acceptance. They include *mindfulness*, *meditation*, *yoga*, *acupuncture*, etc.

28.5 Egypt and the Middle East

Egypt’s ancient civilization which antedates that of Greece made major contributions to the Hippocratic tradition, e.g., the Egyptian notion of displaced uterus causing morbid states. Freud was deeply interested in and influenced by ancient Egyptian myths. Subsequent Islamic culture in Egypt and the Middle East blossomed during the Dark Ages of Christian Europe. As Okasha writes in this volume in Chap. 8, the first Islamic hospital was established by the early ninth century in Baghdad (705 AD) followed by Cairo (800 AD), Damascus and Aleppo (1270 AD) and then with the Arab and Islamic influence in Seville, Spain (1409 AD) and from there is spread to the rest of Europe. A hospital in Cairo established by the Egyptian Sultan al-Mansour Kalaoun in the thirteenth century had sections for surgery, ophthalmology, medical and mental illnesses, i.e., it had a separate ward for psychiatric patients in a general hospital. By the ninth century, Muslim physicians were writing medical textbooks. The Arabic medical profession was cosmopolitan and sophisticated, open to members of all faiths. The eleventh century physician Ibn Jazlah described melancholia with delusion, manic depression, and psychosis, although he attributed these disorders to humors. Arab scientists produced a number of drugs. A thirteenth century work listed 1400 drugs. Avicenna used rauwolfia in the treatment of acute mental symptoms. The teaching of the great clinician Rhazes had a profound influence on Arab as well as European medicine. After the fourteenth century which coincides with European Renaissance and the beginnings of scientific medicine, magic and superstition began to creep back into the medical works of Muslim

writers which some authors call the dark ages of Islam, where the scientific approach in thinking was replaced by magic, superstitious beliefs and sorcery. Thus, as with Greece, further development of medicine in the region had to await the infusion of Western medicine of late, however, there now seems to be vibrant research and education in the psychiatric co-morbidities of medical conditions and cultural influences in the manifestations of psychiatric conditions.

28.6 Where Do We Go from Here?

In spite of the birth of holistic medicine in ancient Greece, Egypt, China, and India and in other indigenous cultures, there is little evidence of their continuing development in the regions/countries of origin. In China and India, traditional notions of mind/body were preserved to an extent but only recently have there been any attempts of integration with modern medicine/psychosomatic medicine. The dominant world-wide trend in psychosomatic medicine is the thread starting from Hippocrates through Freud and Alexander's *psychogenesis of physical symptoms* to Cannon and Selye's *Stress and (mal)adaptation* to Engel's *Biopsychosocial Model* to modern *neuroscience* and *Consultation-liaison Psychiatry* defined by the function and location of the psychiatrist rather than particular theories about mind-body relationship.

The term "psychosomatic medicine" is often identified by many with "psychogenesis of physical symptoms" mainly based on psychoanalytic thought, which had spread throughout the world during the twentieth century. With the influx of European psychoanalysts into the United States to escape persecution from Europe, psychosomatic medicine blossomed in the US and, in turn, after World War II, influenced the establishment of psychosomatic thought throughout the world. Psychosomatic medicine seems to have been influenced by resurgent humanism and humanistic psychology in Germany and France as well as in the former Communist countries in Europe.

In the meanwhile, beginning in the latter part of twentieth Century, the trend in the US and English-speaking countries was to move away from the notion of psychogenesis to a comprehensive, *biopsychosocial approaches* to patients with any medical disease and the recognition and treatment of psychiatric and medical co-morbidities, i.e., *consultation-liaison psychiatry*. Psychosomatic research per se moved on to more specialized research with names like *psychoneuroendocrinology*, *psychopharmacology*, *behavioral genetics*, *epigenetics*, etc. Clinical psychosomatic medicine has also become more specialized, often related to the disease or venue, e.g., *psycho-oncology*, *psycho-obstetrics and gynecology*, *psycho-dermatology*, etc.

Consultation-Liaison psychiatry implies both consultation and liaison activity with different emphasis and venues. The vigor of each activity depends on the orientation of the personnel, and particularly the funding structure. When the National Institute of Mental Health funded liaison activity, it thrived in the United

States, especially in Rochester under George Engel. With the advent of managed care, medical departments refused to pay for psychiatric liaison activity which was un-billable lacking a procedure code, and only consultation activity survived. More recently, there is renewed interest in liaison activity in the form of *Integrated Care* as this activity is shown to be cost-effective (Duarte et al. 2015; Everett et al. 2014; Hamann et al. 2014; Kolko 2015; Schottle et al. 2018; Sledge et al. 2015; Sunderji et al. 2018).

Complementary and Alternative Medicine (CAM) has always been present in sub-populations in most regions of the world including the United States (e.g. naturopathy, homeopathy, etc), but of late, there has been, in the developed world, an explosion of the use of *CAM-related dietary supplements* including vitamins, minerals, DHEA, melatonin, and herbal medicines including St. John's wort, echinacea, etc. Some CAM practices have undergone scientific scrutiny, evolution, and acceptance, e.g., mindfulness, yoga, acupuncture, and some dietary supplements.

28.6.1 *The Future*

The doctor of the future will give no medicine, but will interest his patient in the care of the human frame, in diet and in the cause and prevention of disease. (Thomas Edison)

So quote Pizzorno, Snider, and Micozzi in a chapter in *Fundamentals of Complementary and Alternative Medicine* (Micozzi 2015). They also state that Thomas Edison's insightful prediction is proving true today, as natural medicine finds itself in the midst of an unprecedented explosion into mainstream health care. Western medicine has roots in CAM, and now we may see a full circle. The quote, however, can be interpreted to emphasize research in the cause and prevention of disease, and in the care of the human body and brain through symbolic means- i.e., information infusion through education. In fact, the quote could be slightly rewritten as – *The modern doctor will not only give medicine but will interest the patient in the care of the human being, in promoting health and in the cause and prevention of disease.*

Another important phenomenon that may bridge the gap between CAM and scientific medicine is the *placebo effect*. Placebo (or *nocebo*) effect is always present in any health care procedure, talking, touching, cutting, or pills with inactive (supposedly) ingredients or active (good or bad) ingredients. Furthermore, *deception is unnecessary for placebo to be effective*, i.e., belief of effectiveness is not required for placebo effect (Hall et al. 2018; Hoenemeyer et al. 2018; Kaptchuk et al. 2010; Kaptchuk and Miller 2015; Mundt et al. 2017). Placebo is an example par excellence of the literal ingestion of a symbol in the form of a pill.

What is a placebo, then? In my view, it is a *meme infusion* into the brain. Meme is information that induces *memory* in the brain, as a de novo formation or, most likely, in association with existing memory (Leigh 2010, 2012a, b). This new information in the form of placebo is, when effective, may be akin to software patches introduced to a computer that results in a repair of malfunction. Could specific

memes be developed that can be introduced to the brain in different forms, i.e., words, images, melodies, symbols, other than pills? Placebo research may open up a new field related to the old notion of *psychosomatic medicine*, i.e., *the role of memes (information, symbols) in health and disease*.

Looking ahead, it seems clear that the old distinction between psyche and soma has lost its meaning entirely. What remains is information (memes), the systematic recognition and use of laws of nature by any entity that is able to do so. The psyche is but memes, encoded in various forms and media substrates, both within and without the brain and in the DNA which is just another medium. A person is a construct of memes (information), an integrated whole built bit by bit with components that are genetically and epigenetically determined, with constant infusion of memes (information) from both without and within.

In this digital age, *homo sapiens* seems to be on the cusp of a revolutionary change in its relationship with information. With internet and smart phones which may evolve into smart implanted chips, we may be able to download any information automatically, and even upgrade our brain.

There should therefore be a convergence of medicine, psychiatry, psychosomatic medicine, psychology, and all neurosciences, as well as all humanities including all social sciences and arts. Computer science, informatics, and artificial intelligence would impel and facilitate this integration. As for the practice of such integrated medicine (or perhaps *repair process*), I would foresee specialists in various techniques including psychotherapy (or *meme infusion*), nanotechnology-based repair of receptors and neurons, and other new forms of intervention, probably chosen by super computer algorithms. Prevention at DNA and epigenetic level should become available, for example by gene editing (Howard et al. 2018; Knight et al. 2018). Eventually, it is possible that all diseases can be prevented, and all disorders can be repaired by the use of computers and artificial (post-human?) intelligence.

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Appendix 1: Questionnaire Responses for Italy (G. Fava) and Sweden (K. Orth-Gomer)

Questionnaire Responses from Italy and Sweden

(Although unable to contribute full chapters, Drs. Kristiina Orth-Gomér and Giovanni Fava contributed to this book by completing the questionnaires for their respective countries and they are included in the tabulation.)

Italy

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry in your (or your chapter's) Country.

Please return this as an attachment to your email

Country on which you are reporting: ITALY

Your Name: GA FAVA

Institution: University of Bologna

City & Country (e.g. London, UK): Bologna, Italy

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?

Yes (X) No () In some sense ()

- a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes (X) No ()
- b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes (X) No ()

2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?

Yes () No (X)

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?

Yes (X) No ()

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No (X)

- a. If YES, which?

Psychosomatic Medicine () Consultation-Liaison Psychiatry ()

- b. If YES, the status of such certification is:
 - i. Independent Medical Specialty ()
 - ii. Subspecialty of Internal Medicine ()
 - iii. Subspecialty of Psychiatry ()
 - iv. An independent non-medical discipline, as Psychology, Social Work ()
 - v. Other (Specify): []
- 5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes (X) No ()
If YES, please list names of the organizations and the websites if available:
Gruppo per la Ricerca in Psicomatica (GRP)
Società Italiana di Medicina Psicomatica (SIMP)
- 6. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:
Medicina Psicomatica
- 7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in your country? Yes () No (X)
 - a. If YES, where does it occur? Check all that apply:
Medical School () Residency () Fellowship ()
- 8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes () No (X)
- 9. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)
 - a. It is insignificant (X)
 - b. Some subgroups (e.g. ethnic, religious) practice it ()
 - c. A significant part of the general population practice it ()
 - d. Is the most prevalent healing method used ()
 - e. It is often used in combination with Western medicine ()
 - f. More widely used methods are as follows (Please list, e.g., spiritual healing, meditation, herbal, etc):

10. Please add any comments to your response here:

Sweden

Questionnaire Concerning Psychosomatic Medicine and Consultation-Liaison Psychiatry in your (or your chapter's)

Kristina Orth-Gomér, Karolinska institutet,

Stockholm, Sweden. Current telephone no 0049 3328 300329

E mail: kristina.orth-gomer@ki.se or kristina@orth-gomer.com

Please respond by putting an X in the parentheses (X) and respond to questions as indicated:

1. Is Psychosomatic Medicine different from Consultation-Liaison Psychiatry?
Yes (x) No () In some sense ()
 - a. Is Psychosomatic Medicine more psychotherapy-oriented than Consultation-Liaison Psychiatry? Yes () No ()
 - b. Is Psychosomatic Medicine more research-oriented than Consultation-Liaison Psychiatry? Yes () No ()

2. Is there a Department (or equivalent) of Psychosomatic Medicine in your Institution or in other institutions in your country?
Yes () No (x)

Is teaching of psychosomatic medicine in medical schools required by law or health care system in your country? YES () No ()

3. Is there a Consultation-Liaison Service/Section in the Psychiatry Department in your institution or other institutions in your country?
Yes () No (x)

4. Is there a special certification for Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No ()
 - a. If YES, which?
Psychosomatic Medicine () Consultation-Liaison Psychiatry ()

- b. If YES, the status of such certification is:
 - i. Independent Medical Specialty ()
 - ii. Subspecialty of Internal Medicine ()
 - iii Subspecialty of Psychiatry ()
 - iv. An independent non-medical discipline, as Psychology, Social Work ()
 - v. Other (Specify):[]

- 5. Are there professional organizations of Psychosomatic Medicine and/or Consultation-Liaison Psychiatry in your country? Yes () No ()

If YES, please list names of the organizations and the websites if available:

- 6. Please list the names of professional journals published, if any, in your country that mainly deal with topics in psychosomatic medicine and/or consultation-liaison psychiatry:

The former Acta Medica Scandinavia, now called the Journal of Internal Medicine has rather often original work from the psychosomatic medicine field of research. I think it is more important that we reach those who do not work with psychosomatic questions at all – this is the most important thing for patient care.

The “sub journals” of Circulation and JAMA are further such publications that are important for us in the field of psychosomatic medicine

- 7. Is there formal training in psychosomatic medicine/consultation-liaison psychiatry/biopsychosocial model in your country? Yes () No ()
 - a. If YES, where does it occur? Check all that apply:
 - b. Medical School (x) Residency () Fellowship ()
- 8. Is there a formal certification process of Complementary and Alternative Medicine (CAM) practitioners in your country? Yes () No ()
- 9. Concerning traditional/folk/indigenous practice of healing in your country (please check all that apply)
 - a. It is insignificant (x)
 - b. Some subgroups (e.g. ethnic, religious) practice it (x)
 - c. A significant part of the general population practice it ()
 - d. Is the most prevalent healing method used ()
 - e. It is often used in combination with Western medicine ()
 - f. More widely used methods are as follows (Please list, e.g., spiritual healing, meditation, herbal, etc):

10. Please add any comments to your response here:

Traditional folk medicine is practiced by the Sami (Lapponians) in the vvery North. They live in the North of Norway, Sweden and Finland, they have a common parliament to which thy go in their traditional colorful folk suits and raise a lot of attention in the capitals. But they are very few and do not have much influence.

Appendix 2: Table of the Status of Psychosomatic Medicine, Consultation- Liaison Psychiatry, and Complementary/ Alternative Medicine in Selected Countries

Appendix 2 (continued)

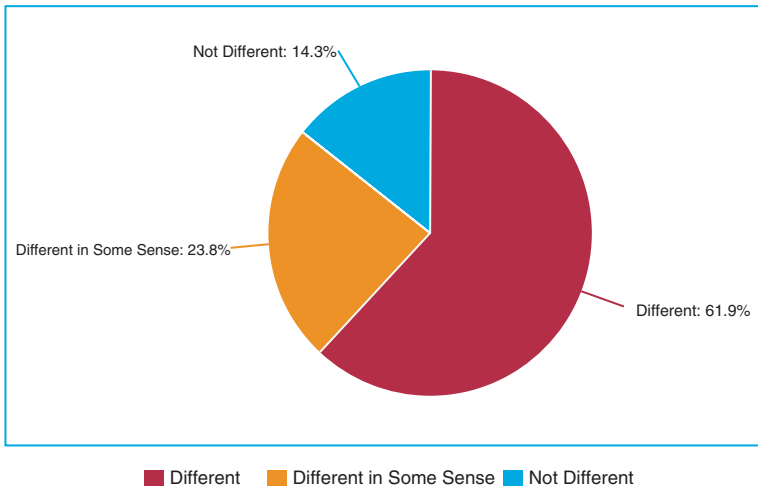
Name	Continent	Country reporting	Prof journals	Formal training in PSM/CL?	Formal training in medical school	Formal training in residency	Formal training in fellowship	Formal certification for CAM?	CAM insignificant	Some groups practice it	Significant part of population practice it	CAM most prevalent healing method	Used in combination with Western medicine	More widely used methods
Okasha, Tarek	Africa	Egypt		1	1	1	1	0	1		1	1		Religious, spiritual, and herbal
Rensburg, Bernard Janse Van; Thomas, Eileen	Africa	S. Africa	1	1	1	1	1	1			1			
Koh, Kyung Bong	Asia	Korea	1	1	1			0			1			
Kubo, Chiharu	Asia	Japan	1	1	1			1			1		1	
Nair, Beena; Kotak, Bhavesh; Jain, Manish	Asia	India		0				1			1		1	
Xiao, Shiyuan; Zhao, Shifu	Asia	China	0	0	1	1		1			1	1	1	
Gribble, Robert	Australia	Australia	1	1	1	1	1	1		1				
Aitken, Peter	Europe	UK		1	1	1	1	0						

Appendix 2 (continued)

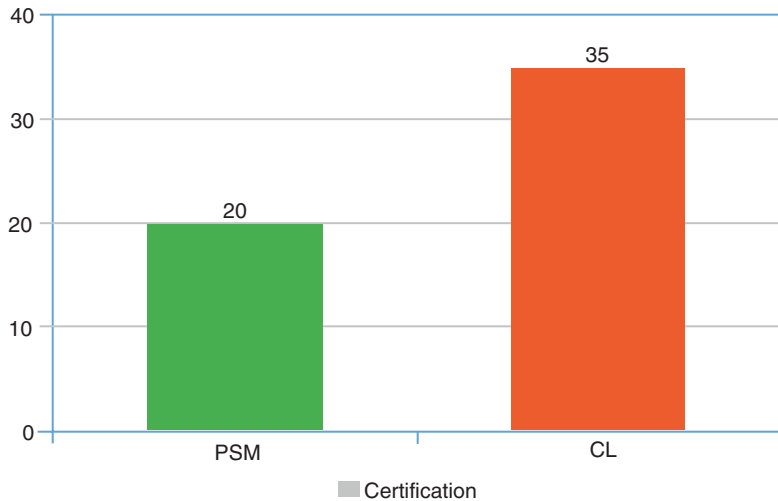
Name	Continent	Country reporting	Prof journals	Formal training in PSM/CL?	Formal training in medical school	Formal training in residency	Formal training in fellowship	Formal certification for CAM?	CAM insignificant	Some groups practice it	Significant part of population practice it	CAM most prevalent healing method	Used in combination with Western medicine	More widely used methods
Wasilewski, Bohdan	Europe	Poland	1	0				0		1			1	
Gagnon, Fabien	N. America	Canada	0	1	1			0	1	1			1	Meditation yoga
Leigh, Hoyle	N. America	USA	1	1	1	1		0		1			1	
Olego, Oscar; Bronstein, Roberto	S. America	Argentina	0	0	0				1	1				
Sum			10	13	12	12	6	7	8	8	7	2	7	
%			50	65	60	60	30	35	40	40	35	10	35	

Legend: 1 indicates "YES" and 0 indicates "NO" except for sum and % rows

Is Psychosomatic Medicine Different from Consultation-Liaison Psychiatry?



Certification in Psychosomatic Medicine and Consultation-Liaison Psychiatry (%)



In Japan and Germany, there is certification both for PSM and CL.

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