

Section: Modern PPT practice

EVALUATION CRITERIA FOR PSYCHOSOMATIC PRACTICE



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Abstract

To diagnose and treat somatic disorders while considering psychosocial factors, medical and psychological practices require a comprehensive and operationalized list of criteria. The Evaluation Criteria for Psychosomatic Practice (ECP) has been developed to address this need. It builds upon the updated version of the Diagnostic Criteria for Psychosomatic Research (DCPR) by incorporating significant psychodynamic factors and restructuring its framework to better cater to the practical demands of clinical assessment, diagnosis, treatment planning, and outcome monitoring. It offers four axes for clinical evaluation that can be used together or separately, depending on the needs of diagnostic process, treatment, informing the patient, or research: psychosomatic symptoms and complaints, risk factors related to personality structure, triggers, and secondary risk factors.

By utilizing the ECP's four axes, clinicians can gain a deeper understanding of how psychosocial factors impact the clinical picture and dynamics of somatic disorders and then effectively communicate this knowledge to patients, improving compliance and collaboration in treatment. Additionally, the ECP's framework allows for a balance of psychological, physical, and social treatment interventions that can be tailored to the specific needs of the patient, ultimately leading to better treatment outcomes.

Keywords: psychosomatic health, personality structure, psychotherapy, stress, diagnostic criteria for psychosomatic practice, positive psychotherapy

Introduction

Psychosomatic medicine “strives to illuminate the connection between the mental events” social interactions, behaviours, “and bodily reactions” (Peseschkian N., 2016) within a self-regulating system of health.

It provides a conceptual framework for two primary objectives:

1. conducting scientific research to understand the impact of psychosocial factors on the development, course, treatment, and outcomes of any diseases, and
2. employing advanced psychosomatic clinical thinking and strategies to incorporate psychosocial assessment and therapy into standard medical protocols for prevention,

examination, diagnosis, treatment, rehabilitation, and health design.

Over the past few decades, psychosomatic research has yielded a wealth of knowledge and led to the emergence of new fields such as psycho-proctology, psycho-oncology, psycho-neuroendocrinology, psychoimmunology, and others.

As early as the 1960s, Dürssen A. and Jorswieck E. (1965) showed that, on average, 100 hours of analytic psychotherapy within five years of completion saves 85% of inpatient treatment days. Based on this obvious economic benefit, in 1967 in Germany, psychotherapy was included in the list of priorities of health insurance companies (Boessmann U., Remmers A., 2023). A meta-analysis showed that psychodynamic

psychotherapy can reduce the use of medical care by 77.8% (Abbass A. et al., 2009). Paying 3,200 euros for psychotherapy for one patient, the insurance company saves an average of 10,425 euros, implying the cost-benefit ratio of 3.26 (Wittmann W.W. et al., 2011).

The Diagnostic Criteria for Psychosomatic Research (DCPR), introduced in 1995 by Fava G.A. et al. (1995) to operationalize psychosocial variables derived from psychosomatic research, has been effective in assessing psychosomatic conditions, regardless of the organic or functional illness's nature (Porcelli P., Rafanelli C., 2015; Porcelli P., Guidi J., 2015; Altamura M. et al., 2015). Based on extensive experience with the use of DCPR in many patients and settings, it was revised in 2017 (Fava G.A. et al., 2017).

The purpose of this article is to present the Evaluation Criteria for Psychosomatic Practice (ECP), which builds upon the knowledge and understanding gained from the use of DCPR and incorporates the latest developments in psychodynamic ideas and theories of somatization. These theories suggest that somatic symptoms may arise as a way for the body and mind to cope with stress (Gubb K., 2013; Kirillov I., 2020), or as a response to certain triggers that activate a senso-motoric simulation (Hesslow G., 2002; 2012; Jeannerod M., 2006; O'Shea H., 2022) – reproduction of previously directly or indirectly experienced symptoms. The latest concepts of OPD-3 and Positive Psychotherapy have led to a re-evaluation of risk factors associated with personality structure. With the introduction of ECP, the causal relationship of psychosomatic symptoms with stressors, personality structure, and secondary psychosocial risks is now better understood through the more precise differentiation of related groups of symptoms and factors leading to them. These new developments allow for more accurate treatment planning, leading to improved outcomes for psychosomatic patients undergoing therapy.

The article will provide a description of the ECP criteria related to the corresponding axes, as depicted in Figure 1.

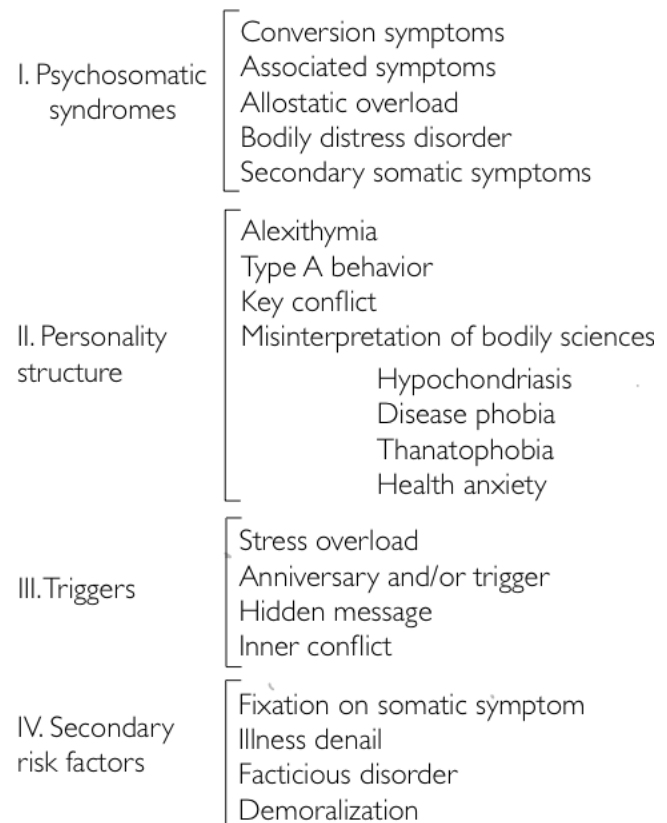


Fig. 1. ECPP

Methodology

2.1. General Ideas of psychosomatics

Thinking of psychosomatics one should consider two perspectives:

1. Psychosomatic aetiology – “bodily ailments and functional disorders of the organism, the etiology and course of which are largely dependent on social and psychological circumstances” (Peseschkian N., 2016). Now research show 2 main mechanisms (Gubb K., 2013; Bouziane I. et al., 2022; Schröder L., et al., 2022) of psychosomatogenesis:

a. Stressogenic. The stress of life events, relationships and mental conflicts exceeding the coping capacities of personality structure leads to chronic inner stress that challenges somatic resilience and disturbs vegetative regulation. This can aggravate existing somatic disorders or even cause them (Alexander F., 1950). The exhaustion of somatic resilience results first in reduced impulse control and conversions (WHO, 2022), then in symptoms of tiredness (allostatic overload), and later in functional symptoms of persistent somatization, classified in ICD-11 as Bodily Distress Disorder (6C20) (WHO, 2022).

b. Associative simulation involves the top-down re-activation of symptoms. Essentially, the senso-motoric cortex retrieves the past somatic

experiences and uses them to anticipate/simulate the potential outcome of an associated triggering situation, leading to the activation of a relevant symptom (Bouziane I. et al., 2022; Schröder L., et al., 2022).

Somatopsychic reactions – the individual mental **and social** response to any bodily symptoms and disfunction defined by the individual constellation of personality structure, inner concepts, and conflicts. Those personal coping strategies can support the treatment and prompt its soon and best outcomes or, reversely, can sabotage it, resulting in a achronic course of the disorder. Somatopsychic reactions can as well develop into comorbid mental problems (demoralization (Tecuta L. et al., 2015; Sweeney D.R. et al., 1970), fixation on somatic symptoms (Biderman A. et al., 2003) or illness denial (Grassi L. et al., 2005; Grandi S. et al., 2011) or disorder (depression (Ma, Y. et al., 2021) or anxiety).

The practically useful set of criteria should:

- reflect the impact of psychosocial variables on the genesis, course, and outcome of the medical condition;
- justify the referral to psychologist or therapist;
- ground the plan of treatment and effective interventions;
- measure the treatment outcomes;
- help to design research on psychosomatics.

Meeting these goals requires a system that would differentiate psychosomatic syndromes from the risks of the personality structure decreasing capacity to process stress and affects, triggers, and secondary risks.

2.2. Psychosomatic syndromes and complaints

The goal of this set of criteria is to identify predominantly psychosomatic syndromes that cause significant distress to patients but do not reach the threshold of discernible organic changes. The primary treatment for such syndromes should focus on psychotherapeutic interventions. Although certain organic disorders, such as Alexander's (1950) "holy seven" (peptic ulcer, bronchial asthma, rheumatoid arthritis, ulcerative colitis, essential hypertension, neurodermatitis and thyrotoxicosis), anxiety disorders, and depression (Guidi J. et al., 2020), are recognized to have a psychosomatic nature, in these cases, the somatic component is given priority in

treatment to manage immediate symptoms, while psychosocial interventions are utilized to support long-term progress and remission. Therefore, these organic psychosomatic conditions are not included in this set of criteria.

We adopted the operationalization of *Conversion symptoms* (Table 1) of DCPR established by Engel (1970) and demonstrated much higher sensitivity (4,5% vs 0,4%) than the DSM-IV (American Psychiatric Association,1994) in a sample of 1,498 patients with a range of medical conditions.

Associated symptoms (table 2) represent the specific mechanism of somatization, namely senso-motoric simulation. These symptoms can occur as part of a conversion disorder or in response to an anniversary or trigger.

Allostatic overload (table 3) described by validated (Offidani E., Ruini C., 2012; Tomba E., Offidani E., 2012; Guidi J. et al., 2016) clinical criteria (Fava G.A. et al., 2010) adopted from revised version of DCPR (Fava G.A. et al., 2017),, yet restructured for better understanding.

The description of Persistent somatization (DCPR) has been adjusted to meet the criteria of *Bodily distress disorder* (Table 4) in ICD-11. It refers to patients whose chronic stress causes a disbalance in their vegetative system, which triggers bodily predispositions and result in the manifestation of multiple somatic symptoms that cannot be fully explained by a medical condition. These symptoms persist over an extended period and cause significant distress and disruption to daily functioning (Kellner R., 1994).

With a rubric of *Somatic symptoms secondary to a psychiatric disorder* (table 5) the clinician can hypothesize that some somatic symptoms (e.g., autonomic arousal (Hanel G. Et al., 2009), cardiovascular (Nemeroff C.B., Goldschmidt-Clermont P.J., 2012) and neoplastic disease (Currier M.B., Nemeroff C.B., 2014) Cushing's disease (Sonino N. et al., 1998) are the result of a psychiatric condition (particularly mood and anxiety disorders) and may remit upon the remission of the psychiatric disorder (Fava G.A. et al., 2010).

Table 1. Conversion symptoms¹ (criteria A–C are required) (Fava G.A. et al., 2017)

- A**
- one or more symptoms or deficits affecting voluntary motor or sensory function (visual, auditory other sensory disturbances, movement, gait, speech disturbances, vertigo or dizziness, non-epileptic seizures, paresis or weakness, chorea, myoclonus, tremor, dystonia, facial spasm, dissociative amnesia and trance without changes in primary perception);
 - lack of anatomical or physiological plausibility and/or absence of expected physical signs or laboratory findings and/or inconsistent clinical manifestations;
 - autonomic arousal
 - symptoms are prominent and cause distress and/or seeking medical care and/or impaired quality of life
- B** Appropriate medical evaluation uncovers no organic pathology to account for the physical complaints
- C** At least 2 of the following 4 characteristics should be present: (1) Ambivalence in reporting of symptoms (e.g. the patient appears relaxed or unconcerned as he/she describes distressing symptoms); (2) Histrionic personality features (colourful and dramatic expressions, language and appearance, demanding dependency, high suggestibility, rapid mood changes); (3) Precipitation of symptoms by psychological stress (the patient is unaware of such association); (4) History of similar physical symptoms experienced by the patient, observed in someone else, or wished on someone else.

Table 2. Associated symptoms (criteria A - D are required)

- A** Symptoms presented are closely resemble the symptoms of physical illness experienced by the patient and/or observed in someone else, or wished on someone else
- B** The symptom and/or its consequences were accompanied by significant changes in 1 or more of the following: physical and/or emotional reactions, productivity and/or rhythm of life, attitudes, outlook and/or expectations
- C** Those changes cause distress and/or seeking medical care and/or impaired quality of life
- D** Appropriate medical evaluation uncovers no organic pathology to account for physical

¹ 6B60 Dissociative neurological symptom disorder in The ICD-11.

Table 3. Allostatic overload (criteria A and B required). Adjusted from the revised version of the DCPR

- A** 1 or more of the following 3 features: (1) At least 2 of the following symptoms: difficulty falling asleep, restless sleep, early morning awakening, lack of energy, dizziness, generalized anxiety, irritability, sadness, demoralization; (2) Significant impairment in social or occupational functioning (3) Significant impairment in environmental mastery (feeling overwhelmed by the demands of everyday life)
- B** The symptoms have occurred within 6 months after onset of identifiable stressor (life events and/or chronic stress) that is judged to tax or exceed the individual coping skills when its full nature and full circumstances are evaluated.

Table 4. Bodily distress disorder² (WHO, 2022) (criteria A and B required)

- A** Multiple symptoms (fibromyalgia, chronic fatigue, esophageal motility disorders, nonulcer dyspepsia, irritable bowel syndrome, atypical chest pain, overactive bladder etc) from different groups (cardio-vascular, respiratory, urogenital, gastrointestinal, skin, pain) persistently within 3 or more mounts causing distress and/or preoccupation with the symptom and/or seeking medical care and/or resulting in impaired quality of life.
- B** Symptoms of autonomic arousal involving other organ systems (e. g. palpitations, tremor, flushing, sweating) and/or exaggerated side effects from medical therapy, indicating low threshold of pain sensation and/or high suggestibility

Table 5. Somatic symptoms secondary to psychiatric disorder (criteria A-C are required). Modified from the revised version of the DCPR

- A** Somatic symptoms, causing distress and/or seeking medical care and/or impaired quality of life
- B** Appropriate medical evaluation uncovers no organic pathology to account for the physical complaints
- C** A psychiatric disorder with somatic symptoms preceded the onset of somatic symptoms (e. g. panic disorder preceding cardiac symptoms)

2.3. Risk factors related to personality structure

DCPR defines the illness behaviour as the “core factor in medicine” that determines

² BC20 in ICD-11

differences in personal perception and action upon the same somatic symptom (Mechanic D., Volkart E.H., 1960). According to the Oxford Languages (2023) the definition of "Behaviour" is "the way in which one acts" therefore the "illness behavior" should imply remedial actions and health-care-seeking behaviour (Sirri L. et al., 2013). However, DPCR very misleadingly confuses misattribution of inner states (Mechanic D., 1995) (hypochondriasis, disease phobia, thanatophobia, and health anxiety) with functional syndromes (persistent somatisation, conversion, and anniversary reaction), and reaction of illness denial.

Instead, ECPP proceeds from the assumption that the genesis and perception of disease and therefore illness behavior and possible complications of treatment may result from the lack of integration of the structural capacities of personality (Arbeitskreis OPD (Hrsg.), 2013; Kirillov I., 2021), operationalized by the constructs of alexithymia (table 6), type A behaviour (Friedman M., Rosenman R.H., 1974). (table 7) key conflict (table 8) and misinterpretation of bodily senses (table 9).

Primary Alexithymia (De Gucht V., Heiser W., 2003) seems to result from the low integration of primary structural capacity to Contact with self (Kirillov I., 2015): to perceive, differentiate and name one's own sensations, feelings, and experiences. *Secondary Alexithymia* appears when vulnerable capacity to Contact with self becomes unavailable under the pressure of experienced stress. Alexithymia correlates with higher risk and worsened outcome of such medical conditions as cardiovascular diseases, gastrointestinal disorders, cancer, and altered immune response to stress (De Vries A.M. et al., 2012; Lumley M.A. et al., 2007; Porcelli P. et al., 2003; Honkalampi K. et al., 2011).

Type A behaviour (competitiveness, high organization, ambitiousness, excessive engagement in work) tends to compensate low integration of capacities of Time and Trust and correlates with some neuroendocrine (Fava M., 1987) specificity. Those tendencies observed in 36.1% of subjects at risk of coronary heart disease and in 10.8% of patients with noncardiac diseases (Sirri L. et al., 2012).

Key conflict is the conflict of and discretion and directness (Kirillov I., 2021) (originally named by Nossrat Peseschkian (1987) as *politeness* and *uprightness/openness*). Suppression (Settineri S. et al., 2019) of

identified (unlike the case of alexithymia) impulses, emotions and behaviors tends to compensate the disbalance of capacity to Care for self and others. This pattern enhances the inner stress and even proved to significantly increase mortality at list among the patients with the cancer and cardiovascular diseases (Chapman B. P. et al., 2013).

The subjective perception of bodily sensations and health status is as valid as outcomes of clinical examination (Bech P., 1990; Rodriguez-Urrutia A. et al., 2016). *Misinterpretations of bodily senses* representing disturbed capacities of Meaning and Idealisation often lead to significant impairment of the quality of life and multiple medical referrals.

Disease phobia (table 9: B) differs from hypochondriasis (Table 9: A) in several ways. First, the fears in disease phobia are specific to a particular disease and are unlikely to shift to other diseases or organ systems (Cosci F., Fava G.A., 2016). Second, these fears tend to occur in discrete attacks rather than persist as constant worries as seen in hypochondriasis (Fava G.A., Grandi S., 1991). And third, individuals with disease phobia often avoid internal and external illness-related stimuli, while those with hypochondriasis tend to seek reassurance or engage in checking behaviours (Noyes R. et al., 2004). Health anxiety (table 9: D) concerning illness and pain is less specific than in hypochondriasis and disease phobia and response to medical reassurance.

Table 6. Alexithymia (criterion A is required)

Modified from the revised version of the DPCR.

- A** At least 3 of 6 characteristics should be present: (1) Inability to use appropriate words to describe emotions; (2) Tendency to describe details instead of feelings (e.g. circumstances surrounding an event rather than the feelings); (3) Lack of a rich fantasy life; (4) Thought content associated more with external events rather than fantasy or emotions; (5) Unawareness of common somatic reactions that accompany the experience of a variety of feelings; (6) Occasional but violent and often inappropriate outbursts of affective behavior

Table 7. Type A behavior (criterion A is required).

Modified from the revised version of the DCPDR.

- A** At least 5 of 9 characteristics should be present: (1) Excessive engagement in work and other deadline related activities; (2) Steady and pervasive sense of urgency; (3) Display of motor-expressive features (rapid and explosive speech, abrupt body movements, tensing of facial muscles, hand gestures) indicating a sense of being under pressure of time; (4) Hostility and cynicism; (5) Irritability; (6) Tendency to speed up physical activities; (7) Tendency to speed up mental activities; (8) High desire for achievement and recognition; (9) High competitiveness

Table 8. Key conflict (criterion A is required)

- A** The patient tends to restrain his reactions to secure relationship, even to the detriment of his/her own interests and comfort

Table 9. Misinterpretation of bodily senses (one or more of following criteria) Criteria for syndromes have been adjusted from the revised version of the DCPDR

- A Hypochondriasis (1-5):** (1) Fear or persistent idea of having, a serious disease based on misinterpretation of bodily symptoms; (2) The preoccupations persist despite adequate medical evaluation and reassurance, with opportunity for discussion and clarification; (3) Distress and/or impairment in social and occupational functioning; (4) The duration of at least 6 months; (5) 5. compulsive maladaptive actions to prevent disease.
- B Disease phobia (1-4):** (1) Persistent, unfounded fear of suffering from a specific disease (e.g. AIDS, cancer), despite adequate medical examination and reassurance; (2) Fears, in the form of attacks rather than in constant, chronic hypochondriac worries; (3) The object of fear does not change with time; (4) The duration of symptoms exceeds 6 months.
- C Thanatophobia (1-3):** (1) at least 2 attacks (within the past 6 months) of groundless fear of dying soon, despite an adequate medical assurance of the absence of any real danger, with the possibility of discussion and clarification; (2) Marked and persistent fear and avoidance of any mentions of death, immediate anxiety reaction to them; (3) Distress interferes markedly with the level of social and professional functioning.

- D Health anxiety (1 and 2):** (1) A generic worry about illness, concern about pain, and bodily preoccupations (tendency to amplify somatic sensations) of less than 6 months' duration; (2) Worries and fears readily respond to appropriate medical reassurance, even though new worries may ensue after some time.

2.4. Triggers

It is important to consider triggers of chronic stress and somatosensory simulations in the diagnostic and treatment strategies for psychosomatic conditions.

The *stress overload* (Table 10) refers to the cumulative impact of macro- and micro-traumas (Peseschkian N., 1987, Peseschkian H., Remmers A., 2020) that can deplete the psychological coping mechanisms and bodily self-regulation, making the individual more vulnerable to mental and somatic health problems. Research has shown that the number of disorders (endocrine, cardiovascular, respiratory, gastrointestinal, autoimmune, skin, and neoplastic diseases) in a population correlates with the load of life events experienced within a year before the onset of symptoms (Novack D.H. et al., 2007; Theorell T., 2012).

Anniversaries (Porcelli P. et al., 2012) or *triggering events* (Table 11) can set off a chain reaction replaying the previous experiences of general arousal, functional symptoms, associated symptoms, or conversion.

Additionally, somatization can result from repetitive internal triggers: 1) *hidden message* (Table 12) - an impulse to ask for help or to assert oneself, suppressed by a key conflict in the structure of psychodynamic patterns (Arbeitskreis OPD (Hrsg.), 2013) of dysfunctional relationships (Peseschkian N., 2016); 2) *Inner conflict* (Peseschkian H., Remmers A., 2020) (Table 13) between primary needs and the perceived threat to them (Kirillov I., 2021).

Table 10. Stress overload (criterion A and/or B is required)

- A Macrotraumas** – high concentration of significant life events and changes (real or imaginary) causing a strong emotional reaction. The amount of LCU³ (life changing units) exceeds 300 LCU for half a year or 500 LCU for a year

³ Social Readjustment Rating Scale (SRRS) in Miller M. A., Rahe R. H. (1997).

- B Microtraumas** – recurring emotional reactions to the discrepancy between the expected (“correct”) and the actual (perceived as incorrect) reality. Those reactions generate ongoing tension and irritability and effect the overall physical condition, mood, relationships and/or performance.

Table 11. Anniversary or trigger (criteria A is required). Modified from the revised version of the DCPR

- A** Emotionally charged trigger, age, or anniversary of death/terminal illness of a loved one (the patient is unaware of such association) that condition symptomatic reaction of: autonomic arousal (e.g., palpitations, tremor, flushing, sweating), or functional syndromes, or associated symptoms or conversion.

Table 12. Hidden message (criteria A and B required)

- A** Ongoing suppression in relationships of one's emotionally charged desires (impulses) to do, say, ask, provoke others to act differently.
- B** The symptom and / or its consequences allow the patient (consciously or not) to discharge the impulse, to convey a message, to provoke desired actions.

Table 13. Inner Conflict (criteria A-C are required)

- A** One complains about excessive emotional, behavioral, and mental reaction.
- B** The patient always associates his/her reaction with a specific trigger (“every time I am expected to obey, I explode with anger”), which can appear in different contexts (at work, at home, with friends, etc.)
- C** The protagonist cannot, without external help, understand and explain his needs behind the overreaction to the trigger.

2.5. Secondary risk factors

When a patient experiences somatic symptoms, their reaction to those symptoms can be influenced by their personality structure and inner conflicts. Unfortunately, some of these reactions can be maladaptive and hinder the effectiveness of treatment. For instance, *fixation on somatic symptoms* (Eccleston C. et al., 2013) (Table 14) can provoke health anxiety (Anderson, R. et al., 2011) and even stimulate the sensorimotor simulation (Edwards M.J. et al., 2012) of associated symptoms. *Illness denial* (Goldbeck R., 1997; Prigatano G. P., Sherer M., 2020; Livneh H., 2016) (Table 15) can cause treatment

avoidance and sabotage, and therefore worsen the patient's medical condition.

Patients with *factitious disorder* (table 16), a condition that affects about 1.3% of primary care patients (Fliege H. et al., 2007) and 6% of psychiatric admissions (Gregory R.J., Jindal S., 2006), may intentionally harm themselves and undergo risky procedures. This can result in significant treatment costs, sometimes amounting to hundreds of thousands of dollars (Feldman, 1994).

In medical settings, *demoralization* (Table 17) is a common occurrence that includes feelings of helplessness and hopelessness or giving up (Schmale A.H., Engel G.L., 1967). This can affect up to 30% of medically ill patients, compared to only 2-5% of healthy individuals (Tecuta L. et al., 2015). Demoralization is also shown to be linked to changes in the serotonergic and noradrenergic systems (Benedetti F., 2011).

Table 14. Fixation on somatic symptoms (criteria A is required)

- A** At least 2 out of 4 characteristics are present: (1) the patient excessively focus on physical suffering, talks about it all the time, looking for the slightest changes of the symptom; (2) desperately seeks to control the symptom; (3) helplessly afraid of new suffering to come, checking the symptom changes and new manifestations; (4) demands a clear diagnosis and effective physical treatment from the doctor.

Table 15. Illness denial (criteria A and B are required). Modified from the revised version of the DCPR

- A** Persistent denial of a physical disorder and need for treatment (e. g. lack of compliance, delayed access for medical help) as a reaction to the symptoms, signs, diagnosis, or medical treatment of a physical illness.
- B** Doctor provides the patient with an adequate appraisal of the medical situation and management (if any) to be followed, with opportunity for discussion and clarification.

Table 16. Factitious disorders (criteria A and/or B is required)

- A** Deliberate display, falsification, induction, or exacerbation of symptoms in oneself or in another (usually dependent person). Seeking treatment or benefits based on these symptoms.
- B** Other benefits associated with the relationship (care, attention, position, etc.).

Table 17. Demoralization (criteria A and B are required; criterion C is a specifier for the presence of hopelessness). Modified from the revised version of the DCPR.

- A** One perceives self as unable to cope with problems and/or feels helpless (lack of adequate support from others), while maintaining the capacity to react
- B** The state is generalized and lasts for at least 1 month
- C** The consciousness of having failed to meet expectations associated with the conviction that there are no solutions for current problems and difficulties (hopelessness)

Results

Summing-up results of ECPP

The General Evaluation table (Table 18) is a tool used to summarize data collected during the medical examination and interview. At present, based on ongoing discussion with medical doctors, and practice-based consensus of 7 practitioners who systematically applied the tool under regular supervision with over 200 patients, preliminary guidelines have been developed to interpret the results of the evaluation. It should be noted that these preliminary guidelines have not yet been subjected to statistical analysis. This is the challenge for further research.

The practitioners who participated in this preliminary testing process have undergone 10 academic hours of training to use the ECPP and incorporated it into their daily practice. Initially, after conducting a medical examination within the frame of 30 minutes, and the modified interview, the practitioners reported to spend approximately 15-20 minutes to evaluate the patient by collating the collected data against every symptom of every criterion. However, after conducting an average of 18 evaluations, they became familiar with the criteria and were able to fill out the General Evaluation table within an average of 5 minutes.

Table 18. General evaluation of ECPP

0= Not at all; 1= Some; 2= Noticeable; 3= A lot; 9= Cannot be evaluated

1. PSYCHOSOMATIC SYNDROMS					
1.1. Conversion symptoms					
1.2. Associated symptoms					
1.3. Allostatic overload symptoms					
1.4. Bodily distress disorders (6C20)					
1.5. Secondary somatic symptoms					
2. STRUCTURAL RISK FACTORS					
2.1. Alexithymia					
2.2. Type A behaviour					
2.3. Key Conflict					
2.4. Misinterpretation of body experiences					
3. TRIGGERS					
3.1. Anniversary/trigger					
3.2. Stress load (micro- & macro-)					
3.3. Hidden message					
3.4. Inner conflict					
4. SECONDARY RISK FACTORS					
4.1. Fixation on symptoms					
4.2. Illness denial					
4.3. Factitious disorder					
4.4. Demoralization					

Evaluation of criteria

- 0 – all criteria are missing
- 1 – there are some criteria, but they are not enough
- 2 – the minimum sufficient presence of criteria, and they are moderately displayed
- 3 – the criteria are more than minimally enough, and they are severely strong

Evaluation of criteria groups

- "the influence of a group of factors is not significant" if there are no rates of "2" and/or "3"
- "significant influence of a group of factors" if at least one rating of "2" is present
- "extremely significant influence of a group of factors" if there are two or more ratings of "2" or at least one rating of "3"

Overall assessment

- "Significant influence of psychological factors" – one or two groups of factors were assessed as "significant" or one group was rated as "extremely significant" – the consultation of a psychologist or cognitive-behavioral psychotherapist is needed for correction
- "Determining influence of psychological factors" - 3 or more groups of factors are assessed as "significant" or 2 or more groups of factors are assessed as "extremely significant" – it is necessary to contact a psychotherapist (preferably psychodynamic), if possible, it is necessary to organize complex psychotherapy (training of physical resilience and awareness, psychodynamic psychotherapy and correction of relationship patterns, reorganization of behavioral strategies)

Conclusions

Nimnuan, Hotopf, and Wessely (2001) demonstrated that around 50% of patients seeking outpatient care present with medically unexplained symptoms. These patients tend to utilize twice the amount of outpatient and inpatient medical care and have twice the annual medical care costs compared to those with somatic illnesses (Barsky et al., 2005). Additionally, patients with medically unexplained symptoms often spend more time in bed than those with severe major medical disorders (Croicu et al., 2014). In order to identify those syndromes and offer appropriate help to these patients, medical doctors must develop psychosomatic awareness.

The first experiences with ECPP show that it can help medical practitioners to set the groundwork for psychosomatic competences. Through just 10 academic hours of training and 18-20 cases of supervised practice, doctors can learn to identify patients with predominantly psychosomatic syndromes and evaluate the relative value and potential impact of major psychodynamic factors on any medical case.

By considering the psychosocial factors at play, medical specialists can develop an effective treatment strategy combining the medical prescriptions and recommendations with encouragement and utilization of the patient's somatic, mental, and social (Hartmann M. et al., 2010) resources. This approach may also involve referrals to health coaching (Wolever R.Q. et al. 2013; Djuric Z. et al., 2017; Sharma A.E. et al., 2016), psychological counseling (Strom J.L., Egede L.E., 2012), or psychotherapy (Wittmann W.W. et al., 2011) when necessary. Understanding these complex factors allows for a more holistic approach to patient care that addresses the interplay between biological and psychosocial factors, leading to more effective and comprehensive treatment outcomes, increased life quality of the patients and reduced utilization of medical services [157–177].

Systematic understanding of relative value and potential impact of major psychodynamic factors on any medical case will open the flow for more effective and individually tailored communication with the patient to inform him/her about the inner dynamic and roots of the existing medical condition, inducing his/her motivation to build the psychosomatic health

actively by developing self-management capacities, coping skills.

Disclaimer of Study Limitations

The ECPP, as described above, represents a preliminary adaptation of the DCPR model to meet the specific needs of clinical practice, drawing on the theoretical foundations of Positive Psychotherapy (Peseschkian N.) and OPD-3. The model has been tested and optimized in practice by the author with 43 patients, as well as by 7 supervised practitioners with over 200 patients. Additionally, the model has been presented and discussed in training seminars with mixed groups of medical doctors of different specialties.

The purpose of this publication is to invite feedback from other professionals in the field and to encourage further collaborative research on this topic. By working together to refine and validate this model, we can improve the quality of care provided to patients and promote more comprehensive and effective approaches to mental health treatment.

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