Archives of Psychiatry and Psychotherapy, 2011; 3 : 41–48

Psychosomatics – how it should be understood nowadays

Bohdan Wasilewski

Summary

Some people still associate the term of psychosomatics with the past rather than with the present. Articles announcing the end of psychosomatics and the need to distinguish psychosomatic diseases are being published [1]. At the same time we observe reintroduction of psychosomatic out–patient consultations and psychosomatic wards to Polish health care system as well as establishment of wards for psychosomatic rehabilitation. The aim of the present publication is to provide medical doctors and psychologists who do not have close links with clinical and psychosomatic rehabilitation an up-to-date and accessible picture of the psychosomatics.

Psychosomatic therapy / Balint groups / contact with the patient / functional disorders / health--related behavior

INTRODUCTION

Psychosomatics is a way of understanding medicine, a way of understanding health and disease – a holistic approach to therapy. Let us say that nowadays it is an antidote to practicing narrowly understood medicine of a pill-and-apparatus. In our understanding it is a tradition in medicine based on the knowledge about how tightly the psyche, the body and the environment are interlinked and how this link is reflected by mechanisms and development of particular diseases.

A contemporary common conviction that "we are not machines which fix themselves on their own, we need drugs to recover" is a completely new thing, because generally we are exactly machines which fix themselves on their own. We have a wonderful factory, still very little examined, which produces therapeutic substances which can keep us healthy for long years, fighting for example with cancer. This factory maintains our health while being constantly exposed to infections, some worst bacteria, and only in unfavourable conditions its effectiveness collapses. This moment, when the barrier is penetrated, is not random [2].

There are people who had functioned fantastically until suddenly a person close to them died, for example a second partner. After such event, they were swept off by a purely physical disease, which was triggered by the loss, by the psyche. Paradoxically, a similar mechanism is observed in the context of retirement. It is an event so long awaited that when it happens, it causes a huge change and puts an end to so many issues, which had kept one alive, that the body practically performs an execution on itself. This leads to a serious disease or – sometimes – leaving this world. This mechanism results from psycho-physical integrity of human beings, who are united into one unbreakable system, which could be discussed extensively on the bases of scientific data [3, 4]. Every-day life provides many examples. When we are affected by a less significant psy-

Bohdan Wasilewski: Psychosomatic Institute, 49 Poleczki Str., 02-822 Warszawa, Poland. Correspondence address: Bohdan Wasilewski: Psychosomatic Institute, 49 Poleczki Str., 02-822 Warszawa, Poland.
E-mail: b.wasilewski@ips.pl

This paper has not been supported by any grant.

chic problem, we start having infections, flues, etc. There are however many links that one do not take into consideration in a normal life. Neoplasm's, for instance, constitute a specific type of medical conditions which are induced by the collapse of our immunity, to a large extent. Apart from being based on biology, the resistance of our immunological system, is based on the psychic, and – as we know today – on the volitional factors. Will-dependant dimension of health and sickness are discussed at present.

As far as the treatment of cancer is concerned we know that people, who break down, do not believe in themselves and their capacities and lack spiritual support have much worse results in therapy and much faster course of disease. We also know that the appearance of cancer symptoms happens in special moments in life. The disease which had consumed someone for many years (or in shorter periods) reveals itself when one is depressed, when the problems accumulate, exactly when something breaks down inside. This mechanism is documented by research and new, yet confirmed knowledge.

People react to the surrounding situation. For example, when one is surrounded by a crisis and many things change in life, one would sometimes say that only the financial aspect become destabilised. If we look further however, financial specialists say that an ethical, moral crisis underlies the financial one. It is a crisis of humanity in breakthrough moment, followed by organisational and financial difficulties. Taken together, they create the phenomenon of crisis, which consequently affects psychosomatic functioning. Thus a psychosomatisation of diseases takes place. Not only does a doctor receive a patient whose leg or arm hurts, but a patient whose soul hurts most of all. Currently, the loneliness – feeling of being lost and abandoned – is the first disease treated more or less consciously by the doctors. All subsequent symptoms result from it [5].

DISCUSSION

One can ask a question why we do not apply the knowledge about the psychosomatic conditions of health which used to be practiced for ages. What made us loose it in such a short and recent period? In historical terms shaman medicine which has a history of a few hundred thousand years and priest medicine of at least 10 thousand years, constitute the roots of medicine. The contemporary drug-dominated medicine is just 100 years old, the antibiotics were discovered at the times of the Second World War, so we face a completely new issue. Recently we have childishly revelled in the myth that people will replace God to some extent and that we can do anything. Generally according to this, if someone dies, there must have been a mistake and it has to be somebody's fault.

We are convinced about somebody's mistake because nowadays everyone must always be young, always beautiful and always healthy. This is supposed to be ensured by the antibiotics and other drugs. In the Polish reality, it translates into a situation when an average patient above 60 years of age, who is treated by a family doctor in an out-patient clinic in a city, takes more than 5 different types of drugs. Moreover, we consequently use many procedures even before a child is born. Even then, it experiences intensive influence of artificially administered hormones and other medical procedures. A child is influenced by hormones, then vaccinated and, as a result, the activity of natural defence mechanisms is largely blocked from the very beginning and such person becomes artificially maintained by drugs. A similar interdependency is observed in the psychological and social dimensions of life. We are brought up in incubators and see the world though a TV screen. As consequence, psychotherapists and psychoactive drugs become integral elements of a common life. This is not a scary vision; it is a new direction of civilisation. We just need to ask ourselves if this new direction should be implemented so extensively; is every activity rational. This question is very up to date because the medicine is a wonderful science with humanistic traditions and, at the same time, it became an element of the industry. Unfortunately, in the cities the functioning of medicine looks like technological processes in a factory.

Yes, often contemporary medical procedures resemble a Ford assembly line, where every participant of the production process deals with a car for a few seconds, places an element, mounts it, puts a stamp and the car moves on. It reflects

a model medical approach, in which the patient is a passive object and has no partner who would be responsible for their treatment. He just deals with, yet another one, new specialist fixing one organ, responsible for one diagnostic or therapeutic procedure. This model is simply failing. We just rushed into a badly blind alley; not because something in people failed, but because the medicine merged with a huge industry. It is a source of employment for hundreds of thousands of people. It determines the picture of medicine and its functioning in practical terms. Insufficient financing of the health care system is to be blamed apart from the power of marketing and financial incentives. When the time and money lack, it is safer to prescribe a drug covering half the existing diseases and complete its activity with a drug which suppresses the psyche. It is even easier to do because still the consequences of such practices are not covered by the medical procedures.

Moreover, if a doctor has 6-7 minutes per patient his or her possibilities of addressing psychical aspects of the disease seem quite limited. In the reality however, it does not exclude a wider and effective contact with the patient. A very good book, which I hope to see translated into Polish, proves it: "6 minutes per patient" by Enid Balint and by a general practitioner Jack S. Norell [6]. The authors demonstrate how much can be done in these 6 minutes. They show how to manage the available time to achieve a personalised contact with the patient even in the most difficult circumstances. It is not only possible, but increasingly necessary, because – as I mentioned – the patients have changed. They are not just patients who want to get a specific medical issue solved, but individuals who experience many personal and social problems and want to share them with a doctor. Recent studies on interactions taking place in the general practitioners' offices show that more time is devoted to extra-medical activities than it is devoted to the strictly medical ones. As I mentioned, people come to see doctor for many reasons. They come because their health deteriorates in its biological aspect as well as in psychological and social dimensions. Diseases, which used to have a rapid and acute course, were experienced and then forgotten [7]. Now they have a chronic course. Recently, many diseases become chronic with a predominant psychosomatic element. In European countries health care becomes a public institution bound to provide services and to handle issues beyond the scope of the classically understood medicine. This is how now a doctor has been transformed into a professional acting as a personal advisor, state official, social worker and only a bit a medical specialist.

The scope of administrative and social activities required from doctors broadens quickly. It changes natural proportions of practical medicine, especially some aspects of medical art, which are being increasingly robbed. This is where the psychosomatics play a role. It tries to maintain all the most valuable aspects of the humanistic tradition of medicine. This kind of medicine approaches the patient as a partner in the therapy. Doctor creates conditions for the recovery and patient practically manages the process of the recovery. For ages, the patients were taught how to maintain their health and performed the majority of therapeutic activities. Doctor mainly assisted them and supported in difficult periods [8].

Now these roles seem to be changing, giving all initiative to medicine confronted very often with a passive resistance on the side of the patients. Psychosomatics struggle to maintain biological and psycho-social influences within their right proportions, even for purely economic reasons. The Germans, for example – who are very down to earth at calculating what is value for money, what is worthless and what costs what – calculated precisely, that the model adopted from the US and practiced by us simply costs enormous money [9]. That is why they maintain psychosomatics at a very high level with 15 thousand beds for psychosomatic patients.

The practice of Polish medicine is that patients circulate between many different specialists, each of whom limits his or her activities to a particular organ according to their specialisation and tries to limit their dealing with other issues because they already feel overloaded in all spheres related to finance, working hours and competence – expectations about their skills and knowledge which their never acquired. Within presently applied specialisation-based medicine the problems which exceed the competence of a particular doctor are referred to different specialists. One forgets that even if there was a doctor

specialising in treatment of the tip of left ear, he or she cannot stop being a medical professional from whom one can expect a holistic treatment. There is a pool of information and medical skill, which cannot be lost. Not only does it cover the internal medicine or general medicine, but also it adds an element of psychosomatic influence and the knowledge about functional disorders which constitute a psychosomatic compound of the medicine. This knowledge is taught at medical universities together with a thousand of academic things, i.e. it's a 501st or 1501st piece of information hammered into students' heads next to the sequence of chromosomes and different proteins at the end. Students leave medical studies equipped with all this huge and little useful knowledge. Training programmes for medical doctors are very little oriented at acquiring skills on how to practically apply medical knowledge. Every doctor should acquire skill of using their intuition regarding the situation and the patient, consonance with the patient, the ability to read their emotions and problems [10, 11]. Every doctor has to be a psychologist even in a minor degree. Even hidden behind an apparatus a doctor has to be a psychotherapist too. Most of all however, a doctor has to be an internal medicine specialist. All specialisations include internal medicine, which after 10–15 years of not being practiced, is lost. Health professionals, who limit their practice to cutting one type of muscles, abandon medicine and cease to be doctors.

It is vital to keep up with the progress in medicine and maintain this ability to be a doctor. I often say that the psychosomatics is, of course, specialist knowledge, but it encompasses an immense scope of psychosomatic information witch every doctor should have. One cannot depart from medicine and lose its humanistic achievements developed through thousands of years. This approach does not contain any exaggeration and it is fully in line with patients' expectations. Moreover, there are many proofs showing that strictly medical activities have limited influence on health. The scope of their influence is estimated at nearly 5%. The main driving factor of good health is lifestyle – the kind of health-related behaviour. Either someone is able to convince patients, understand them, make them an ally and get them to cooperate in the treatment, or this doctor's treatment fails. Therefore, we see that, for example the citizens of South Korea have greater chance for longer life than the citizens of the USA although South Korea spends 5 times less money on health care than the USA [12]. People in South Korea live longer and are healthier than the Americans. The approach discusses in this article is at the source of this difference. What counts, is not only investment in equipment, not only development of complicated hospital procedures. They are, of course needed to solve a certain margin of very difficult technical problems encountered during the treatment by the specialists, but not by the 100 thousand doctors whom we meet on practical terms. These doctors must have a general medical and psychological knowledge apart from their specialist knowledge and be able to encourage the patient's will to live, will to fight the disease [13, 14]. Because despite all the drugs if someone gives up and looses the will to live, they practically sink down. Do not let ourselves be misleading by the fact that we have wonderful achievements in narrow domains like transplantology, construction of artificial organs – all of which excites us very much. These achievements influence however only promiles of patients, as compared to the huge number of issues (stomach diseases, followed by colon diseases, then – skin problems, mental conditions, spinal pain and finally, a person suffers from everything). This is how we create patients of which one is able to fill cabinets of 30 specialists whereas they could be treated by one doctor who can exactly treat at the same time the body and the soul as they are tightly linked together [15].

In order to make a point about the importance of psychosomatic problems I shall present the hierarchy of the related issues. The first, the broadest issue is the psychosomatic competence of doctors, general practitioners and doctors of many basic specialities. This competence is a priority. The second issue is related to specialist treatments which are in the scope of psychosomatics – the specialist out-patient clinics and psychosomatic wards as targeted units. After the Second World War Poland made a good start. Before the war we had out-patient consultations and wards which survived the times of war, for example a unit of Professor Kazimierz Dąbrowski, which was a very interesting place. It was located near Warsaw and had branches in

other locations for treatment of psychosomatic and neurotic symptoms. This structure survived up to the beginning of ideological pressure on medicine started at the beginning of the 1950's. In this period all psychodynamic directions in medicine were attacked together with the psychoanalysis and psychotherapy. Some professors working in these domains were forced to burn their own texts and notes at home. Although in Poland the pressure did not lead to elimination of clinical psychology, as in many other socialist countries, we had to go through a very difficult period and struggle to survive. The attempts to fight psychosomatics continued until recently, totally despite the broad acceptance of this domain in other European countries. For many years, the National Health Fund (NFZ) did not fund psychosomatic services, which resulted in many clinics having to change their name just to be able to continue their work at all. Psychosomatic rehabilitation came to Poland as late as in 2004 and today, thanks to Social Insurance Institution (ZUS), there are about 1000 beds available in psychosomatic wards, located mainly in spa hospitals throughout Poland. It is important that psychosomatic rehabilitation helped to limit the increase in the number of pensions (in Poland this number is catastrophic). Poland has doubtful right be proud of its leading global position in the number of pensioners. The second positive change in Poland is that the National Health Fund (NFZ) again started to finance the psychosomatic services which are provided in the psychosomatic wards and out-patient consultations. Acceptance of the activity of psychosomatic wards and clinics is a big progress, though the activity of such units is understood as similar to psychiatric treatment, which is a specifically Polish approach. In Poland the development of medical services corresponding to German psychosomatics will take some time. In Germany psychosomatic services are based on the internal medicine with the crown of psychiatrics, in Poland it is the contrary. Whatever it is, though, a negative trend has been broken mainly because both the medical environment and the European administration noticed non-functionality of the present situation and the need for a new approach to practicing medicine [16]). New opinion of the World Health Organization (WHO) contributes to this change. It estimates that psychosomatic disorders will be the main health problem in 2020. For Poland this favourable to psychosomatics change can be compared to no longer drifting away from Europe. Stopping and having a lot to do: setting a formal way of teaching the narrow specialisation of psychosomatic therapy and rehabilitation and extending the scope of psychosomatic training during medical studies and specialist training [17].

The most important task, which needs to be reminded of, is to keep changing the main core of medicine, i. e. the family medicine and basic specialisations, apart from having specialised units, which help to clarify diagnostic doubts and support in diagnostically difficult cases, where a cooperation of psychotherapists, psychologists and general practitioners is needed. Practical steps to widen doctors' competence in the psychosomatic and psychological aspects of their practice most often are made in a form of symbiotic actions. Polish Chamber of Physicians and Dentists started to train doctors in order to prevent professional burnout and to provide them with additional psychological training to some extent. This activity is however very limited, without major impact on the overall situation. Although all medical professional representing their respective specialisations consider their fields to be the most important, the priority should be given, with no exaggeration, to activities aiming at introduction of medicine which would include psychosomatics. There are issues beyond the interests of particular specialisations. Saving the core of medicine and its human face - is such a matter [18].

Apart from the medicine as such, there is an analogical problem of managing education of psychologists. Now, many new psychologists entered the market. There are at least 10 thousand people who want to practice therapeutic psychotherapy in Poland, most often they are without appropriate qualifications. They often lack the qualifications to conduct treatment but they can contribute greatly to prevention, by correcting less advanced symptoms in patients before they fully develop the disease, provided that such patients receive additional treatment. In Germany, for example, there are 15 thousand beds in psychosomatic wards. In Poland, if we functioned according to German standards, we

would need to have at about 7–7.5 thousand beds in psychosomatic wards.

In the Psychosomatic Association which is a part of the Polish Medical Association, three years ago we made estimations concerning the number of beds available to psychosomatic patients. It was a very difficult task because many wards dealing with psychosomatics had changed their names in the attempt to survive. We found 54 health care units which, despite unfavourable conditions in the past, still emphasised the psychosomatic activity in their names. On the bases of the estimates, I can say, that there are 1000 beds for patients with psychosomatic disorders, the vast majority of which is located in the wards of psychosomatic rehabilitation. This number of 1000 beds available for psychosomatic therapy and rehabilitation reflects the present situation in Poland. The number includes various types of wards oriented at psychosomatic treatment, which is not reflected in their names. There are also wards which are called psychosomatic but in the reality, they treat patients suffering from psychiatric diseases who have a psychosomatic problem, which is a completely different kind of treatment. The existence of these wards results mainly from the fact that in big psychiatric hospitals admitting sometimes even thousands of patients there are also patients suffering from serious internal diseases who also require some psychiatric treatment. Sometimes wards called "psychosomatic" have little to do with the psychosomatics in the approach we discuss. There are some psychosomatic out-patient clinics and some specialised professionals. Nevertheless, the psychosomatic rehabilitation and some preliminary actions undertaken by the National Health Fund together with some openness from the part of the psychiatric environment constitute only beginning of positive changes. Still, despite attempts by the psychosomatic associations, Polish medicine do not meet European standards of psychosomatic approach to therapy and prevention, and unfortunately, we pay for this.

The Polish Insurance Institution (ZUS) made a noticeable step in lowering a tendency of people to "run away" into pension scheme. Even 37–38% of patients who underwent 24-day psychosomatic rehabilitation leave the pension scheme. It is a significant result, but still it relates only to a small part of people who qualify for such treatment. There are some clinics and university divisions which specialise in psychosomatics, yet they do not influence the overall state of public health. I expect that with greater openness to Europe, some measure will be implemented for this purpose and psychosomatics in Poland will see its golden age. Besides, finally someone in Poland will start to calculate long-term consequences of short-term actions.

The settlement of payments for health care services by the National Health Fund is still done mostly on the basis of the quantity, not the quality. The example of Taiwan is very instructive. In Taiwan the rule that "money follow the patient" was implemented very consequently. As a result of this determined move 400 hospitals out of 1000 went bankrupt. Later analysis showed that it was not because of economic standing or level of equipment, but exactly because of the week contact with the patient, patients lacking sense of security, not participating decision-making, lack of problem-solving together with the patient and insufficient information to the patient. Hospitals which neglected the psycho-social part of the treatment became insolvent and were closed down. If we did the same in Poland a similarly big share of hospitals would go bankrupt not because they are week in terms of technology or equipment, but because in some hospitals patients experience unfriendly treatment; their problems and diseases are not treated in a friendly manner and because of this - become chronic. The hospital is proud of its good effects but the patient is discharged with a disease which becomes chronic for various reasons. In hospitals patients either experience a trauma which they will never be able to get over with or become infected with bacteria and require another treatment and consequently becoming unable to work.

The psychosomatic knowledge is useful in every-day practice, for example, with a frequent problem of headaches. In classical migraine head pain constitutes a majority of elements. Migraine covers a very specific group of symptoms related to muscle contraction. The majority of pain symptoms located in the head has a psychosomatic background and they become completed by organic changes, for example, in vessels. This leads to other symptoms and very often, the disease itself is accompanied by the complica-

tions related to chronic use of painkillers and dependence on sedatives – two distinct problems. The patient's head hurts because he or she did not take the pill and because there still are – as there have always been – unresolved psychological problems which originated the headaches. The headaches which may be very problematic are sometimes the realisation of patient's hidden intentions. For instance, a woman who is afraid of getting pregnant starts having authentic headaches before the intercourse. A fear of malformation, pain or pregnancy is transformed into a completely different and physical symptom. The fear of sexual intercourse is sometimes the triggering mechanism when it results from the fear of getting pregnant. There are other women then those who treat headache as a smart excuse for not having sex, there are those who have very real and strong headache when faced with a possible sexual contact. Their pain is caused by a psychosomatic mechanism triggering pathophysiological mechanisms which originate pain. Another example of symptoms which start in a situation of tension is accumulation of stress in the muscles, especially, muscles of the nape of the neck and, generally, muscles surrounding the spine. These are very substantial tensions, up to hundreds kilograms and they cause deformations of the spine. Some people experience a feeling of having a massive lump of muscles on their neck after coming back from work; it is like an iron band clutching the shoulders and the neck. The neck becomes forced by the muscles into the spine. It lasts 24 hour per day. The muscular tension during the night causes congestion and pain symptoms in the neck, nape of the neck and more specifically, the spine. These functional symptoms are accompanied by a local inflammation, which causes complications in the course of the disease. A chronic inflammation leads to bone concretion in the neck spine. The concretion increases pressure on the blood vessels located in this part of the spine.

Multiple allergies are subject to the same mechanisms. Some patients have genetically based immunological disorders. There are allergies to particular chemical compounds or to dust or house dust mites. The degree of reaction depends however on the mental wellbeing. Patients with a moderate allergy do not experience the symptoms at all as long as they are in a good shape. When their mental condition begins to worsen the allergy exacerbates and it develops fully becoming a severe condition.

CONCLUSION

We need some preliminary information to speak about the psychosomatics in a structured way. In diseases with a predominant psychosomatic component the psycho-social part dominates and the somatic aspects yield to the second plan. Such diseases cannot be cured without providing for a professional and consistent treatment of the first, psycho-social component. In every infection, even flu, psychological factors have their share and they influence both the occurrence and the course of the disease. There is always a kind of psycho-social overlay on a purely physical disease. In some situations this overlaying compound may become dominating. For example, somebody's life was traumatised when he broke his leg and lost his job and then the leg becomes a catalyst of a deterioration of his health. Clients of medical cabinets are, in a way, produced by the life itself: by medical system, by personal situation. Such diseases are originated by a psychosomatic factor and afterwards have mainly somatic symptoms. There are also contrary situations when purely physical diseases give mainly psychosomatic symptoms in its course [19]. Such clinical cases have to be treated by psychologists and psychiatrist. The best option is – like in Germany – when doctors are competent in treatment of both elements and do not refer patients to 10 different specialists. They do not say: "you must be a psycho, go somewhere else". They do what needs to be done. The doctor simply has to be able to deal with such situations because they are not exceptional but common. Because of that, in Germany for example, a special requirement was introduced. In order to enter any specialisation, even surgical, doctors are obliged to undergo a mini-training of 80 hours, learning psychosomatic skills how to come in contact with the patient. It is called Psychosomatische Grundversorgung, i.e. the ability to perform basic psychosomatic care and doctors have to acquire it in order to receive their medical license [20]. Doctors of internal medicine, family doctors or sick fund doctors

– as they are called there (doctors working for National Health Fund) – not only have to practice medicine but also participate in professional trainings and psychotherapeutic meetings, the Balint groups, where doctors – surgeons and internal medicine doctors – discuss the cases from psychological perspective [21, 22]. Studies demonstrated that without these activities doctors do not treat patients well and they accumulate toxic sediment themselves which gives way to serious psychological and physical consequences, called the "burnout syndrome" [23]. It constitutes now one of the most serious threats in the medical professions and other assisting professions. In Poland psychosomatics seem to be a hobby undertaken after coming back from the second job or the third job, practiced to acquire some psychology, some humanity. In Germany it is an obligation.

REFERENCES

1. Wrześniewski K, Skuza B. Wybrane zagadnienia medycyny psychosomatycznej i psychologii chorego somatycznie. Warszawa: Uniwersytet Medyczny w Warszawie; 2007.
2. Wasilewski B, Engel L. Grupowy trening balintowski. Warszawa: Wydawnictwo ENETEIA; 2011.
3. Tylka J. Psychosomatyka. Warszawa: Wydawnictwo Uniwersytetu im. Kardynała S. Wyszyńskiego; 2000.
4. Wasilewski B, Czubalski K, Tylka J. Psychosomatyczne aspekty terapii i profilaktyki. Warszawa: Instytut Wydawniczy FZZ POZ; 1987. p. 5–7.
5. Małyszczak K, Pyszel A, Lindner K,Wróbel T, Mazur G, Kiejna A, Kuliczkowski K, Andrzejak R. General psychological distress and personality traits in physically ill patients. Archives of Psychiatry and Psychotherapy. 2007; 57(60): 1–2.
6. Balint E, Norell JS. Six Minutes for the Patient. Interactions in General Practice Consultation. London: Tavistock Publications; 1973.
7. Raport "Philips Index – badanie jakości życia Polaków". [document on the Internet]. Medycyna Praktyczna. MP-online; 2010 [Cited 2010 Nov 25]. Available from: http://www.mp.pl.
8. Luban-Plozza B, Pöldinger W, Kröger F, Wasilewski B. Zaburzenia psychosomatyczne w praktyce lekarskiej. Warszawa: PZWL; 1995.
9. Deter HCh, Glaesmer H, Mertens R. The economics of treatment and psychosomatic approach. Conference Proceedings: Psychosomatic aspects of therapy and recovery. 2001 Jan 22–23; Warszawa, Poland.
10. Bilikiewicz A, Hebanowski M. Model holistyczny w kształceniu lekarza. In: Imieliński K, editor. Uniwersalizm i medycyna. Warszawa: Wydawnictwo Uniwersytetu Warszawskiego; 1992.
11. Gaertner H. Okiem medyka. In: Magdoń M, editor. Współodczuwanie w medycynie. Kraków: Universitas; 2002.
12. OECD Health Data: Statistics and Indicators; 2010. Available from: http://www.oecd-library.org/docserver/download/fulltext/3010061ec085.pdf?expires=1282510790&id=0.
13. Yonke A, Schneider J. Examining relationships between physicians and their patients: A psychoanalytic model. Journal of Applied Psychoanalytic Studies. 2000; 2(4); 347–364.
14. Lerman CE, Brody DS, Caputo GC, et al. Patients' perceived involvement in care scale: relationship to attitudes about illness and medical care. J Gen Intern Med. 1990; 5: 29–33.
15. Loh A, Leonhart R, Wills CE, et al. The impact of patient participation on adherence and clinical outcome in primary care of depression. Patient Educ Couns. 2007; 65: 69–78.
16. European Commission. Green Paper Improving the mental health of the population: Towards a strategy on mental health for the European Union 2005. Brussels: 10.2005, COM(2005)484.
17. Wasilewski BW. Challenges and limits of European cooperation on education in psychosomatic medicine. Journal of Psychosomatic Research. 2006; 61: 100–122.
18. Wasilewski B, Szewczyk L. Psychosomatyka jako składowa nauczania przed- i podyplomowego. In: Szewczyk L, Kulik A, editors. Aktualności psychosomatyki okresu rozwojowego i dorosłości. Lublin: Proquarat; 2006. p. 9–16.
19. Arnetz BB. Psychosocial challenges facing physicians of today. Social Science and Medicine. 2001; 52(2): 203–213.
20. Deter HCh. (Hrsg.), Ökonomische Aspekte einer patientenorientierten Medizin. Bad Homburg: Verlag für Akademische Schriften; 2009.
21. Bacal HA. The doctor as a prescription for his patient. Canadian Family Physician. 1975; 21(10): 103 –110.
22. Wasilewski BW. Szkolenie psychoterapeutów – Grupy Balinta. In: Grzesiuk L, Suszek H, editors. Psychoterapia. Integracja. Warszawa: ENETEIA; 2010. p. 317–338.
23. Wasilewski BW. Effectiveness of Balint groups in improving doctor–patient relationship and prevention of Burnout-Syndrome by medical professionals. In: Development of Behavioral Medicine in Central Eastern Europe. First Symposium of the Central Eastern European Behavioural Medicine Network Targu Mures; 2005 Oct 14–6; Romania.