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THE SEMIOLOGY OF DISEASES OF ADAPTATION: WHAT IS THE MATTER WITH PATIENTS WHO "HAVE EVERYTHING, BUT NOTHING..."

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Abstract: There is a class of patients WHO present a set of symptoms but DO NOT MATCH ANY defined clinical Picture in the diagnosis manuals. Usually this class of patients are said TO "have nothing", DESpite the SYMPTOMS THEY FEATURE. This article investigateS what is behind thE DIFFICULTY REALIZING the very nature of these situations, and will DO SO in the way OF clinical reasoning AS logically framed. And IT ALSO presents a new way OF THINKING and organizING the data CLUSTER ASSEMBLED in the clinical examINTATION, BY disease cathegories, NAMELY the psychossomatic semiology.
Keywords: psychossomatic, psychoneuroimmunology, semiology, diseases of adaptations.

INTRODUCTION

When a suffering person goes to a health care professional, be it a psychologist, physician, physiotherapist, or the alike, the first task is gathering all the complaints and information that the patients bring, or show in their bodies through exams, together with the data collection that is conventionally called anamnesis, in order to identify and classify their suffering in one of the categories that are usually called a "disease", also known as a "nosological entity" (Porto; Porto, 2014).

The eyes are enough to see something, but to understand and identify this something, – in other words, realize not only see – we need a concept, an idea, especially if the thing to be identified is a logical entity, an abstraction, manifested by signs and symptoms, such as a disease. So, when healthcare professionals begin training to understand what is not going well with the patient and draw up a line of action, the first step is to learn what to identify, what kinds of signs and symptoms to search for, and which ones point to which nosological entities. During the consultation, the professional identifies what is wrong with the patient's health through clinical examination, laboratory tests, and a specific set of questions. This procedure, together with the anamnesis will give the health professional a diagnosis. The diagnosis and all the information the professional has collected lead to the prognosis and therapy. This collection of signs and symptoms and their study is known as "semiology". So, based on the study of the patient's signs and symptoms, along with their clinical history, the professionals will reach their diagnosis by a process of elimination, asking questions that confirm a given hypothesis excluding others. At the end of this investigation, the professional finds a diagnostic category matching the patient's signs and symptoms in the correct number and degree. So the professional concludes that it is a certain diagnosis, excluding all the others.

There is, however, a class of patients who do not fit into any of the categories generally used. These patients form that class of patients who "have everything, but nothing..." In other words, they present themselves with a series of complaints and symptoms, but the examinations and investigations do not find enough information to classify which type of suffering is there. The professional can not classify it into a known disease category that they have been prepared to investigate. This is the patient who presents symptoms without a medical explanation, abbreviated to MUS, Medically Unexplained Symptoms (Tófoli, Andrade, Alves, 2011). It should be emphasized that "medical explanation" here means that the symptom presented by the patient does not make sense within any category of diagnosable sickness. It is very common for this type of patient to see specialist after specialist, in various medical services, with the same result: "You've got nothing! Everything is fine with you..." The only one who disagrees is the patient. The patient is always right: there is indeed something wrong with these patients because they are unhappy, and they have symptoms and complaints whi-

ch are oftentimes considered to be delusional by healthcare professionals. Those symptoms are unexplained, undiagnosed, and therefore incapable of prognosis or treatment. What kind of suffering is this?

The interesting point here is: if the health professional does not find it on their list, it does not mean that it does not exist, but rather, it's much more likely that their list is incomplete! It is not a patient's problem, probably it means that the list of diseases is incomplete. This is the general point of this article: to present a new category of diseases/disorders to be included in the list of concepts that we should keep in mind to understand this set of "unclear" symptoms or signs that do not fit into other categories and present no adequate semiology. In other words: a more comprehensive way of considering the signs and symptoms that the patient presents, along with their history. This is not a conceptual text, but a clinical one, which investigates the way of thinking we learn to consider when we receive a patient. In a certain way, you can find this kind of disease (categories of diseases), in the manual, under different names, but, most of the time, the clinicians do not identify them. Our thesis is that it happens because lack of conceptual tools to grasp them, clinically speaking.

THE CLASSICAL WAY OF THINKING

This text is not intended to be exhaustive, nor to propose definitive concepts, but to outline the fundamental points for the inclusion of a more comprehensive clinical reasoning in the preliminary investigation of patients' symptoms and history, also leading to a more inclusive and extensive consideration in the treatment of their conditions, whatever the professional category is, namely a psychologist, a practitioner, a physiotherapist, etc. The point is, when the health professional receives a patient, the professional will look into his semiology for one of the possible alternatives. The main question is precisely how the clinician thinks, especially when faced with this class of patient who "has everything, but has nothing".

The process of investigation and diagnosis, in a nutshell, is very similar to that "Who am I?" game, in which the participant has to find out which character they have been assigned to represent, using as few questions as possible. In the "Who am I?" game, the participant knows that they have to find the answer within a certain range of possibilities, for example: "movie artists", which is defined in advance. In the case of the "Who am I?" game, when referring to "diseases", it is semiology that will be responsible for mapping out the relevant questions to find out the answer. In our case, which disease or disorder classifies the patient's suffering will lead us to a prognosis and a therapy, regardless of the health professional's field. These categories are our classification of diseases or forms of suffering. Of course, you can't compare a parlor game to a process as technical as the construction of a diagnosis, but the way of thinking is the same: a given question that includes or excludes a set of possibilities, which is refined until there is only one left. It's a sequence of "yes or no" questions that lead to another "yes or no" question until you reach a point where the picture is defined within the desired options. For those who don't know this game, there is an excellent scene in Quentin Tarantino's 2009 film "Inglourious Basterds", where a group of spies play this game with a Nazi officer in a basement bar.

In more formal terms, this reasoning matches the "excludent disjunction", connective of algebraic logic: when a proposition is made up of two statements, there will be only one true statement and therefore there is one which is false. (table 1).

p	v	q
V	F	V
V	V	F
F	V	V
F	F	F

Table 1: next, a truth table that is carried out in the clinical investigation process. The professional states a structure like this: either this symptom is present or it is not, confirming whether the diagnostic hypothesis, is to be confirmed or discarded. For example: the diagnostic hypothesis expressed in the proposition "the patient has moderate depression". Based on this, the professional asks questions such as "yes or no" or "or no", i.e. false (F) or true (V). In algebraic notation: (p v q) => D (if the statement "symptom is present" is true, it implies that the diagnostic hypothesis is true. For example: does the patient enjoy doing things or does he isolate himself socially? In this way, we rule out some hypotheses until we reach a conclusion. The red rectangle indicates the logical value of the proposition in a combinatorial analysis (Alencar Filho, 1982).

Based on this, the clinician can refine the search with structures of this type: whether the person has this symptom (p) or doesn't have this symptom (~p). Thus:

p v ~p - he has this symptom or he doesn't have this

If the person has the symptom, then we can consider that the hypothesis, for example, depression, is true, taking a step toward a diagnosis.

(p -> D) = V

It can happen, however, that ~p(v), that the opposite is true. In other words, the patient enjoys doing things. In this case, ~D will be true, i.e. it is not depression.

In this case, the professional should continue questioning the patient's symptoms, within the list that forms a diagnosis. As soon as they find at least three sets, like the one in the formula above, with a logical value of V, we can seriously think that this is the correct diagnosis, and think about a therapeutic approach. If ~p(V), there is no depression as it does not appear as a symptom,so further investigation is needed.

~p -> ~D = V => try another diagnosis where ~p(V):
Does the patient have another more relevant or suggestive symptom?
Which diagnostic category does this symptom represent?
And restart the process.

The formalization presented is quite simplistic, but it demonstrates the essence of clinical reasoning in an investigation of the diagnostic construction process. These are reasonings which, in logic, are considered to be mutually excludent, "either this or that". This analysis is achieved through a certain set of available options as described in the diagnostic manuals. The curious thing is that when a clinical phenomenon does not find a description, the first attitude is to think that "it's nothing", in other words, it does not exist, instead of questioning whether the manual's list could be incomplete.

WHAT YOU'RE LOOKING FOR IS WHAT YOU ASSUME IT COULD EXIST...

Since the dawn of our understanding of illness, there has always been a clear clinical perception that emotional factors can be involved in organic conditions. In Western societies, we have a historical inclination to divide the study of illness into physical and mental. The recognition of physical illnesses historically had a much earlier development and systematic maturation than the study of mental illnesses, which has always raised great logical difficulties and profound debates (Foucault, 1975;

1978; Szasz, 1976; 1994; Laing, 1978), since very ancient times, as shown by Erasmus of Rotterdam's 1511 formidable text (Rotterdam, 2024). Although, nowadays we have managed to build more refined conceptual tools for its study and treatment, fortunately (Panksepp, 2015, 2016; Panksepp, 2012; Lima, Rodrigues, 2017; Cozolino, 2014).

However, the development of a conceptual line and understanding of organic disorders with strong psychosocial or emotional components[1] is more complicated.

Apparently we have organized our clinical thinking like this: there is a category of disorders and sufferings in which the physical/physiological factor is prominent or even predominant. In this respect, we have to consider the following categories among physically predominant disorders:

- Caused by pathogens: these are conditions resulting from infection by viruses, fungi or bacteria (these are the diseases themselves, in the classic and strict sense).

- Caused by trauma: accidents, falls, or the alike, that cause tissue destruction or compromise the structure of organs or limbs.

- Caused by degenerative processes: these are involutive processes of tissue disorganization, without a clear extrinsic cause, where there is an apparent and "spontaneous" disorganization of tissues and organs.

- Caused by toxic elements such as lead or Mercury or even radiation.

- Caused by allergic or autoimmune processes: these are conditions where the body does not recognize part of itself as itself or those involved in exacerbated immune reactions.

- Caused by intrinsic tissue alterations: these are neoplastic or tumor processes. They differ from the previous ones in that they are not just an involution, but the emergence of altered tissues, with invasive development.

For our purposes here, these categories do not need to be exhaustively explained, but they are examples of processes in which the symptomatology and cause-effect relationship, the logical articulation between the physical symptom is quite evident and sufficient for a diagnosis and treatment. This is the class of patient who "has" or WMSs, symptoms "with a medical explanation".

Of course, these pathological categories all imply psychological/emotional and social consequences, even if their basis is strongly physical. Nevertheless, all the events involving these categories lead to emotional and social changes in the life of a patient. Their lives are interrupted in some way, the pain or discomfort brings sadness and worry, distress and anguish. Sometimes it might be the fear of death, or the abrupt change in lifestyle, such as loss of limbs or senses. In all these cases, there is a strong emotional impact on the patient's way of seeing themselves, their concerns and plans, or even their social relationships broadly speaking. Pathological processes often completely alter the patient's social relationships, such as a stroke that takes away movement and limits communication. In this way, there are no pathological processes, degenerative or other that don't have an associated psychosocial condition that needs to be taken into account, even if it is not part or focus of the specialist treating the patient. In any condition, whenever we treat a person who has fallen ill or had an accident, we treat the person and not the affected organ, and certainly not "the disease", an abstract nosological entity, detached from

1. We understand here "psychological" as the set of cognitions, emotions and needs arising from the person's internalprocesses or from the social context in which they find themselves. Bear in mind that almost 100% of these cognitions,emotions and needs occur in some social context.

the person and their existences. Even so, the psychosocial impact caused by a physical condition of any kind is remarkable. Conditions with a predominantly physical aspect are easy to notice, as well as their psychosocial impact.

There is another category, however, which is made up of mental and behavioral disorders, in which there are no noticeable tissues or functional alterations in organs, but the person has great difficulties in adjusting to their relationships or strong invasive fluctuations in emotions and thoughts which impair their ability to coordinate and organize themselves in a social and relational context. It is clear that even in a common and normal context, the adjustment and balance between cognition, emotion, evaluation of environmental factors, etc. is always difficult and fluctuating. Situations change, as do the problems posed by the environment, the challenges are of various kinds, the environments and social rules in which they occur are different... that is why we do not always show a linear performance in our behavior and conflict resolution and social management. This is because our decisions depend on our personal circumstances at a given time, which also vary. However, certain conflicts and difficulties can significantly compromise this dynamic balance. Then we have a clinical condition of a psychic nature (cognitive, social and emotional). There are various subtypes that we will not describe here, as they go beyond our objectives, but they can be better studied in volume F of the World Health Organization's International Classification of Diseases, with interesting descriptions in its ICD-10 version (WHO, 1993) and equally interesting implementations in its ICD-11 version[2]. They are also part of the class of patients whose symptoms make sense within the understanding of illness. The health professional knows what they have and their symptoms make sense in the nosographic and nosological logic.

A NEW CATEGORY: DISEASES OF ADAPTATION

But, for a long time now, there has been another intermediate zone, a kind of "phantom zone", where the phenomena are quite obscure. These are physical illnesses that are triggered, sustained, or aggravated by psychological factors. The emotions present in these conditions are not clearly a consequence of the clinical situation, as in the cases described above, where we consider the psychosocial impact of the physical illness. But in the case of gastric ulcers, hypertension or asthma, for instance, the emotional factors are not a consequence of the illness processes but are concomitant. In a way, the physical symptoms are dependent on certain emotional conditions. But these cases are not yet the MUS.

The logical difficulties in dealing with this type of problem arise from the fact that when we think, for example, of tuberculosis, the bacillus and the anatomical changes explain all the symptomatology. And when we see a person aflicted by a difficulty in postponing satisfactions, we also clearly see the basis of the suffering in psychic terms. But when we have intense rashes that appear after situations of domestic conflict, for example, where the patient is facing intense difficulties in their relationship, how do we assess that? How do we organize the consultation data, how do we conduct an anamnesis and how do we design a semiology that includes such cases?

Taking these situations into account, we can then, after collecting data from the patient's clinical examination and anamnesis, determine the category of suffering the patient presents, within a more elaborate combinatorial list of psychological, physical, and cause and consequence factors:

1- with notable physical manifestations and known physical causes

2. https://www.gov.br/saude/pt-br/assuntos/noticias/2025/janeiro/11a-revisao-da-classificacao-internacional- de- doencas-sera-implementada-no-brasil-ate-2027 accessed on 07.04.2025.

2 - with notable emotional/cognitive manifestations and their emotional/cognitive causes

3 - with notable emotional/cognitive manifestations and their physical causes

4 - with noticeable physical manifestations with emotional/cognitive causes

Here we will deal with the clinical way of thinking concerning notable physical manifestations with psychological causes. There are two types:

- With conversive physical manifestations

- With physical manifestations of physiologic processes.

The first has been well-detailed since the early works of Freud, especially in their classic "Studies on Hysteria", of 1895, in association with J. Breuer (Freud, 1973), which we will not address here.

The second type is the subject of this text. We understand this subtype as those resulting from the physiological consequences of psychological challenges or conditions. A very simple example to illustrate this modality: when someone points a gun at us in a deserted street at night, we will have a series of physiological reactions triggered solely as a result of the person's understanding that this is an armed robbery and that our life is probably in danger. The famous fight or flight reaction will set in. All the classic physiological signs of this reaction will be activated as a result of a psychological evaluation of the context, initially known as Walter Cannon's fight and flight reaction (Cannon, 2018), which was expanded into Hans Selye's concept of stress (Selye, 1936).

Hans Selye left us with another extremely useful concept, but it is seldom remembered and rarely mentioned, which we bring here to characterize this class of disorders: the diseases of adaptation (Selye, 1959). Adaptation disorder is when the functional or organic impairment does not arise directly from the challenge or agent affecting the organism, but precisely from the effort to cope with this challenge. This includes the process of cognitive evaluation of different situations, of course. A Koch's bacillus, by its presence and action, justifies the symptom. However, hypertension or allergies are not the result of pathogenic action, but the result of the body's attempts to adapt to situations, and the symptom is the consequence of the high cost of this adaptation.

In this category, we have what has been identified in ICD-10 as somatoform disorders, in a certain way. But we have many others in which the relationship between symptom and adaptation effort is not so obvious. I say "not so obvious" because the physiological relationship between sweating accompanied by palpitations is much simpler to understand in its relationship with contexts and cognitive evaluations of the situation than an allergic reaction, for example. A detailed discussion differentiating and relating this to each nosological entity presented by ICD-11 is beyond our scope here, we just want to emphasize the principle.

What really matters here is that Hans Selye's concept of diseases of adaptation characterizes another class of disorders for clinical thinking: physical disorders resulting from excessive adaptive effort (somatoform or not). Our classification can then be enriched with greater clarity. Among the sufferings that arise from physical manifestations resulting from psychological factors, we are left with the following:

With conversive physical manifestations;

With physical manifestations associated with adaptive effort.

- Somatoform, associated with sympathetic autonomic overstimulation.

- Associated with other conditions described in other sections of the ICD-11.

Understanding the symptoms related to wear and tear and adaptive overdemand is not difficult in general, but it can be very challenging in some cases. There is the theoretical aspect that underpins the facts and ways in which these maladaptive disorders can occur, which vary greatly: from psychoneuroimmunological phenomena to issues related to the patient's habits (Sapolsky, 2004). Thus, we need to cover the entire cellular communication machinery of the immune system through to the consequences and reasons for a sedentary lifestyle, among others. Studying these areas and becoming familiar with all the specialized literature is an arduous task that demands a lot of discipline and effort, without a doubt. So, for example, the physiological relationships of an adaptive effort related to the environmental/social demands involved in diabetes, hypertension, asthma crisis, and autoimmune disease episodes are completely different. But in any case, these facts teach clinicians to think about introducing another subcategory into their semiology:

With conversive physical manifestations

With physical manifestations associated with adaptive effort

- Somatoform, associated with sympathetic autonomic overstimulation.

- Associated with other conditions described in other sections of the ICD-11.

- With physical manifestations associated with an inadequate lifestyle.

So we have enough material to build a table (table 1).

MONOCAUSALITY VS. MULTICAUSALITY

In the World Health Organization's ICD-10 (1993, WHO), we find the following guidance: "the term 'psychosomatic' is not used (...) because the use of this term could imply that psychological factors do not play a role in the occurrence, course and evolution of other diseases, which are not so-called." In other words, even then (the first edition is from 1992), there was a consensus in the WHO that all diseases were, in their own way, psychosomatic.

This was a milestone in the end - or beginning of the end - of the Age of Monocausality, so to speak. The Age of Monocausality was the time when the general assumption was that there was a single cause and that was it. The illness had either an organic origin OR it had an emotional/psychic cause. Clinical discussions, then, were about whether the illness had an organic cause or an emotional cause.

This has changed, as we can see, at least since 1992, officially. Psychosomatics no longer has the character of a "single cause" of a class of illnesses (the so-called "emotional" or "psychosomatic" illnesses), but rather a way of seeing illness as having three aspects: biological, psychological, and social. Thus, any illness has a biological aspect (something is affecting the tissues or physiology of an organism); a psychological aspect (the inner life of the patient has a biunivocal participation in these processes) and this illness takes place in a social context that both affects and is affected by this process that we call "illness".

On the other hand, while in theory multicausality is the consensual way of looking at the issue, in practice, in the clinical reasoning of investigating symptoms and signs, a strong excludent inclination prevails,the "either this or that..." approach, due to the logical properties of the conceptual tools used, as we saw above.

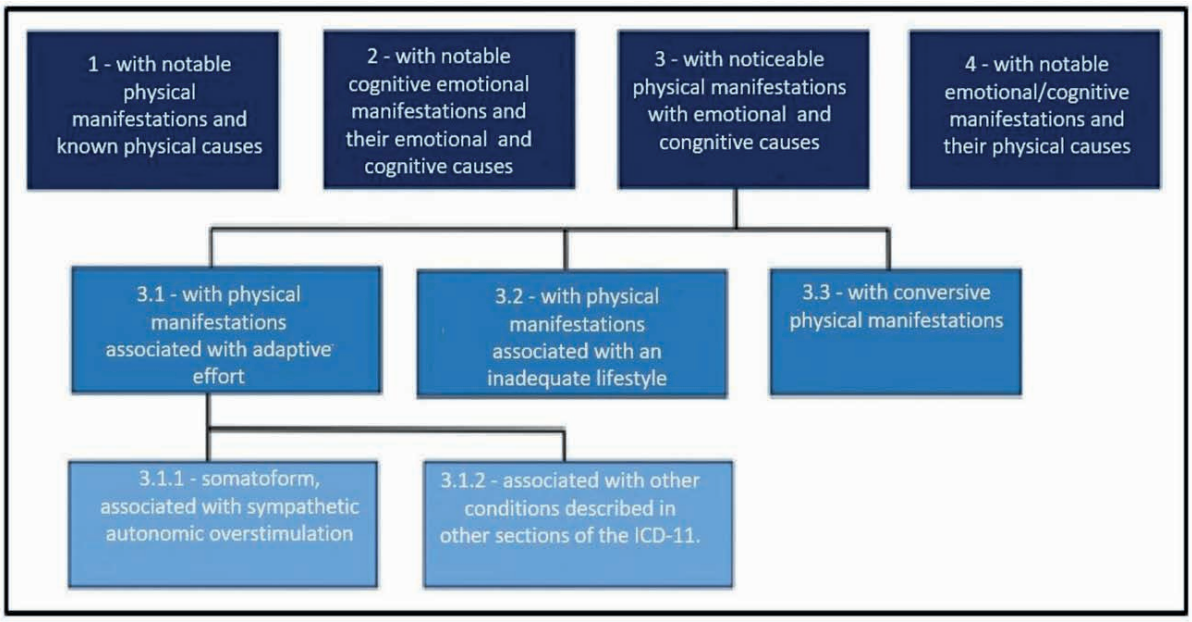

Table 1 - diagnostic possibilities in combinations of predominance of physical or emotional/cognitive factors, with breakdowns of the diagnostic possibilities of the three forms of participation od the psychological factor in the clinical picture, in view of the current state of knowledgr and the pictures described in ICD-11.

A PSYCHOSOMATIC SEMIOLOGY

One way of studying and considering the phenomena under investigation in a more inclusive way is the subject of this paper: presenting the idea of a psychosomatic semiology. In clinical practice, somatoform disorders, according to ICD-10 guidelines, have "the essential characteristic of the repeated presence of physical symptoms associated with the persistent search for medical assistance, *even though doctors find nothing abnormal* and claim that the symptoms have no organic basis". (emphasis here is mine). In other words, even in the ICD-10, this grouping of disorders are characterized more by what is absent than by what patients indeed have. This characteristic of these symptoms being without medical explanation (SEM) is also seen in the ICD-11 and DSM-5, under the names of somatoform disorders and somatic symptom disorders and related disorders. It's not surprising that the logic of these symptoms can go unnoticed by health professionals: the patient who has everything, but has nothing. Even Bertrand Russell would have to read that sentence twice. In addition, as already pointed out, we should also add that psychosocial factors can be involved in illnesses with a well-established medical explanation, such as the impact of chronic stress, depression and social isolation and the progression of cancer (Moreno-Smith, Lutgendorf, Sood; 2010, Mello, Fo.; Burd, 2010).

In other words, there is a logical axis between manifestations without a medical explanation (without belonging to a clinical picture clearly described and positively diagnosable in the ICD-11 or DSM5), and those with a medical explanation (belonging to the pictures described in the manuals). This axis would be the totality of an organism in its environment: biopsychosocial or psychosomatic factors. The only known way to access the meaning and logic of these clinical manifestations is by knowing the patient's context and current life, not simply relating a physical event ranging from the action of pathogens,

toxins, or similar to physiological changes that give meaning to the symptom. That happens for a very simple reason: this is where challenges the patient has faced are, how their bodies react, how they understand their situation and what lifestyle they have developed as ways of coping with stressful and exhausting situations, in the classic concept of coping (Folkman et al., 1986; Lazarus, 2013). Among these forms of coping, it is important to know how the patient replenishes their energy and relaxes after periods of great stress, or how they balance the three essential factors of health: exercise, diet and sleep.

This is the idea that I present as a "psychosomatic semiology", in other words, one that sees getting sick as a biopsychosocial process, as defined by Lipowsky in his classic work on the meaning of the word "psychosomatic" (1984). Theoretical developments that point in the direction of a psychosomatic, i.e. biopsychosocial, viewpoint already have a tradition and are not at all a novelty, as it can be seen in the excellent work by Danilo Perestrello (1996), the first edition of which dates back to 1958. However, the robust foundation of psychosomatic understanding has been somewhat sidelined in the classical training of health professionals because it is not well known and, therefore difficult to understand. The theoretical basis is very solid and it has been for decades, as can be seen in the work of Ader, (Ader, 2000; Ader, Cohen, 1975), Besedovski and collaborators (Besedovski et al, 1979) or the studies on the "behavior of being ill", whose studies began in the 1960s (Kelley; Kent, 2020: Holmes; Miler, 1963), with Wexler determining as early as 1957 that bacterial LPS could regulate the HPA axis (Wexler et all, 1957). These are topics and areas of research that have been studied for almost a century.

The very idea that the body is a unit integrated by the nervous system also has a long tradition, beginning with the work of Charles S. Sherrington (2020), first published in 1906, compiling lectures he gave in 1904, which was aptly named "The Integrative Action of Nervous System". Likewise, the concept of an independent immune system has long since been abandoned, given the enormous volume of data demonstrating the perfect neuroimmunoendocrine integration, with reciprocal influences between the nervous, endocrine and immune systems (Savino, 2022; Ader, 2000). The interaction is so remarkable that it has been proposed that the immune system is a sixth sense, providing information to the nervous system (Blalock, 2005). The integration of the various systems and organs of the body into a biopsychosocial unit is very well described, but, as I said, for some strange reason this has not yet reached the clinics.

The logic of a psychosomatic semiology should not be one of exclusion, but of inclusion. Let's take the basic question: "Are the patient's symptoms and complaints of a physical nature or psychic?" (which is almost a way of asking whether the symptom is real or not). In classical semiology, the answer to this question is exclusive, "it's either one or the other": (p v q). In psychosomatics, it's inclusive: (p ^ q), in other words, "it's physical AND somatic", it's just a question of weighing up the influence of each element. It's not a question of "everything is everything", but a question that in psychosomatic thinking, understanding the functional articulation of the elements involved leads to understanding the symptom, not simply listing and identifying them. That's why we can also say that psychosomatic thinking is "by integration" of the components and classical thinking is "by segmentation", where each part of the body exists more or less autonomously and in isolation. We can see this summarized in Table 2.

Factor/semiology	Classic	Psychosomatics
Type of logic	Excludent logic	Logic of inclusion
Diagnosis	Or one or the other	It can be either
Emphasis	Emphasis on the organ or disease	Emphasis on the whole person and the psychosocial environment
Concept	By segmentation	By integration
Method	Listing and identification	Understanding dynamic elements
Causation	A tendency towards monocausality	Totally multi-causal

Table 2 - comparissons of the classical and psychosomatic conceptions of semiology, showing the points that guide clinical thinking during the investigation and dianosis process.

Therefore, the clinical examination of the patient should seek information that leads to a greater understanding of which physiological system is overloaded, and based on this, it provides investigations into which challenge is draining that system's resources. In the same way that you look for data such as swollen lymph nodes, fever, or blood pressure, you should look for the limitations of a failing system in the face of failed attempts to adapt to a situation. If one thinks only in terms of pathogens, degenerative or neoplastic processes, these physical symptoms really don't make sense and the professional is misled into telling the patient that they "have nothing", even under the protests of the patient, who assures them that they DO have great discomfort and suffering. And then the patient has to look for other tests and clinicians, who are always guided by this classification of pathogens, degeneration, etc., will find "nothing wrong" as well, much to the distress of the patient and the professional too, who is frustrated and often ends up considering the disorder to be purely mental. Actually, the idea that ¨-if the patient does not have anything that I know about, the patient does not have anything, really¨, is quite interesting.

CONCLUSION

Given the enormous body of evidence of a complex and bidirectional systemic integration of the organism (top-down/bottom--up), it is justifiable to include in semiology the search for symptoms and signs that could characterize an overloaded physiology and, perhaps, already in exhaustion, in its various manifestations. That means weighing up the biopsychosocial factors in the origin and maintenance of classic organic conditions. For these reasons, it is advisable to include in the anamnesis a broader and more detailed search for the patient's current life context. This includes social life, support network, level of satisfaction, life planning, assessment of their relative successes, satisfaction with relationships, family and professional life, leisure, sports, and so on. Anything that can characterize an area where the patient is having difficulty building coping strategies, or where the effort to adapt is not succeeding. This will provide an understanding of the physiological nature of the response that demonstrates an overload. Thus, we may see symptoms or signs that sugar metabolism may be involved or a super immune response is being stimulated, involved, in that order, with diabetes or allergic processes. In short, a more comprehensive semiology, a psychosomatic semiology, so to

speak, here understood as a way of seeing getting sick as a biopsychosocial process, starting from the study of the pathways of this integration, anatomical and molecular.

Finally, in a comprehensive and more efficient investigation, we should include a new diagnostic category: "disorders of adaptation", either due to physiological overload or to a harmful lifestyle, resulting from ways of coping with life's difficulties. And proceed with clinical examination and anamnesis that takes this logic into account, both from the point of view of distress and failure of systems in an attempt to cope with an unsuccessful challenge, as well as a series of attempts to build coping strategies or lifestyles resulting from the life situation in which the patients find themselves. This affects not only the clinician's understanding of evasively diagnosed diseases (as described under the heading somatoform disorders in ICD-10 and 11), but can also bring into consideration important factors that may be contributing to the emergence and/or persistence or even worsening of symptoms of conditions that are listed in the classic groups of diseases (such as allergic, neoplastic, degenerative or due to pathogens). Even in these classic conditions, how efficiently the body copes with the challenge of becoming ill will depend on the good condition of the response equipment. If this system is already overloaded with the stresses of life, it will be less able to respond well to treatment and recovery. Not to mention treatment adherence, where a tired, worn-out person will have much less reason to hope and be a collaborative patient. At the current stage of knowledge, it is impossible not to take into account the factors of the patient's living conditions in understanding their illness and building a treatment with better chances of success. Knowing the patient, their lives, their dreams and disappointments is not a question of "humanized care", it is purely a question of technical updating, as these processes have all been extensively studied and there is a gigantic mass of data and research that underpins the need for this procedure.

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