clinical and translational neuroscience

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Review

Mind–Body Integration in Brain Health

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Abstract

Physical and mental health are intrinsically linked. However, healthcare systems, training programs, and clinical practice often operate in silos, creating structural disincentives that exacerbate morbidity, mortality, and economic burden. Integrated care models have consistently demonstrated improved outcomes, enhanced quality of life, and greater cost-effectiveness across a range of neuropsychiatric and chronic disorders. With the launch of the World Health Organization Brain Health Framework (2022) and the Swiss Brain Health Plan (2023–2033), important progress has been made toward integrating mental and brain health. However, current brain health concepts could be further strengthened by more explicitly incorporating the role of the body and physical health, including psychosomatic and social aspects, particularly in terms of their dynamic, bidirectional interactions with the brain. This article further outlines the health-related and economic benefits of integrated care, key challenges to the systematic implementation of mind–body integration within healthcare systems, and proposes strategic directions for embedding body–brain dynamics into research, education, and policy. This includes interdisciplinary teaching, harmonized conceptual models, composite clinical metrics, transferable interventions, and the removal of systemic barriers to establish integrated care pathways and reduce stigma through patient-centered empowerment. Ultimately, the "no health without brain health" ethos demands the conceptual and practical integration of dynamic, bidirectional body–brain interactions.

Keywords: biopsychosocial model; brain health; functional neurological disorder; integrated care; mind–body integration; psychosomatic medicine

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Academic Editor: Ipsita Roy

Received: 14 July 2025
Revised: 4 August 2025
Accepted: 5 August 2025
Published: 14 August 2025

Citation: Maderthaner, L.; Edwards, M.J. Mind–Body Integration in Brain Health. *Clin. Transl. Neurosci.* **2025**, *9*, 37. https://doi.org/10.3390/ctn9030037

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1. Introduction

Physical and mental health are inextricably linked. However, current healthcare systems, training programs, and clinical practice rarely facilitate genuine integration; rather, they often create financial and organizational disincentives that hinder it. Failure to integrate physical and mental health services increases mortality and morbidity, allowing preventable, easily treatable conditions to progress to severe—sometimes incurable—stages while sharply escalating both direct medical and indirect social costs [1–4]. It is established that personal and financial consequences related to brain health are profound. In Switzerland, mental and neurological disorders account for up to 17% of total health spending, with mental disorders alone costing up to CHF 5.6 billion per year, while roughly half of this sum is indirect, arising from lost productivity, disability, and early retirement [5,6].

When we include comorbid or secondary health problems in analysis, there is strong evidence that we underestimate the associated economic and health risks by a factor of three. The majority of deaths (67%) in the context of mental health are attributable to non-communicable acute and chronic illnesses, while unnatural causes such as injury and suicide account for only 18% of deaths [7]. Healthcare costs for mental health disorders only are estimated to account for 4 to 8% of gross domestic product and 16% of global disability-adjusted life years around the globe, while a study in Norway found that 4% of the gross domestic product was spent on chronic pain only [7,8]. A study from the United Kingdom showed that comorbid depression increases the healthcare costs of chronic pain by an additional 63% [9].

In parallel, evidence shows the clinical, quality of life, health, and social economic benefits when integrated care is provided across all medical conditions including severe mental illness (SMI), long-term neurological conditions, functional neurological disorder (FND), or somatic conditions [2,10–14]. Importantly, positive effects on both healthcare costs and health outcomes increase over time, with ≥12-month follow-up data indicating a further reduction of more than 100% [2]. Additionally, integrated treatment programs, like pain management programs and interprofessional FND interventions (physiotherapy, psychotherapy/psychiatry and neurology), have proven to be superior to single-target approaches [13,15]. In fact, studies have demonstrated that integrated care programs can be feasibly and effectively implemented in several clinical settings. The Liaison Psychiatry Services embedded within the UK National Health Service (NHS) offers a long-standing model for integrating mental and physical healthcare across acute hospital settings [16]. Evaluations have shown reductions in hospital bed use (up to 43–64 beds per day) and annual cost savings (~£3.5 million per hospital), as well as patient satisfaction, care quality, and continuity of care, particularly in patients with medically unexplained symptoms (MUSs) or chronic multimorbidity. However, while these services provide access to mental healthcare within physical health settings, they arguably still do not represent fully integrated biopsychosocial care but rather remain services that are "added on" to usual care. In NHS primary care, the Persistent Physical Symptoms (PPS) care pathway addresses this gap by aiming to combine medical, psychological, and rehabilitative elements within a stepped-care framework [17]. While full outcome and economic evaluations remain pending, early feasibility data suggest that the approach is acceptable and implementable in primary care. A large meta-analysis encompassing 39 studies across 10 European countries examined a range of integrated psychosomatic care models in primary care settings [18]. Of the 22 studies that included economic evaluations, 13 found the intervention to be cost-effective or dominant compared to standard care. Notably, group-based interventions for MUSs and fibromyalgia were generally more cost-effective than individual therapies. In the Netherlands, a notable example is the CORPUS trial, which evaluated a psychosomatic therapy program for patients with persistent somatic symptoms. This intervention, delivered by specially trained exercise therapists, integrated psychoeducation, relaxation, mindfulness, graded activity, and cognitive strategies. The model demonstrated high feasibility, good patient acceptability, and reported modest clinical benefits, particularly in subgroups with moderate symptom severity [19]. In Denmark, the "The Extended Reattribution and Management Model" program has enhanced the capacity of general practitioners to manage psychosomatic complaints effectively through structured communication and referral models [20,21]. Other reviews highlight additional key components of effective integrated care, including collaborative governance structures, multidisciplinary team cultures, long-term financing mechanisms, tailored digital health infrastructure for coordination, and continuous monitoring and feedback systems [11,22,23]. Although integrated biopsychosocial care

has demonstrated great potential in terms of effectiveness and cost savings, its widespread, consistent, and lasting implementation remains the exception rather than the norm.

If we are serious about promoting and improving brain health, we need to solve the challenge of providing integrated mind–body care. This article aims to contribute to this effort by examining the current state of integration between the brain, mind, and body in healthcare systems, outlining key conceptual, clinical, and systemic challenges and proposing strategic directions to advance biopsychosocial care within the evolving brain health agenda.

2. Literature Selection and Approach

This narrative review synthesizes evidence from multiple disciplines, including neuroscience, psychosomatic medicine, psychiatry, neurology, and public health. To guide the literature selection, we conducted a structured search in PubMed, Web of Science, and Google Scholar using combinations of terms such as "brain health", "mind–body integration", "psychosomatic medicine", "functional neurological disorder", "biopsychosocial model", and "integrated care." We focused on the literature published between 2000 and 2025, prioritizing systematic reviews, meta-analyses, conceptual papers, and relevant policy documents. Additional sources were identified through citation tracking and expert consultation. Selection was guided by conceptual relevance to the integration of body–brain–mind perspectives in brain health. The process was iterative and informed by interdisciplinary discussion between the authors.

3. The WHO Declaration on Brain Health and the Swiss Brain Health Plan

The World Health Organization (WHO) defines brain health as "the state of brain functioning across cognitive, sensory, socio-emotional, behavioral and motor domains that allows a person to realize their full potential over the life course, irrespective of the presence or absence of disorders." [24]. Building on the foundation provided by the WHO's brain health concept, a comprehensive, systemic approach to brain health is underway in Switzerland with the Swiss Brain Health Plan (SBHP) [25]. It has the vision of promoting brain health across the entire life course and prioritizing a holistic (non-disease-specific), integrated, person-centered public health approach to promote brain health and prevent brain disorders through collaborations across scientific, healthcare, commercial, societal, and governmental stakeholders and insurance providers. To achieve this ambitious goal, it aims to achieve several strategic goals, including raising awareness of brain disorders (e.g., through public campaigns), cross-disciplinary and interprofessional training (e.g., joint training for neurology, psychiatry, psychology, nursing, etc.), interdisciplinary research integrating behavioral science and healthcare and health systems research, and empowering patients, patient and caregiver organizations, and other relevant stakeholders. It aims at linking primary, secondary, and tertiary prevention and strengthening interdisciplinary services as well as the use of new technologies/digital tools and approaches.

The Lancet Global Health report stated that the WHO definition portrayed mental health as a passive "receiver" rather than an active determinant [26]. In contrast, neuroscientific evidence instead supports a bidirectional relationship. For instance, one longitudinal cohort study shows a 4.2-fold higher risk of dementia in individuals with psychiatric disorders and an earlier average onset by 5.8 years [27]. Depression alone doubles dementia risk [28]. Moreover, cognitive decline can precede depressive symptoms, and depressive symptoms can accelerate cognitive decline, demonstrating a dynamic interplay between mental and neurological health [29].

The Swiss Brain Health Plan (SBHP) explicitly recognizes mental health as a core component of brain health and aims to integrate mental and psychiatric disorders into its action framework. Yet the brain's relevance extends beyond its roles in cognition, motor, and sensory functions, as well as the shaping of experience, emotion, and behavior. It also plays a central part in regulating vascular, endocrine, and immune processes throughout the body. Reflecting this understanding, other medical specialties have recently advanced integration efforts, for example, through the concepts of the brain–gut axis in gastroenterology and the brain–heart axis in cardiology [30,31]. The SBHP identifies lifestyle factors such as physical inactivity, unhealthy diet, and poor posture as important targets for prevention strategies and acknowledges the relevance of physical health. However, the complexity and scope of bilateral mind–body interactions as well as contextual and social factors are not yet adequately addressed in the brain health concept. To fully realize the potential of brain health initiatives, a more comprehensive integration of mind–body interactions including social context into clinical practice and neuroscience research is needed.

4. Bidirectional Mind–Body Interaction

Evidence for reciprocal brain–body interconnections includes—amongst others—neuroendocrine and autonomic pathways, immune-to-brain signaling, the hypothalamic–pituitary–adrenal (HPA) axis, and hierarchical body-to-brain and brain-to-body predictive systems involved in movement, perception, and allostasis. For instance, higher cortisol, epinephrine, and norepinephrine levels are correlated with a 58–68% higher risk of incident cardiovascular disease [32], autoimmune disease is associated bidirectionally with depression [33], and chronic psychosocial stress suppresses adaptive immunity via HPA axis hormones and gene expression changes [34]. In FND, maladaptive top-down expectations can block otherwise intact sensory and motor pathways [35,36].

For individuals with SMI, mortality occurs on average 10 years earlier compared to those without SMI, with the majority of these early deaths resulting from treatable and preventable physical health conditions such as diabetes, heart disease, and cancer [14,37]. In parallel, mental illnesses are highly prevalent in people with long-term neurological conditions and are associated with poorer treatment outcomes, poorer medication adherence, and worse quality of life [38,39]. Depression is the most common mental disorder followed by other mood disorders and anxiety disorders in neurological diseases including epilepsy, migraine, neurodegenerative disease, multiple sclerosis, and Parkinson's disease [40–42]. On the other hand, movement disorders and sensorimotor abnormalities are increasingly recognized and even considered core features of schizophrenia and psychosis [43–46]. Neurological soft signs as well as psychopathological symptom dimensions, such as formal thought disorder, are highly prevalent and show distinct neural patterns in individuals with psychosis [47,48]. Furthermore, evidence of neurostimulation (rTMS)—both alone and in combination with psychotherapy—by inducing neuroplastic changes and modulating brain network connectivity in psychiatric disorders—challenge unidirectional mind- or brain-based models [49–56].

In FND, the interplay between the mind, brain, and body becomes vividly evident. It is one of the most common diagnoses in acute and outpatient neurological practice [57]. FND challenges diagnostic boundaries, as it presents with neurological symptoms despite lacking structural pathology. Neuroimaging studies consistently demonstrate that functional movement disorders (FNDs) are associated with dynamic and measurable dysfunctions in brain networks. A key finding is altered activity in the right temporoparietal junction (rTPJ), a region crucial for sensorimotor integration and a sense of agency. Functional MRI studies show reduced activation and integration of the rTPJ in FND patients, both at rest and during agency-related tasks [58–60]. Moreover, FND patients exhibit decreased coupling between

the rTPJ and the default mode network (DMN)—a network involved in self-referential processing and internal awareness—along with hypoactivity in the supplementary motor areas, reduced parietal cortex activation, and disrupted connectivity between motor and limbic regions, particularly involving the amygdala [60–62]. These findings highlight how disrupted interactions between sensorimotor, self-referential, and limbic networks may underlie the prominent physical symptoms observed in FND, including tremor and paralysis. Furthermore, FND is frequently comorbid with neurological conditions like Parkinson's disease, multiple sclerosis, or epilepsy, and rather than reflecting simplistic psychogenic mechanisms, it involves converging physical and psychological processes, notably altered agency, and disrupted sensorimotor integration [63]. This disorder, which requires integrated physical and mental health assessment and rehabilitation, is still widely neglected and stigmatized in health services [64–66].

However, mind–body interconnections are not limited to pathophysiology but extend to treatment behavior—where patient expectations, psychological states, and brain–body signaling play a decisive role in adherence and health outcomes. Non-adherence to prescribed interventions is a significant remediable threat to cardio- and cerebrovascular health.

Adherence to treatment across long-term conditions, such as diabetes, has consistently been reported to remain below 50% in many populations [67–69]. According to a large meta-analysis, non-adherence may contribute to 4–11% of hospitalizations and has been linked to an estimated 125,000 preventable deaths annually in the United States—approximately three times the number of deaths attributed to motor vehicle accidents [70–72]. Moreover, non-adherence has been associated with annual avoidable healthcare costs ranging from USD 100 to 300 billion, representing approximately 3–10% of total US health expenditures [73].

Yet swallowing the pill is only half the equation. What patients expect from a treatment can modulate physiology almost as powerfully as the molecule itself. The importance of placebo and nocebo effects have been observed in many conditions, not only in pain or depression but also in Parkinson's disease, cardiovascular and immune disorders, arthritis, migraine, epilepsy, cancer, and asthma, as well as in FND, and these effects have been linked to neural correlates [74–81].

5. Psychosomatic Medicine

The concept of psychosomatic medicine originated in 1818 and was further developed in the first half of the 20th century, resulting in Engel introducing the biopsychosocial model (BPSM) in the 1970s [82,83]. It expands a bilateral mind–body perspective to include a third, equally essential dimension, namely the social. The BPSM itself embodies a transdiagnostic and transdisciplinary approach by addressing the interaction of biological and psychosocial factors in all forms of illness. This triadic view acknowledges the patient not only as a biological and psychological organism but as a social being embedded in a relational context. This context contributes both to pathogenesis (e.g., early neglect, loneliness, social stress) and to resilience (e.g., family support, community belonging). As such, psychosomatic medicine has been argued to be more than just an interface between disciplines; rather, it represents a meta-framework that supports a paradigm shift toward more socially informed brain health [84].

In many countries, psychosocial and psychosomatic medicine has a long tradition and in some, it is firmly embedded within health services. For example, the Swiss Academy for Psychosomatic and Psychosocial Medicine (SAPPM) unites multiple disciplines, societies, and institutions and confers the protected subspecialty title "Specialist in Psychosomatic and Psychosocial Medicine" [85]. The launch of Young Psychosomatics Switzerland, a SAPPM subdivision, underscores growing interest among early-career physicians.

Other countries have developed services aligned with the principles of psychosomatic medicine even if the term itself is not used, for example, PPS services and chronic pain management programs [86–90].

Recent perspectives in psychosomatic medicine highlight the key role of central neural circuits—for instance, connections between the prefrontal and anterior cingulate cortex, insula, and hippocampus—in shaping bodily functions, sensations, and behavior [91,92]. In particular, neuroscientific findings increasingly support the idea that human brain development is inherently shaped by social experience—from early attachment processes to language acquisition—offering a neurobiological grounding for the "social brain" [93–95].

Despite these advances, the principles of psychosomatic medicine have not been fully realized across brain-related conditions. In many systems, referrals to psychosomatic services still originate more commonly from internal or general medicine than from neurology or psychiatry. For instance, collaboration with services for people with SMI or chronic neurological conditions remains limited. Functional neurological disorder is still less commonly seen as a condition of interest for psychosomatic clinics, even though modern biopsychosocial conceptions of FND clearly overlap with the proposed models and mechanisms of other functional somatic symptoms [35,87]. Some have criticized that psychosomatic units are often grafted onto rather than integrated within other services [96,97]. As such, they often remain structurally, geographically, and managerially separate from other healthcare and acute services, which hinders the dissemination of knowledge and integrated practices. This organizational separation can be overcome by good communication, but it creates a risk of isolation and failure to spread knowledge and best practices to non-specialists working in other fields. Moreover, pervasive misconceptions further impede optimal care. Patients, the public, and even health professionals often dismiss psychosomatic explanations as "not real" and cast symptoms as imagined or "put on", attributing them to malingering or to insufficient willpower. However, Engel's BPSM remains foundational, not despite but because of its conceptual breadth, capturing the phenomenology of human existence across biological, psychological, and social levels [82]. At the same time, some have noted that the model's conceptual breadth and openness—while philosophically coherent and clinically valuable—may pose challenges for empirical research and clinical implementation [84,98–100]. Although there has been considerable progress in recent years, some authors advocate for advancing the BPSM through enhanced methodological precision and the development of clearly defined, operationalized variables—including for interactions of biological, psychological, and social factors—to facilitate its practical application [98,100,101]. Others suggest more conceptual and argumentative rigor and caution against the emergence of arguments that may be based on circular reasoning or imprecise conceptualizations while seemingly insightful, in order to prevent the problematic expansion of disease definitions [99]. Moreover, the selection and weighting of relevant variables amidst a wide range of potentially influencing factors are essential for empirical evaluation, yet they remain complex and methodologically challenging [101]. Suggested strategies include defining dysfunction as dysregulation, specifying causal mechanisms across diagnoses and developing domain-specific models (e.g., for stress or pain), and applying validated tools across biological, psychological, and social domains [98]. Combining self-report, clinician-rated, and physical measures with neuroimaging and/or genetic, cellular, or electrophysiological methods may be promising; however, it requires interdisciplinary and interprofessional exchange and collaboration [102]. While still evolving, transdiagnostic dimensional research frameworks—such as RDoC or HiTOP in psychiatry or Bayesian models, including predictive coding in neuroscience—may offer valuable conceptual tools to more precisely define and test biopsychosocial processes across disorders in the future [81,103–106].

These observations do not undermine the value of the BPSM but rather highlight the need for continued development and integration into other concepts including brain health, aimed at better translating its integrative vision into actionable frameworks of evidence-based integrated care.

6. Discussion

The WHO and the SBHP promote the integration of neuroscience, psychiatry, neurology, and public health and acknowledge the importance of physical, mental, social, and even spiritual factors for brain health. While these frameworks represent an important step toward a more holistic understanding of brain health, the role of dynamic, bi-directional brain–body interactions may not yet be fully reflected [107–109]. Further integration of processes such as autonomic regulation, interoception, illness behavior, social interaction, socioeconomic conditions, immune and endocrine functioning, and gastrointestinal and cardiorespiratory activity could enrich the conceptualization of brain health and help to comprehensively capture the interplay between physical, mental, environmental, and social determinants of health and disease. Moreover, we need to specify how this noble idea of integration should be translated and implemented into practice.

One way forward would be an ambitious program of change, starting from the principle that healthcare should reflect the natural state of human beings. This natural state is one of integration, where biological, psychological, and social aspects are unified and cannot be divided. This state does not change with illness, meaning that illnesses affect biology, psychology, and social functions, and so effective healthcare should care for all aspects in an integrated way. Therefore, if we are considering brain health, our health systems should be designed to address the needs of people with brain conditions in an integrated fashion, not split people between multiple different departments, or address some of the problems and leaving the rest unresolved. This requires a cultural shift to create a parity of esteem between the physical, mental, and social aspects of health and for healthcare professionals to recognize (and to be supported, trained, and rewarded) that integrated care is everyone's business.

In this new approach, the tradition and expertise of psychosomatic medicine can be brought into play—not confined to a separate department but fully integrated across all services for brain conditions. Such integration might even catalyze a more radical development, breaching the artificial divide between neurology and psychiatry and creating a truly integrated clinical and research platform for brain conditions in which each specialty benefits from the insights of the other.

7. Future Directions

To advance this paradigm, concrete steps are required across healthcare, education, and research to ensure that mind–body integration becomes a foundational element of future brain health strategies.

7.1. Explicit Mind–Body Integration in Brain Health Plans

Brain health strategies, such as the WHO's brain health framework and the Swiss Brain Health Plan, should explicitly acknowledge and operationalize mind–body interactions, recognizing the bidirectional influences between mental, neurological, and physical health and weaving physical and mental healthcare into neurology, psychiatry, and functional symptom services alongside public health initiatives.

7.2. Comprehensive Interdisciplinary Training

A key priority is to teach—and reward—the integration of mind–body interactions in medical and allied health education. Cross-disciplinary teaching, especially across neurology, psychiatry, psychosomatic medicine, and psychology, should be standardized to bridge knowledge gaps and foster collaborative practice. Robust interdisciplinary training, exemplified by innovative initiatives such as the Certificate of Advanced Studies (CAS) in Brain Health, an official postgraduate program at the University of Bern (launching in 2024), is crucial and should explicitly incorporate mind–body concepts [110]. However, education on mind–body interactions should be promoted throughout all levels of education—from school to university—rather than being restricted to postgraduate training only.

7.3. Transdiagnostic and Transdisciplinary Research

Since mind–body processes are common across illnesses—not just in functional or psychosomatic disorders—future research should prioritize a transdiagnostic approach. Studies should address determinants, outcome measures, and novel treatments for mind–body interactions that occur both independently and as part of broader medical conditions. Research on the shared underlying mechanisms of mind–body interactions across diverse conditions and disciplines (e.g., functional neurological disorders, chronic pain, cardiovascular disease, severe mental illness) is crucial. This more mechanism-based perspective supports the development of more effective and cost-efficient interventions. Transdiagnostic approaches might require novel metrics integrating clinical, physiological, and psychosocial parameters alongside evaluations of integrated interventions to ensure equitable patient access.

7.4. Concepts of Mind–Body Integration

A global dialog is necessary to refine concepts of mind–body interaction by integrating currently used frameworks, such as the BPSM and neurocircuitry-based or hierarchical Bayesian predictive coding models, as well as other disciplines like basic and animal-based research, public health, psychology, and sociology [87,111,112]. This might require developing objective, composite outcome measures that incorporate clinical assessments, physiological parameters (e.g., laboratory and neuroimaging data), self-reports and functional outcome parameters, and test translational technologies such as computational modeling, artificial intelligence, and sensor technology—ultimately contributing to a robust and shared conceptual framework.

7.5. Addressing Barriers to Implementation

The key ongoing challenge in advancing mind–body integration, however, lies in translating evidence-based concepts of mind–body interconnection into routine clinical practice.

1. Although the benefits of integrated care are well documented, its implementation is often hindered by persistent barriers, including fragmented funding models, rigid institutional structures, professional silos, and prevailing mind–body dualism in medical culture. Future research should therefore not only demonstrate effectiveness but also systematically investigate these real-world obstacles and design context-sensitive strategies to overcome them.
2. Successful implementation requires more than the goodwill of individual clinicians or departments. It cannot depend solely on local enthusiasm, nor should it become an institutional burden due to undervaluation or insufficient reimbursement of integrated services. Instead, meaningful progress demands coordinated collaboration across all relevant stakeholders—clinicians, hospital administrators, policymakers, insurers, and patient representatives.

3. Concrete organizational measures include the development of structured care pathways, such as the establishment of interdisciplinary outpatient clinics and co-managed inpatient units, as well as the integration of regular joint case boards that embed mind–body principles into everyday clinical workflows. At the same time, existing treatment approaches should be critically reviewed for their applicability across disciplinary boundaries.
4. Ultimately, the success of integrated care also relies on empowering patients themselves. Public health campaigns and self-help groups can contribute to reducing stigma, fostering mutual understanding, and promoting equitable access to care. In addition to raising awareness about mind–body interactions and promoting adequate treatment, public education can help to counteract common misconceptions and the potential misuse of self-diagnosis, particularly as disseminated via social media. Misuse and arbitrary remote or self-diagnosis can discourage affected individuals from seeking appropriate care and contribute to a distorted public understanding of psychosomatic symptom processes—misrepresenting them as arbitrary, non-specific, or detached from evidence-based medical practice.

8. Conclusions

The World Health Organization's concept of brain health offers a useful framework for acknowledging the broad influence that the mind—and therefore the brain—exerts on the body and vice versa. Brain health strategies, particularly the Swiss Brain Health Plan, recognize the interconnection between the brain and mental health. However, to date, they fall short of systematically recognizing the full extent of the two-way interaction of mind–body processes as well of contextual and psychosocial factors. Transdisciplinary and transdiagnostic approaches need cooperation across departments and require action from higher order stakeholders and therefore bring conceptual, financial, personal, and organizational challenges.

Nonetheless, the need for explicit mind–body integration is becoming increasingly urgent. A growing body of neuroscientific and empirical evidence highlights how mental, neurological, and somatic processes dynamically interact across the lifespan and disease spectrum. Embracing this complexity opens new opportunities for prevention, destigmatization, and effective, targeted, and personalized intervention. Evidence suggests that such approaches have substantial potential to reduce morbidity, mortality, and the burden on the healthcare system—including overall healthcare costs—while improving quality of care and ensuring more equitable access.

To move from a strategic vision to practical implementation, clearly defined indicators, interdisciplinary care pathways, and prioritized transdiagnostic research agendas are required—elements that would allow the reciprocal body–brain nexus to be measured, monitored, and acted upon in clinical, public health, and research settings.

In short, there is no health without brain health. A modern brain health concept that explicitly incorporates dynamic body–brain interaction by acknowledging neuroscientific evidence and psychosocial aspects is essential for effective prevention, diagnosis, and treatment in twenty-first-century medicine. While systemic change is never simple, the convergence of scientific insight, clinical need, and policy momentum offers a promising window of opportunity. With concerted effort, the integration of the mind and body can become not just an aspiration but a cornerstone of future brain health strategies.

Author Contributions: Conceptualization, L.M. and M.J.E.; methodology, L.M. and M.J.E.; validation, L.M. and M.J.E.; formal analysis, not applicable; investigation, L.M. and M.J.E.; resources, L.M. and M.J.E.; data curation, not applicable; writing—original draft preparation, L.M. and M.J.E.; writing—review and editing, L.M. and M.J.E.; visualization, not applicable.; supervision, M.J.E.; project administration, L.M.; funding acquisition, L.M. All authors have read and agreed to the published version of the manuscript.

Funding: Lydia Maderthaner is supported by a personal research fellowship from the Gottfried und Julia Bangerter-Rhyner Foundation (c/o Schweizerische Treuhandgesellschaft (Bern) AG, Spitalgasse 2, 3011 Bern, Switzerland; www.bangerter-stiftung.ch) Project No. 0429/2024. The fellowship supports international research stays for the purpose of advanced education and training for early-career researchers. No specific grant or external funding was received for the preparation of this manuscript.

Acknowledgments: The authors gratefully acknowledge Selma Aybek (University of Fribourg, Neurology) and Nik Egloff (Swiss Academy of Psychosomatic and Psychosocial Medicine, SAPPM) for their valuable and constructive feedback on the manuscript.

Conflicts of Interest: The authors declare no commercial or financial relationships that could be construed as a potential conflict of interest. M.J.E. does medical expert reporting in personal injury and clinical negligence cases. M.J.E. has shares in Brain & Mind, which provides neuropsychiatric and neurological rehabilitation in the independent medical sector. M.J.E. has received financial support for lectures from the International Parkinson's and Movement Disorders Society and the FND Society (FNDS). M.J.E. receives royalties from Oxford University Press for his book *The Oxford Specialist Handbook of Parkinson's Disease and Other Movement Disorder*. M.J.E has received honoraria for medical advice to Teva Pharmaceuticals and educational events. M.J.E. receives grant funding from the National Institute for Health and Care Research (NIHR). M.J.E. is a deputy editor of the *European Journal of Neurology*. M.J.E is on the medical advisory boards of the charities FND Hope and the British Association of Performing Arts Medicine.

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