COMMENTARY

Psychological Factors Affecting Medical Conditions, a New Classification for DSM-V.
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For full disclosure, I am Editor of *Advances in Psychosomatic Medicine* and a contributor to this volume. Thus this is not a traditional book review but a commentary upon this volume. The term, psychosomatic, is complicated (Lipowski 1984). It has been used to refer to medical disorders that were somehow caused or aggravated by psychological and physical factors. A second meaning was that of a branch of medicine concerned with mind-body relations and finally denotes a research approach looking at biologic, psychological and social variables. Psychosomatics has a new connotation to denote a formal subspecialty of psychiatry. This subspecialty, formerly called consultation-liaison psychiatry, was formally approved by the American Board of Medical Specialties in 2005 (Wise 2008, Gitlin et al. 2004). With the rise in molecular biology as an explanatory model in medicine and psychiatry, psychosomatic relationships waned. As a reaction to this, George Engel urged a new biopsychosocial model in medical education which became a synonym for psychosomatic in the 1990's (Engel 1992, Engel 1982). As Psychiatry tried to become more "scientific" it utilized an important diagnostic approach of operational criteria in successive DSM iterations. The DSM has significant limitations in describing the totality of a patient and in consultation liaison psychiatry it is essential to know "who" is the patient as well as "what" diseases they have (Oken 2007)[1].

This volume critically discusses a recent development in diagnostic strategies in both treatment and research in psychosomatic medicine, The Diagnostic Criteria for Psychosomatic Research (DCPR) (Fava et al. 1995). The initial chapter reviews the development of the DCPR which evolved from the work of clinical investigators such as George Engel, Arthur Schmale, Robert Kellner and Issy Pilowsky (Fava et al. 2004). Utilizing operational criteria for 12 psychosomatic syndromes that provide a qualitative understanding of psychosocial factors involved in the patient's illness, the DCPR offers an important assessment of an individual that goes beyond the quantitative date from various rating scales. The appendix at the end of the volume outlines the operational elements of each of the diagnostic criteria.

The DCPR ascertains if the patient suffers from *health anxiety* which encompasses abnormal illness behavior and broadly based worries about illness, pain and somatic concerns. The next dimension is that of *thanatophobia* which is the individual's conviction of dying in the near future. Such fears commonly occur in panic disorder and in hypochondriasis. *Disease phobia* or nosophobia is often found in hypochondriasis but differs because of its chronic-like quality in that it occurs in acute attacks such as in panic disorder. Closely related is *illness denial*, which may foster maladaptive delays in medical care. Other dimensions include *persistent somatization*, *conversion phenomena, functional somatic symptoms* secondary to a psychiatric disorder such as somatic symptoms within major mood disorders, *anniversary reactions*, *demoralization* which is closely related to Schmale and Engel's giving up – given up syndrome, *irritable mood*, *Type A behavior* and *alexithymia* (Schmale 1972). The DCPR provides a catalogue of dimensions that allow the clinician a conceptual framework for evaluation of disease states. The operational definitions of the DCPR are included in an appendix.

The rest of the volume reports the use of the DCPR in various disease states or medical specialties. A contribution by Drs. Sanino, Tomba and Fava review the psychosocial approach to endocrine disease, with particular attention to the various dimensions of the DCPR. Examples include the common clinical finding of demoralized states and irritable mood in Cushing Syndrome, as well as the persistence of hostility and irritability in hyperprolactinema, even when prolactin levels are normalized. The next chapter by Drs. Porcelli and Todarello review the DCPR in functional gastrointestinal disorders. Half of patients with functional bowel disease present with alexithymic characteristic, while one-third could be judged as having persistent somatization. The underlying neurobiology of functional bowel disease that includes visceral hyperalgesia is discussed. Other disease states such as oncologic conditions are elegantly reviewed by Dr. Grassi and colleagues. Somatization in cancer patients can be ignored by physicians but seriously limits quality of life in such patients, even when remission is medically achieved. Cardiac disease has many psychosocial factors. The recent interest in increased mortality of those depressed patients with coronary artery disease is a demonstration of such psychosomatic relationships has led to the American Heart Associations's suggestion for depression screening for all coronary patients (Lichtman et al. 2008). Thus the chapter on cardiovascular patients is particularly timely. Dermatologic diseases clearly have psychosomatic relationships that are surprisingly ignored by

[1] This paraphrases Sir Williams Osler's quote: "The good physician treats the disease; the great physician treats the patient who has the disease".

mainstream psychosomatic journals. What clinicians have not observed the significant demoralization in adolescents with acne vulgaris? To this end, Drs. Picardi and Pasquini review the links between dermatology and emotional states. This is a uniquely valuable chapter for its review of the literature and demonstrating how the DCPR can be utilized in such entities. The final two chapters in this valuable volume include how the DCPR can be utilized within a consultation-liaison service. The most common diagnosis within North American consultation services is that of adjustment disorder with depressed mood. Such as "wastebasket" diagnosis does little to elucidate the various elements of patients' suffering. The DCPR elements remind us that this is far more complicated than its simplistic suggestion of anxiety over one's medical state but demands far more complex assessment as embodied within the DCPR. The book closes with a discussion on eating disorders. Eating disorders are a clear example of psychosomatic relationships with significant cultural interactions. As with other conditions, the diagnostic criteria for psychosomatic research is particularly useful. Within each chapter there are prevalence rates of the DCPR dimensions within specific patient groups.

This volume should be a guide to all clinicians interested in psychosomatic relationships. With a growing group of psychosomatic specialists throughout the world, we must be very careful not to forget the important qualitative elements in the life story of patients, as well as quantitative phenomena embodied in the illness attitude scales that correlate with the DCPR. It is essential that more research be done on such conditions. Anniversary reactions, alexithymia and the other aspects of the DCPR all further illuminate the individual's response to variables within their psychological state; medical condition; and social system. This volume argues against reductionistic thinking but in fact continues to refine the "new" medical model that Engel advocated as biopsychosocial. All clinicians whether specialists in psychosomatic medicine or other branches of medicine should understand what this volume discusses. It is reasonably priced and well produced and should in all physician's libraries.

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