# Editorial

# Psychosomatic medicine: future tasks and priorities for the new psychiatric subspecialty

# Medicina psicosomática: tarefas futuras e prioridades da nova subespecialidade psiquiátrica

Psychosomatic medicine (PM) is the newest psychiatric subspecialty approved in the U.S. in 2003.[1] PM psychiatrists are specialists in the care of psychiatric disorders in the medically ill. This specialized field has also been referred to as consultation-liaison (C-L) psychiatry, but it was decided to return to the name psychosomatic medicine, which is rooted in its history, journals, and organizations. The three most prominent long-standing journals in the field are *Psychosomatic Medicine* (since 1939), *Psychosomatics* (since 1953), and the *Journal of Psychosomatic Research* (since 1956). The major clinical and research organizations in the U.S. are the Academy of Psychosomatic Medicine and the American Psychosomatic Society, and in Europe, the European Association for C-L Psychiatry and Psychosomatics and the European Conference of Psychosomatic Research. Thus the name of the subspecialty reflects the enduring conceptualization of "psychosomatic medicine" as broadly referring to mind-body interactions in human illness, rather than as a reductionistic theory of psychogenic causation of disease.

PM psychiatrists have special expertise in the diagnosis and treatment of psychiatric illness in complex medically ill patients. PM practitioners treat four types of conditions: comorbid psychiatric-medical illnesses complicating each others' management; psychiatric disorders directly resulting from a primary medical condition or its treatment, such as delirium, dementia or other secondary mental disorders; complex illness behavior such as somatoform and functional disorders; and acute psychopathology admitted to medical-surgical units, such as attempted suicides. PM specialists work as hospital-based C-L psychiatrists, in medical-psychiatric inpatient units, and integrated with primary care or medical specialties to provide collaborative care.

This is an exciting time for psychosomatic medicine. The first two certifying examinations were offered in the U.S. in 2005-2006, and other countries are taking steps toward official recognition as well. Several new major textbooks with international authorship have been published.[2-5] The number of PM fellowship programs in the U.S. is growing, because official recognition means that accredited programs are eligible for federal medical education and Veterans Hospitals' funds, and may accept international applicants who have satisfied the requirements of the Educational Commission for Foreign Medical Graduates (ECFMG®). PM psychiatrists have many valuable roles in medical education, teaching medical students and psychiatric residents about medical-psychiatric interface issues in addition to PM fellows. PM psychiatrists also help train non-psychiatric residents, health psychologists, clinical social workers, and hospital chaplains.

Research in PM traces its roots to the early 20th century in the work of Walter Cannon, followed by other pioneers like Frances Dunbar and Franz Alexander, and later George Engel, Zbigniew Lipowski, and many others. Psychosomatic medicine now involves a wide range of studies examining psychiatric-medical illness interactions. Important contributions have occurred in medically

unexplained symptoms, functional disorders, cancer, transplantation, cardiology, endocrinology, neurology, pain management, AIDS, obstetrics-gynecology, pulmonary, renal and GI diseases. In each of these areas, first generation studies identified the frequency of psychiatric morbidity associated with the most common diseases or hospitalization itself. More sophisticated second generation cross-sectional epidemiological studies established the prevalence rates of a broader range of psychiatric disorders in the earlier studied illnesses, as well as less common, or newly recognized disease states. Early empirical efforts to treat psychopathology in the medically ill have been followed by sophisticated intervention trials focused on psychiatric illness (most often depression) in patients with chronic medical illnesses, with the aims including measurement of psychiatric and medical outcomes, as well as quality of life.

An ambitious research agenda for PM lies ahead. The highest priority should be given to studies of major psychiatric disorders in medical illnesses of high public health impact (e.g.: heart disease, diabetes). Well-designed clinical trials are needed to assess the relative efficacy of treatments in improving medical and psychosocial outcomes. Other vital areas of research include nosology and classification (especially the somatoform and functional disorders); more sophisticated studies of the epidemiology, course, and impact of psychopathology over the course of medical illness; and more investigations of etiology, risk factors, imaging, and genetics.

There are many challenges ahead for PM. Psychiatric intervention has become more difficult during medical hospitalization, as length of stay has fallen, and average medical illness acuity has increased. The diagnostic mix on medical inpatient units has evolved, with more delirium, substance abuse, and psychiatric emergencies. In the U.S., the provision of psychiatric services to the medically ill is hampered by hospital funding cuts, poor reimbursement and separated funding of medical and mental health services by insurers. In addition, there are too few PM psychiatrists to meet the needs. Most PM psychiatrists are on consultation services, rarely found outside teaching hospitals, and their services are reactive and very brief. Optimal care for complex illnesses requires collaborative relationships with primary physicians and access to specialized psychiatrists. Psychiatric liaison, where psychiatrists are integrated members of a specialized care team, is a more advanced model, with greater ability to provide early detection and prevention. However, such models are usually limited to selected services at larger teaching hospitals. There is an overall shortage of PM psychiatrists in the U.S., and they are not evenly distributed, but the expansion of accredited fellowship programs will hopefully help address this shortfall. PM and C-L psychiatrists are in even shorter supply and less well geographically distributed in most other countries.

To achieve ideal collaborative care for comorbid medical-psychiatric illness will require changes in each nation's health-care delivery systems. Thus, it is important for PM psychiatrists to develop liaison with other physician groups, medical disease advocacy groups, mental health advocacy groups, and policy makers in government and business.

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