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Psychosomatic medicine: A new psychiatric subspecialty in the U.S. focused on the interface between psychiatry and medicine

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ABSTRACT – Background and Objectives: In the past, Psychosomatic Medicine (PM) has had ambiguous connotations, and there have been many other names for this specialized fields, including Consultation-Liaison Psychiatry. The objective of this report is to briefly review the background, the history and current status of PM, which recently was recognized in the U.S. a psychiatric subspecialty.

Methods: Historical review and review of the literature.

Results: PM has a rich history. Psychoanalysts and psychophysiologists pioneered the study of mind-body interactions, and crucial events in the development include the funding of PM units in several U.S. teaching hospitals by the Rockefeller Foundation, and the training grants and a research development program funded by the National Institute of Mental Health. By the 1980s, all psychiatry residency programs were required to provide substantial clinical experience in the field, and as of 2005 there were 32 fellowship programs in the Academy of Psychosomatic Medicine's (APM) directory. In 2001, The Academy of Psychosomatic Medicine (APM) applied for the recognition of PM as a subspecialty of psychiatry, and formal approval was granted by the American Board of Medical Specialties (ABMS) in March 2003.

The foundation of PM is a specialized body of scientific knowledge regarding psychiatric aspects of medical illness. This has been articulated in contemporary textbooks, journals and regular scientific meetings of national and international societies. A cadre of scholars and researchers has emerged, and important contributions have occurred. A major goal of the PM field is to improve the psychiatric care of patients with complex medical conditions. There are a number of obstacles and challenges ahead in pursuing optimal integration of PM services into existing service delivery systems of care, but anticipated expansion of accredited fellowship programs in PM will hopefully help address this shortfall. In the past 20 years an international PM network has developed with increasing scientific exchanges, and the US paradigm is regarded as important for the development of PM as a subspecialty internationally.

Conclusion: Formal recognition as a subspecialty in the U.S. has and will strengthen PM and will enhance its growth internationally.

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Introduction

In the past, Psychosomatic Medicine (PM) has had ambiguous connotations, alternatively “psychogenic” or “holistic,” but it is the latter meaning that has characterized its emergence as a contemporary scientific and clinical discipline¹. PM is the newest psychiatric subspecialty approved by the American Board of Medical Specialties. There have been many other names for this specialized field, including Consultation-Liaison psychiatry², medical-surgical psychiatry, psychological medicine, or psychiatric care of the complex medically ill. The name chosen for the field was intended to reflect the field’s history, its focus on the interface between psychiatry and other areas of medicine, and the patient population it serves. PM psychiatrists have special expertise in the diagnosis and treatment of psychiatric conditions in *complex medically ill patients*³. Working closely with physicians in primary care and other specialties, its practitioners treat and study four general groups of patients, sometimes referred to as the “complex medically ill”: those with co-morbid psychiatric and general medical illnesses complicating each

other’s management; those with psychiatric disorders that are the direct consequence of a primary medical condition or its treatment, such as delirium, dementia or other secondary mental disorders (formerly known as “organic” disorders); those with complex illness behavior such as “somatoform” and functional disorders; and, patients with acute psychopathology admitted to medical-surgical units, such as after attempted suicide. Many of these patients have multiple medical, psychiatric, functional, and/or substance abuse disorders, thus are best thought of as the psychiatric counterpart of the multimorbid frail elderly seen by geriatricians.

PM psychiatrists have been trained to deliver services in the general health care sector working with the complex medically ill. They have been known as consultation-liaison psychiatrists practitioners. They may work as hospital-based consultation-liaison psychiatrists, on medical-psychiatric inpatient units⁴, and in settings in which mental health services are integrated with primary care or medical specialties. Thus the field’s name reflects the fact that it exists at the interface of psychiatry and medicine and focuses on the interaction between medical conditions and psychi-

atric disorders. The rest of this article is devoted to a brief discussion of the history and current status of PM.

History

PM has a rich history. The term "psychosomatic" was introduced by Johann Heinrich in 1818, and "psychosomatic medicine" by Felix Deutsch around 1922⁵. Psychoanalysts and psychophysiologists pioneered the study of mind-body interactions from very different vantage points, each contributing to the growth of PM as a clinical and scholarly field. The modern history of the field perhaps starts with the Rockefeller Foundation's funding of PM units in several U.S. teaching hospitals in 1935. The National Institute of Mental Health made it a priority to foster the growth of consultation-liaison psychiatry, the name of the field at the time, through training grants (circa 1975) and a research development program (circa 1985).

The integration of consultation-liaison psychiatry into the core of psychiatric residency training began in the 1960s at individual institutions. By the 1980s, all psychiatry residency programs were required to provide substantial clinical experience in the field. In the U.S., subspecialty fellowship training in PM has been available for over 25 years, with over 1,000 psychiatrists educated in this subspecialty. As of 2005, there were 32 fellowship programs in the Academy of Psychosomatic Medicine's (APM) directory. In the last national survey of U.S. psychiatrists' practices, well over 2,500 psychiatrists were practicing in this field⁶.

In 2001, The Academy of Psychosomatic Medicine (APM) applied to the American

Board of Psychiatry and Neurology (ABPN) for the recognition of "Psychosomatic Medicine" as a subspecialty of psychiatry, choosing to return to the name for the field imbedded in its history, its journals, and its national organizations⁷. Formal approval was granted by the American Psychiatric Association, the ABPN, the Residency Review Commission (RRC) of the Accreditation Committee for Graduate Medical Education (ACGME), and eventually the American Board of Medical Specialties (ABMS), the latter in March 2003. The first certifying examination was administered in June 2005 to almost 500 psychiatrists. As of August 2005, the ACGME has accredited 16 fellowship-training programs in PM.

An impediment to the field's growth has been the split between general medical and mental healthcare, with major adverse effects on quality of medical service delivery and patient oriented care⁸. This split is reflected in disparities and disintegration in the reimbursement of patient care (carve outs, lack of parity in coverage) and funding mechanisms in silos that do not promote cross-disease research and therefore require special attention for the further growth of PM.

Psychosomatic medicine as a scholarly discipline

The foundation of PM is a specialized body of scientific knowledge regarding psychiatric aspects of medical illness. This has been articulated in half a dozen contemporary textbooks, about a dozen active journals, and the regular scientific meetings of a dozen national and international societies². A major new textbook for the field has recently been published and is being widely

used⁹. A cadre of scholars and researchers has emerged involved in a wide spectrum of investigations looking at the medical illness-psychiatry interface. Important contributions have occurred in the interface between psychiatry and HIV-AIDS, cancer, transplantation, cardiology, neurology, endocrinology, pulmonary, renal and GI diseases, obstetrics-gynecology, and geriatric medicine.

Epidemiologic research has repeatedly documented a substantial clustering of medical and psychiatric morbidity, especially in the complex medically ill. This co-morbidity leads to increased mortality, morbidity, loss of quality of life and excess utilization of health care services through several psychosocial and biological mechanisms, among them non-compliance and lack of interdisciplinary communication. Studies in the 1980s and 90s identified the extent and nature of psychiatric morbidity associated with the most common diseases, and its effects on outcomes such as mortality, morbidity, quality of life and excess health care utilization². These studies established the high prevalence rates of a broad range of psychiatric disorders in medical illnesses as well as less common, or newly recognized psychopathologic conditions. Similar studies examined psychiatric morbidity in patients with abnormal illness behavior such as unexplained physical complaints and functional disorders. Inpatients in general hospitals have the highest rates of psychiatric disorders followed by medical outpatients². Compared to community samples, depressive disorders in the general hospital are 2-5 times as common, substance abuse 2 to 3 times as common, and somatoform disorders more than 10 times as common². Delirium occurs in almost a fifth of elderly medical inpatients². The impact of psychi-

atric illness on medical morbidity is substantial. For example, depression has been associated with increased risk of recurrence and mortality from myocardial infarction², increased risk of stroke in hypertensive patients², worse glycemic control in diabetic patients², and increased functional dependency in Alzheimer patients². In fact, psychiatric morbidity in many medical disorders has been shown to be a potent risk factor for increased medical morbidity and disability. Unfortunately, many studies demonstrate that potentially treatable psychiatric disorders in the complex medically ill are typically underdiagnosed and under-treated^{2, 6, 8}.

Early empirical efforts to treat psychiatric morbidity in the medically ill have been followed by intervention trials focused on reducing their associated impact on medical illness such as in cardiac and diabetes patients². In these studies the psychiatric condition is treated, while its effects on medical outcomes, compliance with treatment for the medical condition, and quality of life are assessed. Similar trials are underway for patients with unexplained symptoms and related "functional" syndromes.

Research has also begun to explore the complex mechanisms involved in the development of psychiatric morbidity in the medically ill, including genetic, neurochemical, behavioral or social factors, the latter including the way health care is delivered. Examples include the relationship between the location of stroke and major depression, the role of childhood sexual abuse in chronic pain and illness behavior, interferon-induced depression, causal pathways to delirium, and barriers to care for blood-borne diseases among patients with serious mental illness^{2, 10}.

The clinical practice of Psychosomatic Medicine: models for service delivery

A major goal of the PM field is to improve the psychiatric care of patients with complex medical conditions. Physicians in primary care or internal medicine provide the great majority of the psychiatric care for these patients. These patients are encountered in general or chronic care hospitals, in home healthcare settings, in the offices of primary care or specialist physicians, and in many other health care environments, such as rehabilitation units, nursing homes, and assisted living facilities. The higher concentration of patients with psychiatric disorders in the general hospital and in primary care provides a critical opportunity, working closely with team members in other medical specialties, to identify and treat this important group of patients both to reduce their emotional suffering and improve their medical outcomes. Patients who pass through these portals need recognition, appropriate diagnosis, initiation of treatment, and referral for the follow-up psychiatric care they would otherwise fail to receive¹¹. Failures to identify, evaluate, diagnose, treat, or achieve symptom resolution results in preventable adverse outcomes. A major cause of the failure to identify and treat psychiatric disorders in the medical setting is the absence of on-site or ready access to psychiatric expertise. PM subspecialists deliver emergency services for attempted suicide and serious behavioral disturbances; consults for medical generalists and specialists, and most critically, integrated services for patients with psychiatric disorders and complex medical illness. When an active PM service is integrated with the medical/surgical staff in collaborative pro-

grams to identify and initiate treatment for psychiatric disorders, there is potential for great improvement in both psychiatric *and* medical outcomes².

There are a number of obstacles and challenges ahead in pursuing optimal integration of PM services into existing service delivery systems of care. Most PM psychiatrists are on psychiatric consultation services, rarely found outside teaching hospitals, and their services are reactive, typically emergent or urgent. Optimal care for patients with complex medical illnesses such as cancer or AIDS, or for those patients being considered for transplant or gastric bypass, calls for close working relationships with the primary physicians as well as easy access to specialized psychiatric expertise. Psychiatric liaison, in which psychiatrists are integrated members of a specialized care team, is a more advanced model, with greater ability to provide early detection and prevention¹⁰. However, such services are usually limited to larger teaching and specialty hospitals. Thus, there is an overall shortage of PM psychiatrists in the U.S., and they are not evenly distributed, but anticipated expansion of accredited fellowship programs in PM will hopefully help address this shortfall.

Psychosomatic Medicine's Interface with other medical disciplines

Training of other medical specialists: PM psychiatrists often take part in the training of non-psychiatric residents, particularly in internal medicine, family practice, pediatrics, obstetrics/gynecology, and neurology. They play a significant role in teaching about psychiatric disorders at annual meetings of the

American College of Physicians, the Society for General Internal Medicine, the American Association for Family Practice, the American College of Obstetrics and Gynecology, and others. An important aspect is the combined training of psychiatrists and other medical specialists, in “medicine-psychiatry” inpatient units, collaborative care outpatient clinics, or in other integrated service delivery approaches.

Participation in medical center ethics committees: PM psychiatrists play leading roles on medical center ethics committees, contributing specialized expertise regarding end of life decisions, capacity/competency, involuntary treatment, boundary violations, and other doctor-patient relationship problems. PM psychiatrists have served as chairs of hospital ethics committees far out of proportion to their numbers (Academy of Psychosomatic Medicine Task Force on Ethics, unpublished data).

International developments

In the past 20 years an international PM network has developed with increasing scientific exchanges. The US paradigm is regarded as important for the development of PM as a subspecialty internationally. In Australia, the United Kingdom and Japan formal criteria for sub-specialty status in PM have recently been established. In Turkey it is in process of evaluation. In other countries subspecialty status is a more distant prospect. For instance, in Spain PM is a rotation in the basic psychiatric specialty training, whereas in the Netherlands under the influence of the US developments, such a rotation has become a realistic possibility. It is important to know that in Germany, where psychiatrists do the major-

ity of consultations in the general hospital, specialists in PM are primarily internists who treat patients with depression or abnormal illness behavior in specialized PM departments with a primary focus on psychotherapy. German patients with “organic” psychosis, substance abuse, or attempted suicide are treated by general psychiatrists. Although German psychiatrists provide hospital consultations, this is not a subspecialty within their field.

Conclusion

PM has evolved from its beginnings in psychophysiology and psychoanalysis to become a subspecialty of psychiatry devoted to psychiatric care of the complex medically ill through consultation and integration with the rest of medicine. The future aims of the PM field include:

- Collaboration with other medical specialties and disciplines to develop integrated care for the complex medically ill thus overcoming the burden of fragmentation in the existing service delivery system;
- Development of combined training programs for medical specialists in integrated care on psychiatry-medicine units and other types of integrated service delivery;
- Development, funding, and evaluation of new collaborative research models in psychopathology and complex medical illnesses;
- Changes in health care insurance and financing to overcome the current disintegration and disparities between mental health and general health care.

Formal recognition as a subspecialty in the U.S. has and will strengthen PM and will

enhance its growth internationally. The certification of more psychiatrists with expertise in PM will help address the unmet psychiatric needs of the medically ill, improve the quality of education and training both in psychiatry and in other areas of medicine, promote integrative research, and improve the medical outcomes of this complex patient population. Progress in PM and its contributions to care are endangered by existing splits and fragmentation in health care delivery and financing.

References

1. Lipowski ZJ. What does the word "psychosomatic" really mean? A historical and semantic inquiry. *Psychosom Med* 1984; 46: 153-171.
2. Kornfeld DS. Consultation-Liaison psychiatry: contributions to medical practice. *Am J Psychiatry* 2002; 159: 1964-1972.
3. Gitlin DF, Levenson JL, Lyketsos CG. Psychosomatic Medicine: A New Psychiatric Subspecialty. *Academic Psychiatry* 2004; 28: 4-11.
4. Kishi Y, Kathol RG. Integrating medical and psychiatric treatment in an inpatient medical setting. The type IV program. *Psychosomatics* 1999; 40(4): 345-355.
5. Lipsitt DR. Consultation-liaison psychiatry and psychosomatic medicine: the company they keep. *Psychosom Med* 2001; 63: 896-909.
6. Dorwart RA, Chartock LR, Dial T, Fenton W, Knesper D, Koran LM, et al. A national study of psychiatrists' professional activities. *Am J Psychiatry* 1992; 149: 1499-1505.
7. Lyketsos, CG, Levenson JL, with the Academy of Psychosomatic Medicine (APM) Task Force for Subspecialization. *Proposal for recognition of "Psychosomatic Medicine" as a psychiatric subspecialty*. Academy of Psychosomatic Medicine, July 2001.
8. Institute of Medicine. *Crossing the quality chasm: a new health system for the 21st century*. Committee on Quality of Health Care in America. Washington DC: National Academy Press; 2001.
9. Levenson JL (Editor). *Textbook of Psychosomatic Medicine*. Washington DC: American Psychiatric Press Inc; 2004.
10. Rosenberg S, Brunette M, Oxman T, Marsh B, Dietrich A, Mueser K, Drake R, Torrey W, Vidaver R. The STIRR model of best practices for blood-borne diseases among clients with serious mental illness. *Psychiatr Serv* 2004; 55(6): 660-664.
11. Huyse FJ. From consultation to complexity of care prediction and health service needs assessment. *J Psychosomatic Res* 1997; 43: 233-240.

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