The primary goals of diagnosis are to provide clinicians with a meaningful framework that recognizes the underlying clinical condition beyond the symptom presentation, to facilitate communication among clinicians, and to enhance decision making to improve the patient’s health status. In any field of medicine and clinical psychology, including psychosomatic medicine, the diagnostic process can be considered as much effective as it gets closer to the top achievement levels of these 3 interrelated purposes. However, a wide array of medical symptoms cannot be explained by the biomedical model and confined to the current branches of internal medicine. In turn, several health-related problems, strongly affecting daily functioning and influencing symptom presentation, cannot be fully recognized without the more comprehensive, multifactorial perspective provided by the biopsychosocial model of health and illness. In this perspective, any illness is viewed as the common final pathway resulting from interacting systems at the cellular, tissue, organismic, interpersonal, and environmental levels, so that each of these factors has a relative weight in facilitating, sustaining, or modifying the course of diseases, varying from illness to illness, from one individual to another, and even between two different episodes of the same illness in the same individual. The relationships between physical illness and psychological factors are subsumed in two chapters of the DSM-IV. One, Somatoform Disorders, is included in the main diagnostic axis I and is based on the assumptions that somatic symptoms are likely to mimic ‘real’ symptoms of medical disease while not showing any evidence of it and are not
secondary to another psychiatric disorder. This view pertains to the concept of the excessive distance between the physical problem (inexistent or not being a plausible cause for actual symptoms) and the patient’s perception, thoughts, and behavior. The second chapter is the rubric of Psychological Factors Affecting Medical Condition (PFAMC) that requires the presence of a general medical condition and of psychological factors that adversely affect the course or treatment of the condition, or that increase physical or emotional risk for the patient. PFAMC are placed in the residual section of ‘other conditions that may be a focus of clinical attention’ and therefore are too vague, lack specific criteria, and are not useful and not used in clinical practice. Somatoform disorders have attracted considerable criticism since their introduction in the DSM-III and the need for considerable changes in preparing the 5th edition of the DSM has been highlighted. Somatoform disorders have been criticized because they have been formulated by dichotomous thinking; they include criteria that are too restrictive (e.g. somatization disorder) or too vague (e.g. undifferentiated somatoform disorders); they tend to overpsychologize somatic symptoms (when axis I disorders are present) or to underestimated somatization symptoms (when medical diagnoses are established); they underestimate the prevalence of somatization because they are limited to the more severe clinical forms; they underrecognize the dimensional nature of somatization along a continuum spectrum of degrees (severity, impairment, chronicity, comorbidity, health care utilization); they lack appropriate consideration of subsyndromal symptoms, personality and behavioral factors, and they include syndromes that are not used by physicians for the same illness (such as fibromyalgia and undifferentiated somatoform disorder or functional abdominal pain and pain disorder), thereby producing ineffective communication. Both Somatoform Disorders and PFAMC miss the primary goals of the diagnostic process. The debate is still ongoing, several papers and editorials have been published recently, and some proposals for DSM-V have been advanced. They range from softer (e.g. clustering of the many somatoform disorders in few categories identified by some specifiers) to harder alternatives (e.g. abolition of the rubric of somatoform disorders).

On the basis of a growing body of research, this volume deals with research data and clinical views to formulate a new proposal for the DSM-V, introducing the Diagnostic Criteria for Psychosomatic Research (DCPR) in the chapter of PFAMC. The DCPR syndromes were developed about 10 years ago by an international group of investigators and are based on the recognition that a wide body of evidence that has accumulated in psychosomatic medicine relating to concepts of quality of life, stressful life events, somatization, and personality disorders has not resulted in operational tools whereby different psychosocial aspects of medical diseases can be characterized. The DCPR approach focuses on psychological characteristics of patients presenting symptoms across different medical disorders.
The first chapter by Fabbri and colleagues explains the rationale for the introduction of the DCPR in the DSM-V and emphasizes their usefulness assessing for psychological and behavioral problems affecting the onset, the course, and the treatment of patients in the different medical settings. In the second chapter, Sonino and colleagues examine the psychological factors affecting several endocrine disorders (Cushing’s syndrome, Graves’ disease, Addison’s disease, primary aldosteronism, thyroid dysfunctions, hyperprolactinemia, and hyperparathyroidism). Particular attention is paid by the authors to the association between DCPR clusters and the construct of allostatic load, conceived as the chronic exposure to fluctuating or heightened neuroendocrine response resulting from repeated or chronic environmental challenge. Porcelli and Todarello’s chapter focuses on patients with functional gastrointestinal disorders in whom the most prevalent DCPR syndromes (alexithymia, persistent somatization, secondary functional somatic symptoms, and demoralization) are consistent with the psychosocial correlates outlined in the literature as health care seeking behavior and somatosensory amplification. In the following chapter, Grassi and coworkers underscore that DSM criteria are particularly problematic in oncology because of the need to adapt them to the cancer-related life conditions, while psychological problems identified by the DCPR as health anxiety, demoralization, and alexithymia are associated with several cancer-related physical symptoms, poor well-being and quality of life, and high health concerns. The psychological factors affecting cardiovascular disorders are reviewed by Rafanelli’s group. In this chapter, the role of ‘classic’ (stressful life events, depression, anxiety, anger, and hostility) and DCPR-related (demoralization, health anxiety, irritable mood, type A behavior, and denial) psychological factors are discussed in relation to coronary heart disease, essential hypertension, congestive heart failure, heart transplantation, coronary artery bypass grafting, and cardiac rehabilitation. In the subsequent chapter, Picardi and Pasquini review the psychological factors (demoralization, type A behavior, secondary somatic symptoms, irritable mood, and health anxiety) that influence dermatological conditions such as alopecia areata, atopic dermatitis, psoriasis, and vitiligo. The skin is a sensory organ involved in socialization processes, which is responsive to various emotional stimuli, and affects an individual’s body image and self-esteem. The last two chapters are concerned with two areas closer to psychiatry. Bellomo’s group highlights findings on psychological factors in the setting of consultation-liaison psychiatry and Fassino and colleagues discuss issues of patients with eating disorders. Both conditions have important biological and psychiatric determinants involved in the presentation and the treatment of symptoms and require a multidisciplinary approach in order to provide highly integrated management. Finally, two appendices report the complete list of criteria for the 12 DCPR categories and the structured interview for their assessment.
The goal of this volume is to provide the best tools in diagnosing psychosocial correlates of medical disorders. The distinct DCPR categories are consistent with concepts expressed by a large body of research and outstanding authors in psychosomatic medicine and are therefore suggested as specifiers of ‘psychological factors affecting medical conditions’ in the future DSM-V. The aim of the DCPR is to translate psychological characteristics observed in various medical settings into operational criteria, which may entail clinical value, and may be studied across disorders, regardless of their supposed functional or organic nature. The review papers included in the present volume strongly support the use of the DCPR in medical settings and hopefully will generate interest for a more effective clinical practice.

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