Commentary and Perspective

From time to time, the Journal receives manuscripts that can be thought of as opinion pieces, essays, or editorial comment on matters of topical interest. Such submissions will be refereed in the usual fashion and, if suitable, published in this section. The Editorial Board invites Letters to the Editor or rebutting commentary with the understanding that all submissions are subject to editing.

Physical Factors Affecting Psychiatric Condition
A Proposal for DSM-IV

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Abstract: *A new diagnostic category, "Physical Factors Affecting Psychiatric Condition," is proposed for inclusion in the DSM-IV. In addition, there should be a new category called "Chronic Adjustment Disorder." Psychiatric syndromes meeting Axis I or Axis II criteria that arise as an emotional reaction to a chronic or episodic physical illness or disability should be subsumed under the diagnosis of "Physical Factors Affecting Psychiatric Condition—Specific Axis I or II syndrome." Psychiatric symptoms that do not meet other Axis I or Axis II criteria should be diagnosed as "Chronic Adjustment Disorder." These categories will be especially useful in consultation-liaison settings.*

Introduction

The advent of DSM-III and DSM-III-R has improved psychiatric nomenclature considerably in terms of precision and clarity [1,2]. The multiaxial system has been very useful in educating nonpsychiatrists to the fact that psychiatric conditions often coexist with medical conditions or are secondary to them, as in organic mental disorders. However, consultation-liaison psychiatrists often encounter situations, for which there is no appropriate diagnostic entity in DSM-III-R. Though the diagnosis of adjustment disorder might be appropriate for some of these conditions, DSM-III-R specifically excludes from the adjustment disorder category any condition that has a duration of more than 6 months. Furthermore, DSM-III-R excludes from adjustment disorders any syndromes that meet the diagnostic criteria for other major psychiatric disorders, such as mood disorders and anxiety disorders. Therefore, I propose that a new diagnostic entity be included in DSM-IV called "physical factors affecting psychiatric condition," and, further, that the adjustment disorders include a new subcategory called "chronic adjustment disorder." I propose that following the diagnosis of physical factors affecting psychiatric condition (fictitious DSM-IV code 999.xx:), the last digits could specify chronicity and degree of contribution. This diagnosis would end with a colon, after which the Axis I or II diagnosis should be specified, and the physical condition should be specified following a hyphen (e.g., moderate major depression precipitated and maintained by lung cancer would be 999.23: 296.22-lung cancer). For chronic adjustment disorder (fictitious DSM-IV code 888), I propose the DSM-III-R convention of specifying the type as an extension of the code, followed by a hyphen and the physical illness (e.g., chronic adjustment disorder with anxious mood precipitated and maintained by lung cancer would be 999.21: 888.24-lung cancer). ICD-10 diagnostic code might be used following the hyphen in lieu of spelling out the physical illness, as necessary.

Case Reports

Case 1

A 46-year-old married man with a 9-year history of multiple sclerosis was referred to the psychiatrist for suspected depression. The patient had become progressively more depressed after losing his job 3 years ago because of increasing disability, which resulted in his being wheelchair bound. Currently, the patient feels hopeless and worried and has low self-esteem but

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has no neurovegetative symptoms of depression. He has become irritable of late, with angry outbursts from time to time. Since the loss of his job, he has been staying at home most of the time, resulting in marital discord with his wife, who also stays at home. He is not currently receiving any medications.

Discussion

In this case, the patient clearly shows some elements of depression without fulfilling the criteria for major depression. The presence of a psychosocial stressor (diagnosis of multiple sclerosis, physical disability) might argue for an adjustment disorder, but DSM-III-R specifically excludes this diagnosis if the reaction has persisted for longer than 6 months. One might stretch the point and argue that as the stressor (multiple sclerosis) is continuing, the patient might still be adjusting, but DSM-III-R indicates that even when stressors are continuing, a new level of adjustment is expected within 6 months. Organic affective syndrome might be considered, but the patient's symptoms are more likely a reaction to the consequences of the physical illness (disability, inability to work, and so forth) rather than a direct effect of multiple sclerosis on the brain. Proposed diagnosis: physical factors affecting psychiatric condition: chronic adjustment disorder with depressive features-multiple sclerosis (999.23: 888.00-multiple sclerosis).

Case 2

A 35-year-old single, employed woman with ulcerative colitis of many years' duration was referred to the psychiatrist for suicidal ideation. The patient showed depressed mood, hopelessness, helplessness, low self-esteem, psychomotor retardation, anhedonia, sleep disturbance, and weight loss (which might have been related to ulcerative colitis as well). She felt despondent about her poorly controlled medical condition, and she refused to undergo total colectomy. On careful questioning it was established that she had developed symptoms of depression each time there was an exacerbation of her colitis. There was no family history of mood disorders.

Discussion

Her current symptomatology met all the diagnostic criteria for major depression. Of course, it could be argued that the depressive episode was initiated by the exacerbation of her ulcerative colitis, but again, the depression was a psychological reaction to it rather than a direct effect of ulcerative colitis on the brain (although ensuing fatigue, electrolyte imbalance, and so forth, may have secondarily contributed to the depressive syndrome). Though adjustment disorder may again be considered, DSM-III-R clearly excludes from adjustment disorder syndromes that meet the diagnostic criteria for mood disorder. Thus, the precise diagnosis for this syndrome would be depressive episode, that is, an emotional reaction to an exacerbation of a physical condition (ulcerative colitis). A better diagnosis would be physical factors affecting psychiatric condition: depressive syndrome-ulcerative colitis (999.23: 296.33-ulcerative colitis). In using the term "depressive syndrome," I am adopting the notion of a psychiatric syndrome as a final common pathway [3].

Case 3

A 57-year-old married man who had suffered a myocardial infarction (MI) 3 years ago was referred to the psychiatrist for suspected depression. Although he had recovered from the MI, he continued to have rather severe angina pectoris, inadequately controlled by medications. Shortly after the MI, he sold his prosperous business and became a "hermit," spending most of his days watching videotapes and relating very little with his family and friends. On psychiatric examination, the patient was noted to be discouraged about his continuing angina that he felt would eventually kill him. Of note is that his father had also suffered from angina and had died at the age of 59 of an MI.

Discussion

Though there were clearly depressive features, the patient's symptomatology did not meet the criteria for major depression. He was worried and generally upset, but the anxiety features did not warrant the diagnosis of a specific anxiety disorder. More striking was his personality change—from active and outgoing to reclusive. I believe this is an example of physical factors affecting psychiatric condition: chronic adjustment disorder with personality change and depressive symptoms-angina pectoris (999.23: 888.40-angina pectoris).

Case 4

A 68-year-old woman was referred to a psychiatrist for general anxiety and "panic attacks" following a fainting episode some 8 months ago. The patient developed

increasingly frequent syncopal episodes, which contributed to her fears of dropping dead, with increasing frequency of the panic episodes, resulting in her being confined at home with fear of being outside alone. The panic attacks occurred at least two or three times a week now, and included the associated symptoms of sweating, shortness of breath, numbness, fear of dying, trembling and shaking, and some dizziness. The panic attacks were not usually associated with the syncopal episodes. A careful medical work-up revealed Stokes-Adams syndrome.

Discussion

The patient's symptomatology met all the diagnostic criteria of panic disorder with agoraphobia. Nevertheless, the age of onset and the course of the anxiety disorder clearly indicate that the symptoms of Stokes-Adams syndrome were instrumental in the patient's psychiatric symptomatology, while the atrioventricular node dysfunction by itself was not the physiologic cause of the psychiatric symptoms. Adjustment disorder would not be an appropriate diagnosis as the criteria existed for another Axis I diagnosis (panic disorder with agoraphobia). Proposed diagnosis: physical factors affecting psychiatric condition: panic disorder with agoraphobia-Stokes-Adams syndrome (999.23: 300.21-Stokes-Adams syndrome).

Case 5

A 70-year-old man on the surgical unit was referred to the psychiatrist for suspected depression. The patient had been admitted to the hospital about 2 months before with a hip fracture and had undergone hip replacement surgery. His postoperative course was complicated with fever, anorexia, weight loss, and dysphagia. He had lost approximately 30 pounds during the hospitalization. The consultation was precipitated by the patient's refusal to swallow food. Although he was now afebrile with no apparent cause for the severe anorexia, the only way the patient was sustained at this point was by tube feeding. On psychiatric examination, he stated that he had choked several times in the previous weeks in attempts to swallow food. Part of the problem, as it turned out, was that his dentures no longer fit because of his weight loss, which made it painful for him to chew adequately and difficult to swallow the inadequately chewed food, therefore he choked. After several attempts of this kind, the patient woke up several times at night in terror as he felt himself choking on his saliva. He had, in fact, developed a phobia of swallowing, including liquids and water. There was no evidence of depression.

Discussion

The patient fulfilled all the diagnostic criteria for a simple phobia, including intense anxiety when asked to swallow and avoidance of any situations requiring swallowing, necessitating tube feeding and continued hospitalization; he recognized that his fear was excessive and unreasonable. In this case, the patient's phobia was directly related to his experience of choking, that were, in turn, caused by weight loss that caused his dentures not to fit properly. Desensitization treatment and new dentures cured the patient's phobia in several months. The appropriate diagnosis for this patient would be physical factors affecting psychiatric condition: simple phobia of swallowing- Masticatory difficulty due to ill-fitting dentures (999.14: 300.29-masticatory difficulty due to ill-fitting dentures).

Discussion and Conclusion

DSM-III-R has a very useful diagnostic category—psychological factors affecting physical condition. DSM-III-R is deficient in that it does not have a comparable nomenclature for physical factors affecting mental condition. I propose that the addition of the category "physical factors affecting psychiatric condition" would not only provide a nice symmetry, but would also emphasize the fact that physical conditions often affect the mental and emotional states of patients in ways different from organic mental disorders, and in the full spectrum of psychiatric symptomatology from minor adjustment disorders to specific major psychiatric syndromes on Axis I or II.

Similarly, the category of adjustment disorders should be broadened to include chronic adjustment to chronic or recurring stressors. The category of adjustment disorder in DSM-III-R is a time-limited, subthreshold disorder. I believe that there is clearly a subset of adjustment disorders that are *not* time limited. On the other hand, it is my opinion that the subthreshold nature of adjustment disorders should be preserved in DSM-IV; that is, adjustment disorder should not be diagnosed if the disturbance meets the diagnostic criteria for a specific mental disorder such as anxiety or mood disorder. Once a disorder meets the diagnostic criteria for a specific syndrome, there is usually an autonomous course that must be treated with specific interventions, no matter what may contribute to the etiology. Thus, a depressive syndrome (major depression) is a final common pathway entity that calls for careful eval-

uation and usually psychopharmacologic treatment, whether it is caused by an environmental stressor such as bereavement, adjustment to recurrent physical illness, or severe genetic loading.

My proposal is conceptually similar to Fogel's [4] in that it indicates the psychiatric syndrome in Axis I and the specific contributing physical condition in Axis III, but goes further by creating a separate category in Axis I (physical factors affecting psychiatric condition), and by indicating both the physical factors and the psychiatric conditions in Axis I.

The assignment of the dual diagnoses of physical factors contributing to psychiatric condition and the Axis I or II diagnosis (and specifying the association between the psychiatric syndrome and the physical illness by a hyphen) will facilitate research, especially in consultation-liaison settings. The research questions would include: What physical illness contributes to which Axis I and II conditions, and to what degree? What are the best pharmacologic, psychologic, and environmental treatment modalities for these specific conditions? In what way is chronic adjustment disorder to one physical illness different from another? (and so forth).

For those psychiatric symptoms and conditions that do not meet the criteria for specific mental disorders, the diagnosis of adjustment disorder would be appropriate. However, adjustment to physical disease/disability, which is often chronic or episodic, deserves separate consideration from adjustment to an external psychosocial stressor. In fact, some such adjustment reactions to physical conditions may be unavoidable, and even adaptive, unlike adjustment disorders to external stressors. Maladaptive denial of physical illness [5] might be another subcategory of chronic adjustment disorder. Making the diagnosis of physical factors affecting psychiatric condition, and specifying the condition to be chronic adjustment disorder, and further specifying the physical illness as a part of the diagnosis will enhance the objectives of the DSM-IV approach of precision in chronicity, severity, and the relationship between the psychiatric and physical illnesses.

Should Axis III include the physical illness specified in Axis I? I believe the answer is yes, it should include all medical illness, whether it contributes to the Axis I psychiatric diagnosis or not. Axis III simply provides information concerning the biological/medical dimension of the patient, which serves as a consideration in managing the patient. The physical illness specified after a hyphen in Axis I, however, should be integrated in the treatment plan of the psychiatric disorder.

What about patients who have both a major psychiatric disorder and adjustment problems to a physical illness? If a major psychiatric disorder develops within a specified period of the onset of a chronic physical illness, the index of suspicion for physical factors affecting psychiatric condition should be raised. As my proposal lists both diagnoses, the presence of the major psychiatric syndrome will be apparent even if there may be some disagreement among clinicians concerning just how much the physical factors contribute to the major psychiatric syndrome.

What about patients with a preexisting major psychiatric disorder such as bipolar major depression who develop a physical illness that, in turn, contributes to the psychiatric symptomatology, which may or may not be identical to the preexisting symptoms (e.g., severe anxiety and change in behavior in addition to depression)? My proposal will clearly indicate this relationship by first listing the preexisting psychiatric diagnosis, followed by the physical factors . . . diagnosis; for example, bipolar disorder, depressed, physical factors affecting psychiatric condition: chronic adjustment disorder with mixed disturbance of emotions and conduct-multiple sclerosis (296.52, 999.23: 888.40-multiple sclerosis). In this case, this patient would have both specific psychiatric disorder and adjustment disorder diagnoses, which are clearly justified because of the specific nature of the patient's present conditions.

What about patients with chronic neurologic disease (e.g., Parkinson's disease), in which the distinction between organic mood disorder and mood disorder due to adjustment difficulty may be difficult or impossible to make? My proposal would call for making both diagnoses. Recognition of the potential etiologic role of the neurologic condition would lead to vigorous treatment of the underlying condition, and recognizing the adjustment difficulties to the chronic condition would lead to mobilization of supportive resources and rehabilitation efforts.

The multiaxial approach of DSM-III has helped clinicians veer away from an either-or approach and encouraged physicians to understand that psychiatric conditions often coexist with physical illness. In DSM-IV, I believe we should advance one more step by specifying the relationship between a psychiatric syndrome and a physical illness when such a relationship exists. The recognition that adjust-

ment disorders can be chronic, and the creation of a new category, "physical factors affecting psychiatric condition," would be one such step.

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