Anxiety and Psychosomatic Illness
The Problem of Classification

Since the DSMIII no longer classifies illness as psychosomatic, we must immediately redress the title of this paper (1). Rather than using the term psychosomatic illness, the new classification would list the specific psychiatric disorder as the primary diagnosis (Axis I) and the co-existing pathophysiologic disorder under Axis III. As an example, in a patient with mitral valve prolapse accompanied by panic, the Axis I would be anxiety disorder (panic disorder) and the Axis III would be Psychological Factors affecting Physical Condition. Such classifications tend to eschew a specific or directional relationship between the two. The wisdom of this causal-directional separation is questionable. To a large extent, it tends to disestablish the specificity theories that dominated earlier concepts regarding the psychogenicity of specific diseases such as Alexander's holy seven: ulcerative colitis, rheumatoid arthritis, hyperthyroidism, hypertension, peptic ulcer, bronchial asthma, neurodermatitis (2). In so doing, it may once and for all abolish the idea that some diseases are more psychosomatic than others. Rather, the new classification would allow the idea that any illness, mental or somatic, may be accompanied by symptoms relative to one or the other. Thus, the patient with a parimary affective disorder with vegetative symptoms and signs is as likely to be viewed as somatic as well as mental in his assessment, diagnosis and treatment. On the other hand, a patient with symptoms and signs of ulcerative colitis might have manifestations of anxiety which would be identified respectively in Axes III and I. The relationship of
anxiety to ulcerative colitis might be generative, derivative, or independent of the latter. Each, however, is treatable in its own right, a practice that has preceded the above formulation.

DSMIII goes further in its dissective identification of mental and somatic disorders in as much as it takes cognizance of the setting in which illness develops and is frequently treated (Axis IV), the assessment of the severity of psychosocial stress. This axis allows for the identification of environmental and social factors that may have a bearing on the illness, either in terms of its development or in terms of its consequence, that is, its affect on the patient, his family or significant others. A fifth Axis urges the formulation of a prognosis especially for the mental disorder, but could be requested as easily for the somatic and the social dysfunction. A second axis gives cognizance to personality disorders and/or developmental disabilities that are assumed to relate in some way to the manifestation of the Axis I disorder. To some extent, the problem-oriented record approach to the patient developed by Larry Weed and others identified a similar formulation of somatic signs and symptoms (illness) (3).

The significance of both these schemes is in their design to give greater descriptive and temporal dimension to the multiple facets of illness. As a consequence, they emphasize the contemporary biopsychosocial approach to the patient formulated by George Engel and other psychosomaticists as they began to explore the social, as well as the psychological and biological dimensions of illness (4, 5). While formulations regarding the mental disorders have begun to emphasize the biological, there has been a simultaneous redirection by many physicians concerned with somatic processes toward the psychosocial aspects of illness.

The Identification of Affects and their Origins

Thus, affects and emotional states have been identified as aspects of all somatic processes. Frequently, these are of such intensity and duration as to require further assessment and treatment in their own right. At times, it is truly difficult to separate the affect from the somatic process in terms of whether the symptoms are derivative or generative of it. In considering the role of affects in illness, it is first necessary to depart from our previous preoccupation with anxiety as the basic and/or only affect resulting in or developing from somatic processes. We have gradually come to see depression as an affect with its somatic processes equaling that of anxiety in both prevalence and intensity. Although other affects and affect states may and should be considered, these two are most easily identified and assessed at the present time. A discussion of them will suffice for our present consideration. To a considerable extent, each one is associated with other states and