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Freedland, K.E.; de Geus, E.J.C.; Golden, R.N.; Kop, W.J.; Miller, G.E.; Vaccarino, V.; Brumback, B.; Llabre, M.M.; White, V.J.; Sheps, D.S.

published in

Psychosomatic Medicine
2009

DOI (link to publisher)

[10.1097/PSY.0b013e3181954848](https://doi.org/10.1097/PSY.0b013e3181954848)

[Link to publication in VU Research Portal](#)

citation for published version (APA)

Freedland, K. E., de Geus, E. J. C., Golden, R. N., Kop, W. J., Miller, G. E., Vaccarino, V., Brumback, B., Llabre, M. M., White, V. J., & Sheps, D. S. (2009). What's in a name? Psychosomatic medicine and biobehavioral medicine. *Psychosomatic Medicine*, 71(1), 1-4. <https://doi.org/10.1097/PSY.0b013e3181954848>

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What's in a Name? Psychosomatic Medicine and Biobehavioral Medicine

This issue marks the 70th anniversary of the founding of *Psychosomatic Medicine*. It is also the inaugural issue for adding, *Journal of Biobehavioral Medicine* as our new subtitle. Why, after 70 years of successful publication, does our journal now have a subtitle? Why was this particular subtitle chosen? And what does this change mean for the future of the journal?

In their introductory editorial in January 1939 (1), Helen Flanders Dunbar and her associate editors¹ noted that “psychosomatic medicine” was a new term that was not yet well known in the medical community. They expressed concern that it could lead to misconceptions and misunderstandings unless it was clearly defined. They defined it as the study of the “. . . interrelation [of] the psychological and physiological aspects of all normal and abnormal bodily functions . . .” They rejected mind-body dualism in psychosomatic medicine, asserting that “. . . the complex neurophysiology of mood, instinct, and intellect differs from other physiology in degree of complexity, but not in quality,” and that “. . . psychic and somatic phenomena take place in the same biological system and are probably two aspects of the same process . . .”

The contents of the first issue of *Psychosomatic Medicine* reflected this perspective, and today's readers would find that some of the articles in that issue concerned surprisingly contemporary topics.² For example, it included an article on the role of hostility in essential hypertension (2) and a review of experimental research on the structure and functions of the hypothalamus (3). Thus, from its very beginning, *Psychosomatic Medicine* has been publishing articles on the roles of the central and peripheral nervous systems, and of psychological, behavioral, and social variables, in the development and progression of cardiovascular disease, diabetes, obesity, cancer, and other serious medical conditions.

While rejecting mind-body dualism, the original editors embraced two other kinds of dualism. One of them pertained to the types of medical conditions and outcomes that were considered to be within the field's and the journal's domain. In addition to papers on relatively “hard” medical outcomes, such as cardiovascular disease, early volumes also included articles on “soft” outcomes, such as conversion hysteria and functional gastrointestinal complaints (4). In the ensuing

years, many other papers also focused on similar problems, such as chronic pain, somatoform disorders, and unexplained somatic symptoms, such as chronic fatigue (5).

The other kind of dualism concerned the psychiatric and psychological factors that were thought to be plausible explanations for the outcomes of interest. Some were observable phenomena, or at least were measurable via self-report questionnaires, psychophysiological instruments, human or animal experiments, or other objective techniques; were reasonably familiar to nonpsychiatric physicians and laypeople; and could be readily described in common sense terms. Examples included factors, such as hostility (2), frustration (6), tension (7), depression (7), and various types of overt behavior (8). Others were unobservable psychoanalytic constructs that were more obscure for nonpsychiatrists, such as intrapsychic conflict (9), oral dependence (10), and hypertrophied conscience (11).

Over the years since our founding, the relatively soft and obscure strands of psychosomatic medicine have, unfortunately, helped to foster some of the misconceptions and misunderstandings that our founders hoped to prevent. The term “psychosomatic” has acquired a variety of meanings, and some of them are quite negative. For example, a 1994 survey of newspapers in the United States and the United Kingdom found that, out of 215 articles in which the word “psychosomatic” was mentioned, 34% used it in a stigmatizing, pejorative manner; it often connoted a symptom or condition that was considered to be imaginary, unimportant, malingered, or due to a character flaw (12). “Psychosomatic” also carries negative connotations for many laypeople (13) as well as for many physicians and nurses (14,15), especially in some countries and cultures. In addition, psychosomatic complaints figure prominently in a substantial proportion of the clinical encounters with which many physicians would rather not have to contend, i.e., those with “difficult patients,” “frequent attenders,” and “excessive utilizers” (15–23). Some patients who are dismissed as presenting baseless psychosomatic complaints, actually have unrecognized medical conditions, such as hypothyroidism (24), but this fact does little to burnish the image of psychosomatic disorders among physicians.

Regardless of the negative reactions that these phenomena may elicit from some quarters, they continue to have a substantial impact on patients' quality of life and on their patterns of healthcare utilization (25,26). We still publish some of the best articles on somatoform disorders, chronic fatigue syndrome, chronic pain, etc. (24,27,28), and will continue to do so. In recent years, however, interest in these disorders has been eclipsed by “hotter” topics, in terms of the manuscripts we receive, the ones we publish, and the ones that have the highest impact. For example, we have published numerous articles on the genetic substrates of psychological phenotypes,

¹Franz Alexander (Associate Editor for Psychoanalysis), Dana W. Atchley (Internal Medicine), Stanley Cobb (Neurology), Hallowell Davis (Physiology), Clark L. Hull (Psychology), Howard S. Liddell (Comparative Physiology), Grover F. Powers (Pediatrics), and Theodore P. Wolfe (Reviews). In addition to serving as the first Editor-in-Chief of *Psychosomatic Medicine*, Dr. Dunbar was one of the founders of the American Psychosomatic Society, the journal's owner.

²The full text of every issue of *Psychosomatic Medicine*, dating back to January 1939, is available online at www.psychosomaticmedicine.org.

DOI: 10.1097/PSY.0b013e3181954848

such as anger, stress, and depression and their relationships with cardiovascular disease (29–34); on psychoneuroimmunological factors in medical illness (35–49); and on neuroimaging studies of depression and other health-related manifestations of affective dysregulation (50–52). Some of the most frequently cited articles that have been published in this journal in recent years concern depression, hostility, or hopelessness as predictors of medical morbidity and mortality in heart disease, diabetes, or cancer (53–59).

During the tenure of our current Editor-in-Chief, one of our goals has been to increase the journal's impact and readership among nonpsychiatric physicians and scientists. Unfortunately, the negative attitudes about most psychosomatic phenomena that pervade the medical community have been a significant impediment to achieving this goal. We have had, for example, informal discussions with a number of nonpsychiatric physicians who have never read this journal or who have never even heard of it. When asked to guess what sorts of articles we publish, most of the answers have focused on somatoform disorders, difficult patients, excessive healthcare utilization, etc.

Consequently, we decided to conduct a more systematic survey of faculty physicians at two university medical centers in the United States. The survey provided the respondents with a list of some of the most highly cited articles from recent volumes of the journal, most of which had little or nothing to do with somatoform disorders, difficult patients, or excessive utilization of health services. We then provided a list of three possible titles for a journal that publishes such articles and asked, "In your opinion, which of the following titles would best fit a journal that publishes this type of research? Please rank each title 1, 2, or 3 in order of your preference." The titles, in the order they were most frequently ranked, were *Biobehavioral Medicine*, *Biopsychosocial Medicine*,³ and *Psychosomatic Medicine*.

Around the same time, specialists in consultation-liaison psychiatry decided to change the name of their field to psychosomatic medicine, and psychosomatic medicine was designated by the American Board of Neurology and Psychiatry as an official psychiatric subspecialty.⁴ Psychiatrists are one of our core constituencies, but *Psychosomatic Medicine* is a multidisciplinary journal rather than one that identifies primarily with the psychiatric subspecialty of psychosomatic medicine (in contrast to *Psychosomatics*, the official journal of the Academy of Psychosomatic Medicine). Furthermore, there is considerable overlap between the interests of subspecialists in psychosomatic medicine and the contents of *Psychosomatic Medicine*, but they are not completely identical.

The results of our survey, and the elevation of psychoso-

matic medicine to the status of an official subspecialty, prompted us to consider changing the title of the journal, or, alternatively, keeping the title but adding a new subtitle. It is not easy to change the title of a scientific journal, especially one that has been in existence for decades. Even if a new title might be more fitting than the old one, changing it can have adverse consequences. If implemented too abruptly, such a change could, for example, offend some of the journal's most loyal subscribers and contributors, and it could cause a temporary decrease in the journal's impact factor. With that in mind, the editors recently proposed to give *Psychosomatic Medicine* a subtitle, *Journal of Biobehavioral Medicine*, rather than replacing the former with the latter, at least for now.

"Biobehavioral" is defined in Merriam-Webster's Medical Dictionary as: "of, relating to, or involving the interaction of behavior and biological processes," and in the American Heritage Medical Dictionary as: "of or relating to the interrelationships among psychosocial, behavioral, and biological processes, as in the progression or treatment of a disease." It is not a new term; it appeared in the medical literature in the early 1970s (60,61), and possibly even before then. Since then, it has been used in numerous scientific articles pertaining to the roles of stress, emotion and mood, social isolation, behavioral patterns, personality traits, neurobehavioral structures and functions, genetic factors, and other psychosocial and behavioral characteristics in conditions such as cardiovascular disease (62–72), cancer (73–75), smoking (76), aging (77–79), and HIV/AIDS (48,80). It tends to connote a focus on observable or measurable independent variables, on surrogate (e.g., transient arrhythmia) or hard (e.g., myocardial infarction) medical outcomes, and on behavioral (e.g., nonadherence) or biological (e.g., inflammatory) mediators. In short, it is the best available adjective for some of the best research we have been publishing, and for the kind of articles we want to attract.

After giving our proposal due consideration, the Council of the American Psychosomatic Society approved the new subtitle at their fall 2008 meeting. In doing so, they helped the Society's journal reach out to the broader medical community, better positioned us vis-à-vis the new subspecialty of psychosomatic medicine, and took an initial step toward reconciling the journal's identity with its 21st century content.

Some day in the not-too-distant future, this journal may no longer be called *Psychosomatic Medicine*. It may eventually become *Biobehavioral Medicine*, or perhaps *The Journal of Biobehavioral Medicine*. That is for a future Council to decide. But regardless of what this journal calls itself, it is, and it has been for the past 70 years, the world's premiere journal of biobehavioral medicine.

Note to Readers

We are interested in your reaction to our new subtitle, and in your thoughts on whether the journal's main title should remain the same or eventually be changed. Please e-mail your comments to PsychosomaticMedicine@gmail.com.

³After completing the survey, we learned that the Japanese Society of Psychosomatic Medicine had recently launched a journal named *Biopsychosocial Medicine*.

⁴Psychiatrists who subspecialize in psychosomatic medicine have expertise in the diagnosis and treatment of psychiatric disorders in "complex medically ill patients." This definition of medical illness includes conditions such as stroke, heart disease, and diabetes; somatoform disorders; and psychiatric syndromes that are due to the direct, physiological effects of a medical illness.

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