1. Various attempts have been made to formally classify psychiatric disorders, the two major systems being:

   1.1. The **ICD-10 Classification of Mental and Behavioural Disorders** (World Health Organisation, Geneva) is part of the 10th edition of the International Classification of Disease. This appendix follows the common abbreviation of **ICD-10**. It is the international system used by the majority of clinical psychiatrists in Great Britain.

   1.2. The **Diagnostic and Statistical Manual of Mental Disorders (fourth edition)** (American Psychiatric Association Washington DC). References to it in this appendix follow the common abbreviation of **DSM-IV**. It is a system devised mainly by and for workers in the USA, however UK psychiatrists were consulted in its formulation.

2. The two systems above have been in existence for many years but only in their current editions have they been closely comparable.

3. This appendix summarises the generally recognised clinical features and aetiology of the somatoform disorders, namely hypochondriacal disorder, somatoform autonomic dysfunction, persistent pain disorder, somatisation disorder and undifferentiated somatoform disorder.

4. This appendix is generally based on the ICD-10 system with any major comparisons and distinctions with DSM-IV being discussed where relevant. The ICD codes (a number which is usually prefixed by the letter F) are also provided.

DEFINITION

5. The somatoform disorders are conditions in which the main feature is the repeated presentation of physical symptoms in spite of negative findings and reassurances by doctors that the symptoms have no physical basis. Physical symptoms are in this case an expression of psychological disorder: this relationship is known as somatisation. Many physical complaints may be transient or respond to an explanation of the benign nature of their origin, however occasionally they may persist and form a somatoform disorder.

HYPOCHONDRIACAL DISORDER F45.2

including body dysmorphic disorder (dysmorphophobia)

6. Hypochondriacal Disorder is a mental disorder as distinct from “hypochondriasis”, the “hypochondriacal attitude” or “hypochondriacal personality”, these encompassing a continuum of beliefs regarding an over-concerned and overprotective view of health and feelings of vulnerability to disease. It is not known whether the presence of this attitude or personality type is a risk factor in the development of hypochondriacal disorder, this being an intense and prolonged fear of either having or developing a disease.

Clinical manifestations

7. The main feature of hypochondriacal disorder is the anxious preoccupation with the possibility of having one or more serious physical (or more rarely, mental) illnesses.

8. There are two general forms of the disorder, one in which the patient is convinced of disease being present, the other being the fear of developing a disease (disease phobia or nosophobia).

9. In both forms however the patient constantly seeks medical reassurance, often from many differing sources as there is a conviction that the diagnosis has been missed or that any newly noticed aspect of the body and its function are indicators of disease. However any reassurances given have only a temporary effect.

10. Features of depression and anxiety are very common and may assume and intensity which merits a separate additional diagnosis.

11. In hypochondriacal disorder the belief is very firmly held but never of delusional intensity ie the patient can be persuaded that the symptoms are innocuous. (A delusion being an unshakeable belief which is firmly held but on inadequate grounds, is not affected by rational argument or contradictory evidence and is not a conventional belief held by those of the same cultural background). If the belief **does** constitute a delusion then the condition is classified in the “persistent delusional disorders” and not under hypochondriacal disorder.

12. **Body dysmorphic disorder (dysmorphophobia)**

    This is a conviction that a part of the body is abnormal in appearance, but is not diseased. It often centres on the nose, ears or the sexual organs. This diagnosis is included in hypochondriacal disorder in the ICD-10 but has a separate diagnostic category in DSM-IV. The individual becomes very conscious of the “offending” part and activities may be curtailed in order to avoid being seen in public.

Diagnostic Criteria for hypochondriacal disorder ICD-10

13. There is a persistent belief of at least 6 months duration of no more than two serious physical diseases at least one of which is named by the patient OR there is persistent preoccupation with a presumed deformity or disfigurement (body dysmorphic disorder). The beliefs must cause distress or impair functioning and cause the patient to seek medical help. There is persistent refusal to accept medical reassurance that there is no physical cause for the symptoms (short term acceptance of the reassurance does not exclude the diagnosis).

14. The diagnostic criteria in DSM-IV are roughly similar to ICD-10 with the addition that “appropriate physical evaluation does not support the diagnosis of any physical disorder”.

SOMATOFORM AUTONOMIC DYSFUNCTION F45.3

Clinical manifestations

15. In this disorder the patient presents with symptoms of an organ or system which is largely or completely under autonomic control, (ie is outside the normal conscious level of control) which the patient attributes to a physical disorder.

16. The symptoms are of two types, neither of which indicates a physical disorder of the system concerned. The first type is characterized by objective signs of autonomic arousal such palpitations, sweating, flushing and tremor. The most common are:

    16.1 the cardiovascular system ("cardiac neurosis" and the formerly termed Da Costa's syndrome or effort syndrome)

    16.2 the respiratory system characterised by psychogenic hyperventilation.

    16.3 the gastro-intestinal system characterised by symptoms such as "nervous diarrhoea" and some forms of irritable bowel syndrome.

    16.4 The second type comprises nonspecific symptoms such as fleeting pain, burning and tightness, the patient referring these to a specific organ or system.

17. In some of these disorders consequent minor disturbance of physiological function may be present, such as hiccup, flatulence and hyperventilation however these do not disturb the essential physiological function of the organ.

Diagnostic criteria

18. **ICD-10**

    Symptoms of autonomic arousal that are attributed to one of the following systems: the heart and cardiovascular system, upper and lower gastro-intestinal tract, the respiratory system and the genito-urinary system. Two or more of the following must be present: palpitations, sweating, dry mouth, flushing, epigastric discomfort, "butterflies" or churning and in addition one or more of the following: chest pains or discomfort, excessive tiredness on minor exertion, aerophagy, hiccup, reported frequent bowel movements, increased frequency of micturition, feeling bloated or distended. There is no evidence of disturbance of function of the organ about which the patient is concerned.

19. **DSM-IV**

    There is no equivalent diagnosis in this system, however these symptoms are included under the category of hypochondriacal disorder.

PERSISTENT SOMATOFORM PAIN DISORDER F45.4

Clinical manifestations

20. The patient complains of severe and persistent pain which is inconsistent with, and cannot be explained by, physiological or anatomical factors or by a physical disorder. The condition is characterised by a **prolonged** presentation; transient conditions such as tension headaches do not fall within this category.

21. The onset of pain may occur in close time relationship to an emotionally distressing event or psychosocial conflict.

22. The patient usually refuses to consider the psychological nature of the cause of pain and a past history of conversion symptoms is sometimes seen.

23. Symptoms of depression may be present however their presence is variable. Where pain and clear depressive symptoms occur simultaneously, treatment with antidepressants or ECT often removes both the depression and the pain. It is most probable that this scenario represents primarily a depressive disorder. However in those cases in which the pain symptoms considerably pre-date the onset of depression, treatment of the depression does not inevitably relieve the pain although some improvement may occur. (It has been noted that this group shows more obsessionality, anxiety and rigidity and lack evidence of secondary gain).

24. Some people who have long standing symptoms may develop a specific presentation which presents many difficulties for management. It is characterised by an obsession with the perceived pain which dominates most aspects of the individual's life. They are acutely aware of the pain almost all of the time focusing on the pain, often rubbing the site or checking the painful area. They become overdependent on analgesics instead of finding better ways of coping with the pain. In some cases the patient becomes preoccupied by feelings of rejection and bitterness due to their perceived lack of interest by the medical profession. The individual often becomes an invalid and loses any function they may have had due to disuse and refusal to make any efforts to function despite the pain. They are often extremely demanding of their family, expecting to be waited on and may become tyrannical. They often complain that no-one can understand how they feel and believe their pain is the worst thing anyone has had to bear. Those with no detectable organic pathology can be extremely difficult to manage, relatives often believing that "something has been missed" as the pain is apparently so severe. This attitude confirms the sufferer's beliefs and also produces a willing cohort of servants, which often serves to compound the problem. Some have termed this the "chronic pain personality".

Summary of Diagnostic Criteria ICD-10

25. Complaints of persistent, severe pain for at least 6 months in any part of the body which cannot be adequately explained by physiological processes or physical disorder: it may be diagnosed only during a mood disorder, somatisation disorder or hypochondriacal disorder or where there is no other identifiable disorder such as schizophrenia.

Summary of Diagnostic Criteria DSM-IV

26. There is preoccupation with pain for at least six months and either there is no underlying pathology, OR where there is related pathology the pain or impairment is grossly in excess of what would be expected from the physical findings.

SOMATOFORM DISORDER UNSPECIFIED F45.9

27. This category is used when the full criteria for any of the above conditions are not met.

SOMATISATION DISORDER F45

28. The main feature is that the sufferer repeatedly complains of multiple and varied physical symptoms over a considerable period of time without any demonstrable organic basis, or they complain of symptoms which are grossly in excess of any minor physical abnormality. They often consult many doctors for several years before referral to a psychiatrist is resorted to.

29. The disorder leads to disruption in social, interpersonal and family relationships and some degree of this impairment in functioning is required in order to make the diagnosis. The symptoms fluctuate in intensity and dependence on medication (analgesics or sedatives) often results from frequent courses of medication.

30. Depression and anxiety feature commonly and if they are sufficiently marked may justify an additional concurrent diagnosis. However the onset of multiple physical symptoms after the age of 40 is more likely to signify a primary depressive disorder.

31. **Summary of diagnostic criteria in ICD-10**

 31.1 There is at least for two years duration, multiple and variable physical symptoms with no detectable physical disorder.

 31.2 Preoccupation with symptoms causes distress and leads to seeking repeated (3 or more) consultations.

 31.3 There is persistent refusal to accept medical reassurance.

 31.4 At least six symptoms from at least two separate groups of the following: gastro-intestinal, cardiovascular, genitourinary, skin and pain symptoms.

32. **DSM-IV**

The main difference in DSM-IV is that the syndrome begins before the age of 30 and persists for several years, no organic pathology being present, or if there is, the symptoms must be grossly in excess of the findings. DSM-IV also requires that at least 13 symptoms from a list of 35 symptoms including vomiting, abdominal pain, nausea, bloating, intolerence of several foods, pain in extremities, joints or back, pain on micturition, shortness of breath when not exerting oneself, palpitations, chest pain and dizziness.

Briquet's syndrome

33. In the context of somatisation disorder an eponymous syndrome named after Jules Briquet (who first described the condition in 1859) exists. However to qualify for a diagnosis of Briquet's original syndrome the sufferer must be female, have the origin of symptoms before the age of 35, with over 25 symptoms to be present from nine out of ten groups of symptoms.

UNDIFFERENTIATED SOMATOFORM DISORDER F45.1

34. In those cases where physical complaints are multiple and unfounded but the typical clinical picture of somatisation disorder is not met, this category may be used. The picture may vary inasmuch as the forceful manner is lacking, the complaints may be relatively few in number or there is no impairment of social and occupational functioning.

AETIOLOGY

Factors applicable to somatoform disorders in general

35. The development of the somatoform disorders depends to a large extent on the personality and the defences individuals consequently use in the face of internal conflict, the underlying personality traits being due to a large extent to genetic factors and early development.

36. Behavioural, sociological and psychoanalytical theories have all attempted to explain the development of these defences and the subsequent disorders, many of the concepts and models incorporating various aspects of these disciplines.

Psychological theories

37. One major theory is that dangerous or threatening ideas are not dealt with directly but are shifted onto the body and this into physical symptoms. This process is unconscious and the ensuing relief of internal conflict is termed **"primary gain"**.

38. **"Secondary gain"** is the more directly observable advantages that having a symptom brings such as gaining sympathy and attention, the avoidance of the usual obligations or obtaining support both in practical and financial terms.

Illness behaviour

39. Illness behaviour is the observable actions of individuals when they experience physical sensations or symptoms of disease. This clearly differs amongst the various personality types and is related to the attitudes they subsequently hold. For example, some people are very stoical and minimise their symptoms, some dramatically display their disability, whereas others give very colourful and bizarre descriptions of their suffering.

40. Illness behaviour also differs culturally and ethnically, one of the most studied being the differences between Anglo-Saxon and Mediterranean groups in that the latter are more likely to show hypochondrial concern and be convinced of a physical origin of symptoms.

Sociological theories

The sick role

41. Parsons developed the idea of the “sick role” as a normal and frequently observed phenomenon but which, in some circumstances, may become abnormal. When someone becomes ill and the illness has been professionally sanctioned, the person is allowed to assume the “sick role”.

    With this role come concomitant advantages in that the sick person is

    41.1 Exempt from usual social obligations.

    41.2 They no longer have to work or go to school.

    41.3 They are treated with sympathy and understanding.

    41.4 They are allowed to show weakness and distress.

    41.5 It is important to note however that in order to gain these advantages they are obliged to seek appropriate help and accept treatment. They cannot be given the above four advantages if they do not comply with this as it calls into question the validity of the illness.

42. Previous experience of illness either in themselves or observed in others has an influence on the way people behave when they are ill and in this way the sick role may be a learned phenomenon with “rewards” such as time off work and being waited on by relatives, these rewards reinforcing further similar behaviours.

43. These concepts apply to many people but to differing degrees and the adoption of the sick role in the presence of disease is normal and desirable in order to optimise recovery.

44. Hypochondrial concern in some cases can be seen as a resort to the sick role in the face of stress and if mild and occasional falls within the normal range of coping mechanisms. To some people normal everyday stresses are so great that the sick role is adopted most of the time whereas to others it is only employed in the face of extreme stress when other coping strategies have failed. The degree to which these concepts are espoused largely determines whether there is a hypochondrial disorder ie an illness.

45. Less easily conceivable psychoanalytic interpretations have been propounded including the use of physical symptoms as self punishment for hostile feelings towards someone close to the individual and the withdrawal of psychic interest from others, this being redirected to the individual’s own body.

Specific aetiological factors

Hypochondriacal disorder

46. Studies have shown that pure hypochondriacal disorder is uncommon and is more often a symptom of a depressive illness, an anxiety disorder or a paranoid disorder. The majority of cases are seen in depressive disorders. In 80% of cases the hypochondriacal ideas remit when the underlying condition is treated.

47. Some research suggests that the mechanism of the disorder may be that the hypochondriacal patient interprets as a sign of disease commonly occurring sensations and symptoms which are normal or which other people dismiss as trivial (such as the heartbeat, sweating, small sores, freckles, gastro-intestinal peristalis etc). These people also hold the belief that "good health" equates to the complete absence of symptoms of any kind. It is thought that these concepts are constitutionally determined or learned in early life.

48. Certain situations may encourage hypochondriacal beliefs or attitudes especially those which focus upon illness or the body such as students at medical school or athletes.

49. Occasionally hypochondriacal delusions are the initial features of an incipient schizophrenic illness. They may also feature during the course of schizophrenia and depressive disorders.

Hypochondriasis in the elderly

50. Hypochondriasis in the elderly is a common problem. The certainty of the diagnosis is complicated by the existence of physical disabilities that accompany the ageing process. These concentrate attention on one part of the body and may lead to the appearance of imagined discomfort in that part. An increase in social stress and loss of sources of self-esteem are also influential factors. Approximately one-third of elderly hypochondriacs undergo a fortuitous remission which is usually related to changes in the social environment.

51. In the elderly, the hypochondriacal reaction is frequently an adaptive response to an unfamiliar, serious social stress. Hence, improvement is often related to fortuitous disappearance of the stress. Other situations which may precipitate hypochondriasis in later life are partial isolation, largely attributable to socio-economic restrictions, and a deterioration in marital satisfaction due to prolonged disability affecting one partner.

Body dysmorphic disorder

52. This is often triggered by a chance remark in adolescence, the sufferer frequently being of a "sensitive" personality type. In some cases there may be very slightly unusual appearances to the part for example the nose may be fractionally large, however in many cases the abnormality is undetectable by others. Lack of confidence and ignorance often contribute to some forms of dysmorphophobia.

Persistent somatoform pain disorder

53. In almost half the cases the pain develops immediately following physical injury, however as a result of early experiences and personality factors, the sick role (valid in the early days following injury) is inappropriately prolonged. Dependence on analgesics may ensue and the patient may undergo repeated but unsuccessful surgical intervention. They often are very persistent in their requests for surgery and are reluctant to relinquish the sick role.

54. In some cases there is evidence that the presence of the pain results in the patient getting support from the environment that otherwise may not be forthcoming. This may take several forms including social support and financial benefit. In this case the diagnosis may overlap with that of a compensation neurosis or in some circumstances, malingering.

Somatisation disorder

55. Somatisation disorder is more common in females, although not exclusively and often begins in adolescence. It may run a life-long course.

56. Certain personality disorders have been shown to occur more frequently in those with somatisation disorder, notably histrionic, sensitive-aggressive and passive dependent types.

57. There is no evidence of a genetic transmission, however there is evidence that the disorder runs in families. It has been postulated that having a mother who herself continuously complained of physical illness may be a potent determinant of similar behaviour in her children. Whilst the prevalence is 20% in the first degree relatives of those with the disorder.

58. There is an excess of anti-social personality disorder and alcoholism in the first degree male relatives of those with somatisation disorder and it has been suggested that these may constitute sex-typed alternative pathways, with males becoming alcoholics and the females developing somatisation disorder.

CONCLUSION

59. Pure hypochondriacal disorder, somatoform autonomic dysfunction, persistent pain disorder and somatisation disorder usually represent a reaction to inner conflict or occasionally are a reaction to external stressors. The reaction is determined by that part of the personality which relates to illness behaviour and the adoption of the sick role. The patient with a somatoform disorder may also have a physical disorder, however the psychological reaction to the physical disorder is out of proportion to the severity of the condition.

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