

Review Article

Hypochondriacal States

By F. E. KENYON

Summary. A brief historical introduction traces the evolution of the concept of hypochondriasis. It is suggested that the term should now be used only as a descriptive adjective when there is a morbid preoccupation with health or body. Social and cultural factors are outlined, as well as problems of measurement. The psychopathology, as formulated by Freud and others, is also described. Clinical aspects are discussed under the headings of general symptoms, pain, smell, bodily appearance, sexual, gastro-intestinal, cardio-respiratory, eyes, and ears, nose and throat. Psychiatric syndromes mentioned are: hypochondria as a possible primary state, personality disorders, phobic-anxiety state, neurasthenia, obsessional neurosis, hysteria, depression, paranoid psychosis and organic. In general, hypochondriacal symptoms seem to make the prognosis rather worse. Treatment is to be aimed at the primary condition, which is most commonly depression, anxiety state or conversion reaction.

HISTORICAL INTRODUCTION

The term hypochondria is derived from the Greek with a literal meaning of 'below the cartilage', thus referring to an anatomical area housing various viscera under the ribs; but the latinized form of the name came eventually to be accepted as a feminine singular substantive noun. This transference of meaning paralleled changing concepts of pathology, especially in relation to the four humours, until ultimately various mental states came to be associated with changes in the organs of the hypochondria, notably the spleen and the liver. The suffix *-iasis* denotes a process or the condition resulting. It was not, however, until as late as the nineteenth century that hypochondria became specifically associated with a morbid preoccupation over health. A cognate term sometimes used synonymously is *atrabilious*—literally black bile—showing once again the same historical origins, as does *melancholia* also. *Valetudinarian* comes from the Latin (*valetudo*—state of health) and has been in use to denote undue preoccupation with one's health since the sixteenth century.

From this varied historical background (Kenyon, 1965; Ladee, 1966; Fischer-Homberger, 1972) there has emerged a confusing variety of usage. At a popular level, 'hypochondriac' has remained as a term of abuse, implying either actual malingering or having imaginary complaints, whereas previously it had been equivalent to mad or senseless, or even a mental disorder due to a disturbance of the digestive tract. Hypochondriasis has also been considered as a mechanism of defence, or as a manifestation of either a neurotic or psychotic disorder. Finally, it has been seen as a type of body image disorder, or even to exist in its own right as a primary nosological disorder.

But in its modern usage the essential part of any definition would be a morbid preoccupation with one's body or state of health, either mental or physical, with the further implication that this is the subject of complaints to others.

SOCIAL AND CULTURAL FACTORS

Out of this welter of meanings, a few general factors can be isolated. For instance, Stoeckle

(1966) reclassifies them under four headings: (1) bodily complaints; (2) attitudes and beliefs about the body; (3) concerns about illness; (4) the act of complaining to the doctor or complaining too often. But sociological theories are always changing and new terminology constantly being introduced. Wadsworth (1974) refers to complex theories of causation, with the admonition that doctors must also break into the patient's pattern of thought as to what is wrong. He comments, 'Social scientists contribute by investigating how and why these patterns of thought develop, and what effect they have on the individual's communication with doctors and nurses, and on his response to ideas about treatment and rehabilitation.' Other workers use such terms as the sick role (Parsons, 1951), illness behaviour (Mechanic, 1966), abnormal illness behaviour (Pilowsky, 1970a), or disease-claiming behaviour (Dewsbury, 1973). One implication from this type of approach is that this is learned behaviour and therefore offers up therapeutic possibilities in terms of learning theory (Kendell, 1974).

Much attention has been paid to the act of complaining and to possible differences between complainers and non-complainers. There are many complex factors leading to the decision to seek help. For instance, what feelings, 'symptoms' or complaints are deemed to be the domain of the doctor and how best to communicate them. Or a decision to complain instead to a friend, relative, spouse, hairdresser, barmaid, chemist, priest, Samaritans, or write to a magazine. Perhaps there is not enough emphasis on prevention in the National Health Service, with the family doctor as the key figure. A poor relationship with him, 'not wanting to bother him as he's so busy', or various defence mechanisms may be important factors in causing delay in seeking help. And yet the modern trend seems to be in the opposite direction, with the notion that there is a pill for every pain, and stoicism and the stiff upper lip remain unfashionable.

One study of women with malignant disease showed the importance of personality. The women were given the Eysenck Personality Inventory. It was found that pain-free patients had low N and high E scores. A second group,

who experienced pain but did not complain, had high N and low E scores, indicating increased emotionality with a tendency not to communicate distress. A third group experienced pain, complained of it to the nursing staff and received analgesics; they had high N and high E scores. The first two groups were regarded as non-complainers and the third as complainers (Bond, 1971).

Cross-cultural studies (Murphy, 1973) have shown that not only are some syndromes entirely culture-bound, for instance Koro or the shrinking penis (Yap, 1965), but other more commonly shared illnesses manifest themselves in special ways. Depressive disorders seem to present much more commonly with somatic or hypochondriacal symptoms in non-European cultures (Teja *et al.*, 1971; German, 1972), although it must be remembered that these more 'primitive' societies have more physical illness anyway. But more fundamental still is the hypothesis that purely psychological symptoms are not of much consequence in less sophisticated groups, and that the patient must have a special concept of health and a specific relationship with his doctor in order to develop hypochondriasis. People in these groups may feel threatened by evil spirits or other magical influences but not by ill-health.

However, in our culture it is a common belief that doctors are primarily interested in physical symptoms, so that patients may present with these as a way of establishing contact and a dialogue. On the other hand, some physical symptoms may be iatrogenic, caused by doctors by injudicious history taking, examination or over-investigation. Other powerful influences are modern advertising techniques and the mass media.

There are some interesting national differences, in that particular hypochondriacal complaints seem to be especially common in certain countries, although foreigners may foster national stereotypes in others. Historically, hypochondriasis—under the guise of such diagnoses as 'the vapours' or 'the spleen'—was seen by others as being peculiarly British, hence the name 'the English malady'. That the French tend to be preoccupied with their livers and 'biliousness' may be partly a reflection of the

high incidence of alcoholic cirrhosis. Lately the Italians have gained a reputation for hypochondriasis, and the Germans, apart from being very bowel-conscious, also suffer from a condition called *Frühjahrs Müdigkeit*—feelings of tiredness in the Spring.

Some special groups who are allegedly more prone than others to hypochondriasis are: male sex (Mechanic, 1972), lower social classes (Hollingshead and Redlich, 1958), the very young (Kanner, 1966), the old (Post, 1965), Jews (Hes, 1958; Fernando, 1975) and medical students (Woods *et al.*, 1966; Hunter *et al.*, 1964).

Fashions in treatment also change, and in recent years there seems to have been an increase in self-medication. Jeffrey *et al.* (1960) studied drug consumption on a housing estate; two out of three took non-prescribed medication, women more than men, and self-described 'nervous' mothers were more frequently self-medicators. In another study of 1,000 unselected patients from ten general practitioners, 25.4 per cent received a repeat prescription from their doctors and nothing else, while nearly 18 per cent had had the same drug for over six months. These 'long-repeat' patients had certain identifiable characteristics (Balint *et al.*, 1970). The rediscovery of the placebo response again highlights the importance of the patient's attitudes and expectations in the context of the patient-doctor relationship. After all, the vast majority of pills and potions prescribed in the past have lacked specific pharmacological actions, yet many patients not only survived but got better. But those with fears centring around their bodies and health are especially vulnerable to exploitation, particularly if rejected by the medical profession, when they may resort to all species of 'fringe' medicine and perhaps fall prey to the most unsafe of these.

PROBLEMS OF MEASUREMENT

There are very real methodological problems in trying to answer such seemingly simple questions as the incidence and prevalence of hypochondriasis, and whether or not it is on the increase. It is known that minor bodily symptoms are very common in the population at large, and that relatively few are reported

to doctors (Wadsworth *et al.*, 1971). In a healthy population selected on the basis of having had no illnesses or medication for the previous three days, it was found that only 19 per cent of the 414 stated that they had experienced none of 25 symptoms listed in the previous 72 hours; 30 people experienced 6 or more symptoms (Reidenberg and Lowenthal, 1968). Nonetheless, certain tentative findings have now been generally accepted; that, for instance, between a tenth and a fifth of the total population are mentally ill or emotionally disturbed, with women predominating in a proportion of nearly 2 : 1 (Shepherd *et al.*, 1966). In this study over 60 per cent of those given a formal diagnosis were classified as neurotic, and not more than about 10 per cent of identified cases were referred to a psychiatrist. There is also a positive association between physical and psychiatric disorders, with 'clustering' of both types of disorder in some individuals (Eastwood and Trevelyan, 1972).

Various attempts have been made to measure hypochondriacal symptoms, although these have not always effectively differentiated personality traits from such symptoms as phobias or delusions. The use of the MMPI, with its overlapping of hypochondriasis and hysteria scales, has already been reviewed (Kenyon, 1965). The Whitely Index (Pilowsky, 1967) is a questionnaire which, on a principal components analysis, has yielded three factors: bodily preoccupation, disease phobias, and conviction of the presence of disease with non-response to reassurance. This Index has been used in other studies, such as the investigation of pain in female patients with malignant disease mentioned above (Bond, 1971), and in a comparison of the effectiveness of treatment by chiropractors and physicians (Kane *et al.*, 1974). In another principal components analysis (Bianchi, 1973), varimax rotation produced eight components, of which five were considered to be configurations of hypochondriasis. However, even the most sophisticated statistical techniques are dependent on the raw data, which in the latter case was based on 24 historical, clinical and experimental variables obtained from 118 psychiatric in-patients, excluding schizophrenics.

As hypochondriacal symptoms are so com-

monly associated with depression, many scales purporting to measure significant affective change also incorporate questions concerning hypochondriasis. The well known Hamilton Rating Scale is a case in point; a recent factor analysis of it found that males had higher ratings than females on Hypochondriasis (Mowbray, 1972).

PSYCHOPATHOLOGY

Freud (1895, 1912, 1914) originally classed hypochondria (with neurasthenia and anxiety neurosis) as an 'actual neurosis' which resulted from a physical process arising from the toxic effects of dammed-up libido. Hence it had no primary symbolic meaning and was not amenable to psychoanalysis. This theory has never been satisfactorily explained, nor has it been developed by later analysts. Freud (1911) also postulated a partial link between the actual neuroses and the psychoneuroses in the idea that hypochondria bore the same relationship to paranoia as anxiety neurosis did to hysteria.

Other workers have variously stressed the importance of anal eroticism, masochism, regression or defence against psychosis. Some studies have singled out infantile narcissism, unconscious hostility or guilt, dependency needs, secondary gain, or the combination of a wish to be loved and to suffer at the same time (Kenyon, 1965; Lipsitt, 1974). But differences in terminology and psychodynamic formulations bedevil much of this work, and the introduction of other terms, such as organ neurosis, pre-genital conversion, erotization of organs, vegetative neurosis, somatoneurosis or pathoneurosis, does little to clarify the situation.

Another approach has been to regard hypochondriasis as due to a disturbance of the body scheme or image. Fisher (1970) amongst others has developed elaborate scales for measuring various facets of this, though his whole impressive edifice rests on the rather shaky foundations of classical psychoanalytical theory, projective techniques and self-report questionnaires. It was French workers who introduced the term *coenaesthesiopathy*, referring to the sum total of all organic sensations which are normally vague and in the back-

ground, but which give a person his feeling of existence.

That hypochondriasis is a pathological form of human existence has been stated by Ey (1966) in the course of a wide-ranging analysis. He also discusses the seeming paradox, 'Can an imaginary sickness be considered a sickness?' Ladee (1966) gives a phenomenological-existential account of hypochondriasis, with the experience of decay as a central feature and anxiety as a frequent manifestation.

CLINICAL ASPECTS

General and specific somatic symptoms

In a series of 512 patients seen over a ten-year period at the Maudsley Hospital and diagnosed as either primary or secondary hypochondriasis (Kenyon, 1964), somatic complaints were classified in three different ways: by distribution in different parts of the body, by system involved and according to whether unilateral or not. In the first, the three commonest regions involved were head and neck, abdomen and chest, in that order. By bodily system, it was musculo-skeletal, gastro-intestinal and CNS (headaches included here). On average, 16 per cent had predominantly unilateral symptoms, and of these 73 per cent were left-sided. This may relate to the symbolical significance of the left (sinistral, sinister, morbid, evil) or be due to the relatively less well developed right cerebral hemisphere (handedness was not recorded). But, curiously enough, pictorial representations of Melancholy nearly always show him leaning to the left side!

Among 295 patients who were subsequently admitted no significant physical abnormality was found in 47 per cent. The most commonly associated psychiatric symptoms were depression, anxiety, tiredness and weakness.

Although symptoms are mostly diffuse or generalized, one particular symptom or area of concern such as pain or disturbed sleep can present as the only complaint, and may well occupy the patient's whole attention and dominate his life. It can also be used to explain all the patient's difficulties, thus playing down any personal inadequacies. This monosymptomatic form can vary from a mild preoccupation

to a frank delusion. If symptoms of anxiety or depression are present, they are minimal, atypical, difficult to detect or explicable as secondary phenomena.

Pain

This has been defined as—'an unpleasant experience which we primarily associate with tissue damage or describe in terms of tissue damage, or both' (Merskey and Spear, 1967). Mental pain is a rather vague concept: it may mean just suffering or grief, the nearest psychiatric state being depression. A patient can experience psychogenic pain, but not an imaginary one. Some of the variables involved are the perception of pain, toleration, complaints and how complained of or reacted to. These may vary according to age, sex, social class, family size, personality and emotional state. Associated psychopathology may be concerned with guilt, aggression, sexual conflict, depression or secondary gain.

In Kenyon's (1964) series, pain was a prominent symptom in nearly 70 per cent. Among a hundred consecutive psychiatric outpatients in Pakistan (Sohail, 1973) 68 per cent complained of pain significantly more on the left side. Headaches were commonest (55 per cent), followed by chest pain (20 per cent) and abdominal pain (16 per cent).

Rather more diffuse and vague pains are very common, particularly muscular ones, and these may get labelled 'growing pains', 'rheumatism' or 'fibrositis'. The vogue for wearing copper bracelets is an eloquent testimony of this. Other common pain syndromes, which may have important psychiatric implications, are backache ('low back pain', Wolkind, 1976), atypical facial pain (Webb and Lascelles, 1962) and abdominal pain, particularly in children (Apley, 1975) and right iliac fossa pain in females (Merskey and Spear, 1967).

Smell

Delusions of smell may be the predominant complaint, often attributed to the bowels and usually associated with either paranoid or depressive features (Pryse-Phillips, 1971). Sometimes it is halitosis or a more generalized odour, perhaps in conjunction with excessive sweating and anxiety. Much modern adver-

tising is concerned with bodily hygiene (BO or 'body odour'), the popularization of deodorants, perfumes and the like, often with explicit sexual overtones. Indeed, recent work on pheromones has again emphasized the sexual significance of olfaction. But it seems that commercial pressures have gone too far, since vaginal deodorants have not become generally accepted.

Bodily appearance

Many shy, sensitive, self-conscious, narcissistic individuals become preoccupied with some supposed defect of their appearance, to the exclusion of all else. This 'ugliness complex' (Schachter, 1971) is common during adolescence. Features complained of may be associated with the nose, chin, ears, hair, skin, teeth, breasts or body weight. The term dysmorphophobia was introduced in 1886 for this type of disorder (Hay, 1970). One point of contrast is that these patients wish to appear normal but feel that others notice that they are not, whilst hypochondriacs want to draw attention to themselves by saying they are not normal.

It is important that these patients should be carefully evaluated before recourse to plastic surgery, since some may be deluded, depressed or severely disturbed personalities (Olley, 1974a, b). Otherwise symptom substitution can occur, deterioration into a psychotic condition, or a suicidal attempt. But there is also evidence that correction of some minor blemishes, such as acne, squint, or an ugly nose (Hay and Heather, 1973) can help the maladjusted, such as the young delinquent.

Sexual hypochondria

In the male this may involve anxieties over general virility, small size of penis (Todd *et al.*, 1971), or sexual potency (Bancroft, 1974). Guilt and other problems concerning masturbation are still encountered. More diffuse and possibly more serious fears, in either sex, may be about sexual orientation, or even the possibility of changing sex (Kenyon, 1974b, c; 1975). In the female there may be excessive concern over her sexual adequacy generally, or the quality of her sexual response and orgasm (Fisher, 1973; Uddenberg, 1974). Various menstrual irregularities such as dysmenorrhoea

or apparent menorrhagia can be prominent complaints (Munro, 1973). Perhaps the menopause is associated with most hypochondriacal concern, but a great deal depends on the woman's personality and expectations. Research findings depend so much on what group is studied, by what methods, where and by whom. Psychiatrists, not unexpectedly, are likely to see only those with severe associated emotional problems. In a general population sample of 539 women, a high prevalence of minor psychiatric illness was found in the age group 40–55. There was evidence for an increase in psychiatric morbidity occurring before the menopause and lasting until about a year after the periods had stopped. Vasomotor symptoms increased markedly when the periods stopped and persisted for up to five years after the menopause. Environmental factors, particularly in relation to children, seemed to be associated with increased psychiatric morbidity at this time of life (Ballinger, 1975). Recent publicity about hormonal replacement has again given prominence to the menopause. But careful research has established that the only symptoms directly related to oestrogen deficiency are hot flushes, sweats and dryness of the vagina. Improvement in other symptoms with oestrogen replacement is less dramatic, and for these the hormone is often little more effective than placebo (Beard, 1975). Although pregnancy tends to be associated with increased introspection and body awareness (Wolkind, 1974), many neurotic women say they only feel really well during pregnancy, at least in the middle trimester.

Bladder function can also be the focus of much anxiety. The problem of chronic cystitis in women has apparently become so widespread that a self-help organization (the U & I Club) has been formed to help sufferers. But this is not a diagnostically homogeneous group and may well contain a significant proportion with psychiatric problems (Kenyon, 1974a).

Gastro-intestinal

Symptoms referred to the gastro-intestinal tract are common. They can present as vague complaints of 'indigestion', nausea, dysphagia, regurgitation, 'biliousness', bad taste in the

mouth, flatulence or pain (Jones *et al*, 1968). Aerophagy can be an unrecognized aggravating factor. Preoccupation with bowel function, particularly constipation, can reach extreme degrees. It is sometimes difficult to prevent these patients from undergoing repeated investigations or unnecessary surgical procedures. The irritable or spastic colon is now a well recognized syndrome (Chaudhary and True-love, 1962).

Cardio-respiratory

Many anxious and introspective patients complain of 'palpitations', their hearts 'turning over' or missing a beat. They sometimes have vague ideas that they have a 'tired heart', and they may have been too severely restricted in the past because of rheumatic fever or the finding of a cardiac murmur. A 'cardiac neurosis' can also follow a myocardial infarct, iatrogenic factors reinforcing the natural fear of another attack. Left-sided chest pain of characteristic type (Baker, 1955) and not associated with any serious physical pathology, may well form part of the so-called effort or Da Costa's syndrome (Wood, 1968). Patients may also experience a type of inspirational dyspnoea with a feeling that they can never take a really deep and satisfying breath. An investigation of out-patients presenting with chest pain at a cardiac clinic threw further light on the psychosocial aspects of angina, but found little correlation between social disability and cardiological status (Mayou, 1973a, b). Other patients are for ever feeling their pulse or worrying over their blood pressure.

Ear, nose and throat, and eyes

Some patients are constantly preoccupied with poor hearing which they attribute to 'wax', and may spend a lot of time picking at the external auditory meatus or putting in various drops. Others complain of dizziness, vertigo, tinnitus, hearing their pulse beat at night, or general hyperacusis. Rather more nebulous complaints of 'catarrh', sinusitis or recurrent sore throats may be met. The feeling of a lump in the throat or globus hystericus may well be organically determined (Watson and Sullivan, 1974). Irritating habits, such as

constant sniffing, clearing the throat or cough may be complained of more by others than by the patient.

A common complaint of neurotic patients as regards their vision is of 'floaters' (*muscae volitantes*), but there is a wealth of psychosomatic symptomatology to be found in ophthalmic practice, as demonstrated in a monograph which considers the eye and the visual world in the context of the phenomenology of the body (Heaton, 1968).

PSYCHIATRIC SYNDROMES

Hypochondria

The nosological position of hypochondria has long been controversial. Is there such an entity as primary or essential hypochondria which is not part of another syndrome? The best known British advocate of primary hypochondria was Gillespie (1928, 1929), who offered the following definition: 'A mental preoccupation with a real or supposititious physical or mental disorder; a discrepancy between the degree of preoccupation and the grounds for it, so that the former is far in excess of what is justified; and an affective condition best characterized as interest with conviction and consequent concern and with indifference to the opinion of the environment, including unresponsiveness to persuasion.' But of the 13 cases he quoted he himself only accepted 5 as falling within his own definition. If it exists at all, at least as so defined, it is a rarity.

Apart from theoretical speculations or the exhaustive analysis of a few specially selected cases, there are few published studies of large groups of patients with hypochondriacal symptoms. But two of the most comprehensive studies do demonstrate that such a heterogeneous group can be broken down into other more conventional syndromes, with no clear-cut primary state emerging (Ladee, 1966; Kenyon, 1964). Another smaller series showed some differences between 'primary' and 'secondary' hypochondriasis with regard to clinical presentation, course and treatment required (Pilowsky, 1970b). But the series was a highly selected one and all assessments were made by the author himself, which is a disadvantage when so

much hangs on the estimation of the degree and relevance of affective changes, such as depression and anxiety.

Others have tried to overcome this difficulty by postulating some sort of dichotomy which in most cases boils down to the familiar concepts of neurosis and psychosis (Kenyon, 1965). Another modification would be to postulate a continuum of increasing 'seriousness' of concern over health, beginning with over-awareness of bodily sensations and going on to mild apprehension, phobic concern, over-valued ideas, delusional conviction.

Personality disorders

Two general aspects are the premorbid personality characteristics of patients diagnosed as suffering from a hypochondriacal state, and the use of the term itself as a personality trait or attribute. For the latter, it is often used in a very general way (when not simply pejorative), as signifying continuing over-concern with physical or mental health and judged by such behaviour as over-indulgence in patent medicines, food fads, frequent visits to the doctor with vague somatic complaints, preoccupation with bowel function, extreme interest in physical culture, or exaggeration or overreaction to trivial or commonplace ailments. But perhaps a common characteristic here would be concern over avoiding disease rather than fear of having one.

There is little agreement on premorbid personality type, from the classical Freudian triad of orderliness, obstinacy and parsimoniousness or the wider concept of the obsessional or anancastic type, to those who find no characteristic type or stress the paranoid traits (Kenyon, 1965). Simply calling the subjects 'body-sensitive' begs the question. But it does seem true that certain types are more vulnerable than others in this respect, and these can be summed up in the largely descriptive categories of the anxious-obsessional, immature-hysterical, and sensitive-schizoid. A recent follow-up study (average 5.6 years) of a group of untreated psychopaths found that one-quarter had become chronically hypochondriacal with a paranoid attitude (Maddocks, 1970).

Phobic-anxiety states

Mild phobias are frequent. One survey found a frequency of 77 per cent, the most common reason for seeing a doctor being fear of a medical procedure (Agras *et al.*, 1969). Fears of illness and of death and dying are also common and may well become the subject of hypochondriacal concern. In general, the phobic patient can be reassured that he has not got the dreaded disease, in contrast to the firmly fixed unshakeable belief of the deluded. Popular phobias are of cancer, V.D., heart disease or of going mad. A general fear of disease has been called nosophobia (Ryle, 1948), and various subgroups have been described. But it is not at all clear how nosophobias relate to more general forms of hypochondriasis and whether they are not simply a special form of it (Marks, 1969). Phobic symptoms are accompanied by a variable amount of 'free-floating' anxiety, but some of the physical autonomic symptoms may become the focus of attention, for example, tachycardia, tremor. Another commonly associated manifestation is depersonalization (Sedman, 1970; Myers and Grant, 1972) in which there is a subjective feeling of unreality, often with strange bodily sensations like numbness or paraesthesiae.

Neurasthenia

A once popular diagnosis was neurasthenia, of which fatigue was the cardinal symptom. These cases are now more usually considered under the headings of anxiety state, depression or schizophrenia. Slater and Roth (1969) comment: 'While the picture of pure neurasthenia as described by the psychiatrists of fifty years ago seems to have become rather a rarity, patients are still seen whose sole complaint is weakness and hypochondriacal concern with their lack of mental energy. They are often at the same time restless in an aimless fidgety manner, over-sensitive to noise and light and easily irritated by the presence of others. They avoid company, live a solitary carefully regulated life, and are incapable of following any regular occupation.'

Obsessional neurosis

Phobias can become the source of obsessional ruminations, and rituals may be used to ward off

supposed contamination and infection (Beech, 1974). Preoccupation with cleanliness, hygiene, bowels and such like offers fertile ground for the growth of hypochondriacal symptoms.

Hysteria

The checkered history of hysteria (Veith, 1965; Lewis, 1975) is closely linked to that of hypochondriasis, and at one time it was commonly believed that the two conditions were basically similar, hypochondriasis being regarded simply as hysteria in the male. But, like hypochondriasis, hysteria has also proved to be something of a chimera, particularly on follow-up of a mixed group so diagnosed (Slater, 1965). The label 'hysteria' (Reed, 1975; Lewis, 1974) confuses several different concepts, including popular usage, personality type, conversion hysteria, anxiety-hysteria, a psychopathological mechanism or a narrowly defined syndrome. Of the last the best known is the St Louis or Briquet Syndrome (Guze, 1967; Guze and Perley, 1963) which by definition is confined to females who before age 35 admit to having sought treatment for 25 symptoms in 9 out of 10 symptom groups. Hysterical conversion symptoms may prove a diagnostic trap, as may the 'hysterical overlay' in organic illness. A physician tends to see a different range of cases from the psychiatrist. One such series divided hysteria into four groups: firstly, simple hysteria (no organic illness but a simple disability such as aphonia); secondly, as a complication of organic illness; thirdly, as a special form of self-poisoning; and lastly as a complicated, chronic, disabling polysymptomatic syndrome (Carter, 1972). The borderlines between malingering, dissociation, primary (unconscious) and secondary (conscious) gain are not always clear cut. Nor is there always agreement on the basic characteristics of the hysterical personality (Lazare, 1971; Chodoff and Lyons, 1958).

Depression

The perception of bodily sensations is an important aspect in experiencing an emotion. In a re-appraisal of the James-Lange theory of emotion in the light of present neurophysiological knowledge, it was concluded that in

normal emotion bodily feelings are relatively unimportant, but in morbid emotion these may so predominate that they become the sole manifestation of the mood change (Tyrer, 1973). This formulation would also help to explain so-called masked depression or depressive equivalents (Ibor, 1972). But the position has again been confused by endless arguments as to how many 'types' of depression there are, hypochondriacal symptoms sometimes being used to distinguish between them (Kendell, 1968; Roth and Kerr, 1970). What is clear, both from the writer's own series and from others, is that a depressive affect is a frequent accompaniment of hypochondriacal symptoms, and in many cases the condition is primarily an affective one. In Schneider's concept of 'vital depression' a characteristic feature is the sense of a physical localization of the 'depression', for example, a sense of pressure in the chest (Burns and Nichols, 1972).

Other workers, when comparing two groups of depressed patients, one with and one without somatic symptoms, were hard put to it to find a series without physical complaints. Some differences were eventually found comparing a depressed-hypochondriacal group from a general hospital with a matched group of depressed patients without hypochondriasis from a psychiatric clinic. The main differences were that the former showed poorer sexual and marital adjustment, fluctuating course often precipitated by death or other external causes, greater chronicity, less disruption of social, family and occupational activities, relative lack of depressive affect and less evidence of anxiety (Kreitman *et al*, 1965).

Hypochondriacal delusions, e.g. bowels blocked, are commonly found in cases of depression in later life (involutional melancholia). Delusions can sometimes be of extreme nihilistic type, as in Cotard's Syndrome, when the patient says his body no longer exists or he is dead. Cotard also described and contrasted patients with persecutory and nihilistic delusions; in the former hypochondriasis was chiefly physical to begin with, but later became mental hypochondriasis; the opposite happened in the nihilistic group (Hirsch and Shepherd, 1974).

In morbid (atypical) grief reactions, hypochondriacal symptoms can occur similar to those suffered by the deceased during his or her last illness (Granville-Grossman, 1971). But it is the much less obvious forms of depression that are likely to be missed, when they are entirely masked by somatic symptoms. It is important to recognize these both because of the potentially good response to anti-depressant therapy and because of the possible risk of suicide. It has been stated that there is an inverse relationship between hypochondriasis and suicide, but this was based on the study of very special subgroups and from a different culture (Stenback and Jalava, 1961). Indeed the agitated patient who is concerned that he has some fatal or incurable disease should be regarded as very much at risk.

Paranoid psychosis and schizophrenia

The psychotic forms of hypochondriasis have been of particular concern to French and German workers (Ladee, 1966). The relationship to paranoia depends on how narrowly this is defined (Lewis, 1970); if the term is used for the presence of paranoid delusions with virtually no other symptoms, it is in any case a very rare condition. Perhaps the syndrome of morbid jealousy comes nearest, though this is usually in the setting of an abnormal personality. Paranoid traits, however, were found in about 10 per cent of the writer's series of patients.

One frequently quoted case is that of Daniel Paul Schreber (1842-1911), who went through a long hypochondriacal phase but in fact suffered from paranoid schizophrenia. He is one of the most famous patients in the history of psychiatry, and Freud's (1911) evaluation of the case came to be accepted as the classical psychoanalytical explanation of psychosis. However, this was not the result of any personal examination by Freud, as he only studied the patient's writings (Macalpine and Hunter, 1955). Further, at the time information was not available on the patient's extraordinary childhood and the methods of upbringing used by his highly eccentric physician father (Schatzman, 1973). Late-onset schizophrenia or paraphrenia may well present with a prodromal stage of hypochondriacal preoccupations later becoming more frankly delusional. To avoid

possible confusion in terminology, it has been suggested that these should be referred to as somatic delusions rather than hypochondriacal.

It is not surprising, with these inherent difficulties in diagnosis and definition, that divergent views exist as to the co-existence and inter-relationship of paranoid and hypochondriacal symptoms. Most authors think their occurrence with paranoid psychosis to be rare, as the essential psychopathology here is based on projection; symptoms are not seen as emanating from the body but as due to external influences.

In one Scandinavian series (Retterstöl, 1968) only 0.4 per cent of 3,441 cases of paranoid psychosis presented with hypochondriacal delusions as the main complaint. The psychopathology varied: the delusion might be a symbolical reaction to a provoking conflict situation, or based on an earlier life history, previous somatic illness or psychic trauma, or be seemingly inexplicable in a schizophrenic setting. In an English series (Lucas *et al.*, 1962) of 405 unselected schizophrenic in-patients 71 per cent were deluded, paranoid delusions being the most common, but 20 per cent of the 127 males and 21 per cent of the 161 females had hypochondriacal delusions. But unlike other categories studied, there was no correlation between them and sex, mental status, religion or social class.

Occasionally simple schizophrenia may present with hebetic, vague hypochondriacal complaints and an apparent inability to settle or live up to earlier expectations.

Organic

In acute organically determined psychoses, such as delirium tremens or cocaine psychosis, hypochondriacal symptoms may be seen as well as in chronic ones, like arteriosclerotic dementia.

That some patients react stoically to crippling diseases whilst others readily sink into a depressed hypochondriacal state is a platitude; there are many variables, such as acuteness of onset, nature of resulting disability and so on, but perhaps the most important ones are the patient's personality and life situation. Such reactions may be seen after injuries, particularly head injuries, as in the post-concussional

syndrome and especially so when compensation is involved (Miller, 1961). Assessment may be made even more difficult by the finding of a relatively high incidence of non-specific EEG abnormalities in hypochondriacal patients (Paal, 1968). Nonetheless, many sufferers from chronic fluctuating diseases, such as multiple sclerosis, diabetes mellitus and epilepsy, seem surprisingly free from hypochondriacal complaints.

Prognosis and treatment

Generally speaking, hypochondriacal symptoms as part of another syndrome seem to make the prognosis worse, as, for example, in depression. But in psychoses with hypochondriacal delusions the prognosis is more dependent on the basic type of disease rather than the nature of the delusions. Personality disorders, particularly the rigid obsessional ones with longstanding hypochondriacal preoccupations, are difficult to influence, especially in the middle-aged male. Similar symptoms on the basis of an hysterical personality, more often seen in younger females, are likewise difficult to treat. Some large series have been followed-up and give some clues to the natural history, but comparison is often unrewarding because of the heterogeneity of the groups and because of different diagnostic criteria, which are not always made explicit (Kenyon, 1965).

Treatment is essentially that of the primary condition, which will most commonly be a depressive illness, phobic anxiety state, hysterical reaction or, more rarely, a personality disorder or schizophrenia. Good results in monosymptomatic hypochondriacal psychosis have been claimed from the use of the drug Pimozide (Riding and Munro, 1975). In one investigation of response to ECT (Hobson, 1953) hypochondriasis was found to be an unfavourable prognostic feature. Other studies on the indications for ECT (Roberts, 1959; Mendels, 1965; Carney *et al.*, 1965), whilst adding further positive features, have tended to confirm the original negative finding. An exception was in African patients in Senegal, where there was an excellent response (German, 1972). On the other hand, antidepressant drugs with or without a tranquillizer are well worth trying. Psychotherapy (Lipsitt, 1974) or behaviour

therapy (Floru, 1973) are other possible methods of treatment, especially in neurotic cases. Leucotomy should be a last resort and kept for seriously disabled cases who have failed to respond to other methods of treatment and are tortured by their hypochondriacal symptoms, as well as being tense and agitated.

CONCLUSIONS

It would now seem best to drop altogether the terms hypochondria and hypochondriasis, but to retain hypochondriacal as a descriptive adjective. If this usage is accepted, it would be proper to refer to hypochondriacal traits, symptoms, ideas, fears, and so on, with the added implication that there is a morbid preoccupation with mental or bodily functions or state of health. This would leave the options open as to the precise psychopathology and mechanisms involved. 'Somatic' would still be used in a much more general sense, as synonymous with physical or bodily, as in such terms as psychosomatic or somatic pathology.

Symptom 'choice' is affected by a number of different, sometimes inter-dependent variables. For example, personality can be either pathogenic in predisposing to certain types of illness, or pathoplastic in determining the form of the illness. Other determinants can be intelligence, social class and such habits as smoking, diet, alcohol and amount of exercise. There may also be a constitutional vulnerability, previous injury or illness, or a positive family history. Child-rearing practices, as well as early learning and conditioning, can also be important. If it is in the nature of a conversion reaction, the symptom will have been chosen for its symbolic significance.

The final common pathway may involve biochemical, autonomic, vasomotor, neuro-endocrine or immune response mechanisms. In practice, there remains an ill-defined group of patients, who present with multiple hypochondriacal symptoms, without demonstrable physical pathology. They come with thick hospital folders, their supply of symptoms is seemingly inexhaustible. They may also be passively hostile and manipulative, or more openly querulous, potentially litigious and bordering on the paranoid. After a time, and

particularly if psychiatric referral is used as a last resort, it is difficult to disentangle cause and effect, and iatrogenic and drug effects add to the vicious circle. These 'professional patients' often end up with the psychiatric label of personality disorder.

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F. E. Kenyon, M.A., M.D., F.R.C.P.(Ed.), F.R.C.Psych., *Clinical Lecturer, University of Oxford; Consultant Psychiatrist, Warneford Hospital, Oxford OX3 7JX*

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