# Somatoform Disorders: Comorbidity With Other DSM-III-R Psychiatric Diagnoses in Greece

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**From a total sample of 1,448 psychiatric outpatients, 175 (12.1%) received a diagnosis of a somatoform disorder according to DSM-III-R criteria. One hundred twenty-two (70%) of these patients had another current axis I diagnosis, and this rate increased to 79% (139 of 175) when lifetime psychiatric diagnoses were recorded. The most frequent comorbid diagnoses were depressive disorders, i.e., dysthymia and major depression, and then anxiety disorders, mainly panic disorder. One hundred ten (63%) of the somatoform patients met the criteria for a personality disorder, significantly higher than the rate (52%) for the rest of the total sample (n = 1,273), who were used as a control group. The most frequent comorbid personality disorders were histrionic, dependent, and personalities of cluster B in general. Hypochondriasis was the only somatoform disorder that was additionally significantly related to obsessive-compulsive personality disorder. Somatoform patients with a concomitant personality disorder manifested more severe overall psychopathology as measured by the Minnesota Multiphasic Personality Inventory (MMPI) and a worse level of functioning than those without. The results of the present study show that (1) patients with somatoform disorders have a high rate of comorbidity with other clinical syndromes and personality disorders, and (2) the presence of a personality disorder is related to more severe overall psychopathology and a worse level of functioning. All of the above indicate that special attention must be paid to the interaction between somatoform disorders, other clinical syndromes, and personality structure at the level of both clinical and research practice.**


PHYSICIANS have recognized somatizing patients for centuries. These cases have been given a variety of overlapping labels, notably "hysteria," "hypochondriasis," and "melancholia."[1] In 1980, DSM-III[2] introduced the term "somatoform disorders" for a group of disorders for which the essential features are physical symptoms suggesting physical disorder without any demonstrable organic findings or known physiological mechanisms and with positive evidence or strong presumption that the symptoms are linked to psychological factors or conflicts. The DSM-III somatoform disorders comprise five specific entities: somatization disorder that is the antecedent of Briquet's syndrome, conversion disorder, psychogenic pain disorder, hypochondriasis, and atypical somatoform disorder. DSM-III-R[3] adds two new entities, body dysmorphic disorder and undifferentiated somatoform disorder, while DSM-IV[4] preserves all seven entities in the section of somatoform disorders.

A field of particular research interest is the comorbidity of somatoform disorder with other psychiatric disorders. There are studies reporting that somatoform disorders in general or some in particular manifest a high comorbidity with other axis I diagnoses, mainly depressive and anxiety disorders.[5-14] Similarly interesting is the correlation of somatoform disorders with axis II diagnoses, i.e., personality disorders, a field that has not been heavily researched, with the exception of the relation of somatization disorder with histrionic and antisocial personality disorder.[5,15-18] There are a few studies that investigated this topic more broadly, and found that somatoform disorders in general[19,20] or some of them, such as somatization disorder[21,22] or hypochondriasis,[12] are highly correlated with personality disorders. This correlation is particularly interesting, as there are studies supporting the view that the presence of a personality disorder considerably influences the symptom severity, outcome, number of relapses, and treatment response of a clinical syndrome. These studies refer to patients with depressive and/or anxiety disorders.[23-32]

The aim of the present study, which is the first of its kind in Greece, is to investigate (1) the comorbidity of somatoform disorders, both as a total and as specific entities, with other clinical syndromes (axis I) and personality disorders (axis II), and (2) whether patients with a concomitant diagnosis of a personality disorder have more severe psychopathol-

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ogy compared with patients without a diagnosis of a personality disorder.

## METHOD

The study sample consisted of consecutive outpatients who attended the Community Mental Health Centers of the Northwestern District and the B University Department of Psychiatry of Aristotelian University of Thessaloniki in Greece over a period of 5 years (1990 to 1994) and received a diagnosis of somatoform disorder according to DSM-III-R[3] criteria. A DSM-III-R diagnosis (as previously a DMS-III diagnosis and now a DSM-IV diagnosis) is standard practice in both Centers, and all scientific personnel who are involved in diagnostic interviews are trained and experienced in its use. Furthermore, the great majority have been working in this scientific field for over one decade. The axis I diagnoses of the present study were made at the disposition conference by consensus of the whole therapeutic team. This procedure guarantees a high axis I diagnostic reliability, as also shown in other studies performed in these settings.[28,33] For the axis II diagnosis of personality disorders, the Structured Clinical Interview for DSM-III-R axis II (SCID-II) was used in conjunction with the SCID Personality Questionnaire.[34] The instruments have been translated into Greek, and their diagnostic sensitivity has been validated for the Greek population.[35] The current level of functioning was assessed with the Global Assessment of Functioning (GAF) scale of the DSM-III-R. All remaining patients who attended both Centers during this period (1990 to 1994), followed this diagnostic procedure, and received any other axis I and/or axis II diagnosis were used as a control group for axis II diagnoses. Finally, all patients under study who had at least a ninth-grade education completed the Minnesota Multiphasic Personality Inventory (MMPI), which was adapted for use in Greece.[36] The MMPI, a test for assessing patient personality characteristics, is also a useful device in assessing psychopathology[37] and thus has been used for this purpose in many comparative studies between groups of patients. MMPI results that were invalid (i.e., false-positive or false-negative) were excluded. It is important to emphasize that all patients participated in the study voluntarily after informed oral consent was obtained.

## RESULTS

From a total sample of 1,448 patients who attended both Centers, 175 (12.1%) received a DSM-III-R diagnosis of a somatoform disorder. Their demographic and clinical characteristics are presented in Table 1. Patients with a somatoform disorder did not differ significantly regarding any demographic characteristic in comparison to patients (n = 1,273) with other diagnoses ($P > .05$). The most frequent somatoform disorder was conversion disorder, followed by somatization and undifferentiated somatoform disorder. In conversion disorder, there were significantly more women, (81%, 46 of 57) as compared with hypochondriasis (52%, 12 of 23, chi-square [$\chi^2$] = 6.70, $P < .05$), undifferentiated somatoform disorder (60%, 21 of 35, $\chi^2 = 4.70$, $P < .05$), and the other remaining diagnoses (64%, 813 of 1,273, $\chi^2 = 10.22$, $P < .01$). Similarly, in somatization disorder, there was a significant preponderance of females (78%, 28 of 36) as compared with hypochondriasis ($\chi^2 = 4.22$, $P < .05$), and a tendency for statistical significance in comparison to patients with other diagnoses ($\chi^2 = 2.95$, $P < .1$) except somatoform.

**Table 1. Demographic and Clinical Characteristics of the Sample (N = 175)**

| Characteristic | No. | Mean ± SD | % |
|---|---|---|---|
| Sex | | | |
| Male | 54 | | 31 |
| Female | 121 | | 69 |
| Age (yr) | | 36.1 ± 11.5 | |
| Education (yr) | | 10.2 ± 4.5 | |
| Marital status | | | |
| Single | 61 | | 35 |
| Married | 100 | | 57 |
| Divorced/widowed | 14 | | 8 |
| Somatoform entity | | | |
| Somatization | 36 | | 21 |
| Undifferentiated | 35 | | 20 |
| Conversion | 57 | | 33 |
| Hypochondriasis | 23 | | 13 |
| Somatoform pain | 4 | | 2 |
| Body dysmorphic | 6 | | 3 |
| Somatoform NOS | 14 | | 8 |
| Age of onset (yr) | | 25.5 ± 9.4 | |
| Duration (yr) | | 10.6 ± 6.2 | |

Of the somatoform patients, 70% qualified for another diagnosis of current disorder and 79% for another lifetime disorder (Table 2). The most frequent comorbid disorders were depressive disorders (49% current and 61% lifetime), mainly major depression or dysthymia, followed by anxiety disorders (30% current and 35% lifetime), mainly panic disorder with or without agoraphobia. There were differences between the specific somatoform disorders regarding the frequency of comorbid diagnoses. Thus, the frequency of "any" axis I diagnosis was as follows: in somatization disorder, 78% (28 of 36) current and 89% (32 of 36) lifetime; in hypochondriasis, 78% (12 of 23) current and 87% (20 of 23) lifetime; in undifferentiated somatoform disorder, 77% (27 of 35) current and 86% (30 of 35) lifetime; and in conversion disorder, 56% (32 of 57) current and 65% (37 of 57) lifetime. Conversion disorder coexists less frequently with any axis I diagnoses compared with other somatoform disorders. This comparison is statistically significant for the somatization disorder ($\chi^2 = 4.51$, $P < .05$ current and $\chi^2 = 5.41$, $P < .05$ lifetime),