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A systematic review of the epidemiology of somatisation disorder and hypochondriasis

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Abstract

Background: This paper reviews current knowledge regarding the prevalence and associated features of somatisation disorder and hypochondriasis in population-based and primary care samples. **Method:** A systematic review of the literature, which used a standardised definition of somatisation disorder or hypochondriasis and which examined the characteristics and associated features of these disorders in population-based samples or primary care settings. **Results:** In population-based studies the prevalence of somatisation disorder and hypochondriasis was too low to examine associated features reliably. In studies using abridged criteria, a clear female predominance was not found in either disorder; there was a consistent relationship with few years of education. There was a close relationship with anxiety and depressive disorders, with a linear relationship between numbers of somatic and other symptoms of distress in several studies, including longitudinal studies. No studies showed that these symptom clusters fulfil the criteria of characteristic onset, course and prognosis required to merit the status of discrete psychiatric disorders. **Conclusions:** On existing evidence, somatisation disorder and hypochondriasis cannot be regarded as definite psychiatric disorders. There is some evidence that numerous somatic symptoms or illness worry may be associated with impairment and high health care utilisation in a way that cannot be solely explained by concurrent anxiety and depression, but further research using population-based samples is required.
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Keywords: Somatisation disorder; Medically unexplained symptoms; Hypochondriasis epidemiology; Population

Introduction

Somatisation disorder and hypochondriasis are among the somatoform disorders included in our major taxonomies (ICD-10 and DSM-IV). Yet the empirical evidence for this classification remains inconclusive [1,2]. The main feature of somatisation disorder is recurrent and frequently changing physical symptoms, which cannot be explained by any known medical condition, and the hallmark of hypochondriasis is excessive worry about illness and the belief that one has an undiagnosed physical disease [3,4]. It is not clear whether these features form discrete categories, which are best conceptualised as individual psychopathological disorders, or whether they are better conceptualised as personality characteristics, maladaptive coping styles, nonspecific symptoms of other more pervasive psychiatric disorders, or simply normal variants [5,6]. This paper considers whether there is evidence for somatisation disorder and hypochondriasis as useful and discrete categories outside the specialised clinic settings in which the categories were originally defined. We studied somatisation disorder and hypochondriasis together because they appear to have much in common: multiple medically unexplained complaints, prominent illness and sick role behaviour and invalidism, disproportionate disability and preoccupation with health and illness.

In this systematic review we have determined the prevalence of these disorders in population-based samples and in primary care. We have also considered the consistency of symptom clustering and pattern of comorbidity. The fact that somatisation disorder and hypochondriasis are found in ICD-10 and DSM-IV suggests that these are already established as discrete psychiatric disorders, but this would require that they fulfil certain criteria. Firstly, there should be a characteristic cluster of symptoms that is discrete and is associated with a recognised natural history and predictable longitudinal

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course [7,8], There should also be a characteristic set of predisposing and/or precipitating factors, a characteristic family history, and these should be accompanied by specific ancillary features, such as undue disability or role impairment, or maladaptive medical help seeking. No previous attempt has been made to assess the evidence for a characteristic cluster of symptoms across different settings.

As a first step towards clarifying the status of somatisation disorder and hypochondriasis we have searched the literature to assess whether the cluster of symptoms described under these terms is found in different settings, including population-based samples. The concept of the somatoform disorders originates from experience in specialist clinical settings, where patients with these disorders were originally described and where the behaviours of repeated requests for investigations and treatment and the failure to accept reassurance from doctors were apparent. However, in these specialised clinical settings, selection factors may produce a biased picture; people with severe forms of the condition predominate. This may give the appearance of a discrete cluster of symptoms with a characteristic course and pattern of comorbidity (e.g., with depression), when, in fact, this is an artefact of the setting. For example the apparent comorbidity of these disorders with depression observed in specialised clinic settings may be a spurious association, as the depression may be responsible for the marked disability and repeated treatment seeking rather than the disorder itself. Thus, it is important to determine whether the association with disability and frequent treatment seeking occurs also in other settings.

The main aim of this review is to identify and collate the evidence indicating that somatisation and hypochondriacal disorders described in population-based samples and primary care settings show the characteristics listed above, which might support the concept of discrete disorders. The paper describes first the data relating to somatisation disorder and hypochondriasis as defined by standardised diagnostic schema. Since these diagnoses are so rarely found in population-based samples we included also studies in primary care and studies that used abridged versions of these definitions.

Table 1
Four studies that used analytic techniques to cluster patients in population- or primary-care-based samples

Author(s) of study	Schwartz et al. [10]	Liu et al. [9]	Gara et al. [11]	Pincinelli et al. [12]
Population studied	Population-based (ECA respondents with 3+ symptoms)	ECA respondents who were involved, two-wave study	Primary care	Primary care patients with 3+ symptoms but not ICD-10 cases
No. of subjects	*N* = 1626	*N* = 4000	*N* = 1455	*N* = 1617
Method of analysis	Grade of membership model	Factor analysis and structured equation modelling		Grade of membership model, 22 somatisation symptoms with 40 anxiety and depressive symptoms
Factor that corresponds to SD	*Type 5 (n=50): "classic SD"—all 24 somatic items*	*Factor 1: all symptoms, i.e., general somatisation (including weakness)*		*Type 1: full set of somatization symptoms*
Other factors				
1	Type 1(*n*=660): sexual indifference headaches (females only)		Headache (and other pain)	Type IV: headaches and loss of interest in sex
2	Type 2 (*n*=193): menstrual difficulties	Factor 2: menstrual difficulties in women and pain in men		Type III GAD
3	Type 4 (*n*=85): musculoskeletal symptoms (males only)		Musculoskeletal	
4	Type 3 (*n*=293): depressive symptoms			Type II: anxiety and depression
5			No patterns/few symptoms	Type V: sleep problems
6	Type 6 (*n*=231) excess gas, constipation		Gastrointestinal	
7	Type 7 (*n*=114): chest pain, fainting, dizziness, palpitations, blurred vision, headaches, nervousness, food intolerance, "da Costa's"		Cardiorespiratory	
8		Factor 3: blind/deaf/loss of voice "conversion"		
9			Genitourinary	

The italicised row indicates that in three studies a group emerged that included all the somatic symptoms included in the assessment.
Other factors are arranged in the table so that the similarity or differences across studies can be observed.

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