
Hypochondriasis and Somatization: Two Distinct Aspects of Somatoform Disorders?



Rolf Leibbrand and Wolfgang Hiller

University of Mainz, Germany



Manfred M. Fichter

*Klinik Roseneck Center for Behavioral Medicine
and the University of Munich*

We investigated boundaries and overlap between somatization and hypochondriasis on different levels of psychopathology: (1) comorbidity between hypochondriasis and somatization on the level of diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV; American Psychiatric Association, 1994); (2) comorbidity with other mental disorders; (3) differences in clinical characteristics; and (4) overlap on the level of psychometric measures. The sample consisted of 120 psychosomatic inpatients. Somatoform, hypochondriacal, and depressive symptomatology, cognitions about body and health, and further aspects of general symptomatology were investigated. Diagnoses of Axis I and II were based on DSM-IV. Our results suggest a large overlap on the level of DSM-IV-diagnoses: only 3 of 31 hypochondriacal patients had no multiple somatoform symptoms, while 58 of 86 patients with multiple somatoform symptoms had no hypochondriasis. However, the overlap between hypochondriacal and somatization symptomatology on the level of psychometric measurement is only moderate, indicating that hypochondriasis is a markedly distinct aspect of somatoform disorders. © 2000 John Wiley & Sons, Inc. *J Clin Psychol* 56: 63–72, 2000.

Although the diagnostic concepts of hypochondriasis and somatization disorder are clearly defined by criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV; American Psychiatric Association, 1994), the distinction between the two disorders remains problematic. In DSM-IV hypochondriasis is defined as “pre-

Correspondence concerning this article should be addressed to Rolf Leibbrand, Psychologisches Institut der Universität Mainz, Abt. Klinische Psychologie, Staudinger Weg 9, D-55099 Mainz, Germany.

occupation with fear of having . . . a serious disease, based on the person's misinterpretation of bodily symptoms," whereas somatization disorder (as well as subthreshold somatization syndromes) is characterized by a specified number of medically unexplained somatic complaints. As a consequence of diagnostic criteria fear of disease in hypochondriasis has to be related to physical symptoms, while conversely medically unexplained symptoms might cause fear of disease or at least serious doubt about one's health status. Both phenomena could be dependent on each other or even two aspects of the same disorder (Escobar, Schwarz, Rubio-Stpec, & Manu, 1991; Murphy, 1990; Schmidt, 1994), and boundaries are indistinct.

Clinically, however, two types of somatizers can be observed: patients with unexplained physical symptoms suffering from intense fear of disease and patients complaining (sometimes very expressively) about physical symptoms and looking for a diagnosis or the meaning of their symptoms but having no fear of disease at all. As a proposal for the clarification of boundaries between hypochondriasis and somatization Schmidt (1994, p. 310) points out that in somatization the physical complaint itself is more pronounced, whereas in hypochondriasis harmless physical sensations may be given a catastrophic interpretation. Not all somatizers share this hypochondriacal feature.

Barsky, Wyshak, and Klerman (1992) investigated the comorbidity profiles of mental disorders in 42 hypochondriacal patients and found that about 21% of these patients also met the criteria for somatization disorder. At first glance this rate seems to be relatively low, but considering that somatization disorder is very rare with a prevalence of about 0.1% in the community (Escobar, Burnam, Karno, Forsythe, & Golding, 1987), this figure is probably much higher for subthreshold (yet clinically relevant) variants occurring with a prevalence of about 4.4% in the community (Escobar & Canino, 1989), and therefore is indicating a substantial overlap between hypochondriasis and somatization symptoms.

However hypochondriacal fear also occurs in patients with obsessive-compulsive disorder (OCD) and with depressive, anxiety, and delusional disorders. Kellner (1992, p. 278) summarizes that the coexistence of hypochondriasis with other syndromes is so common that several researchers believe that hypochondriasis is not an independent syndrome but always a variant of another syndrome. In particular it has been supposed that hypochondriasis could be part of panic disorder, which is related to intense fear and physical symptoms as well, or vice versa (Noyes, Reich, Clancy, & O'Gorman, 1986; Warwick & Salkovskis, 1990). However, Barsky et al. (1994) found substantial differences between panic disorder and hypochondriasis although there is a high comorbidity rate and a large overlap in some aspects of the general symptomatology between the two disorders as well. Similar results were found for depression, OCD, and other specific Axis I disorders (Schmidt, 1994). As a consequence, many authors differentiate between a secondary hypochondriasis (Kellner, 1992; Pilowsky, 1970), occurring in the course or as a part of another psychiatric disorder, and a primary, independent hypochondriacal syndrome. According to these authors, secondary hypochondriasis does not justify a separate diagnosis as comorbid disorder. However, the overlap between somatization, anxiety, and depression is very large as well and symptoms of one of these disorders often occur in the course of another one; the question whether somatization, anxiety, and depression are dependent or independent phenomena cannot be decided on the basis of co-occurrence. For that reason, they are diagnosed as comorbid disorders. Likewise hypochondriasis cannot be classified as dependent or independent phenomenon on the basis of co-occurrence with other disorders. The distinction between secondary (co-occurring) and primary hypochondriasis might be misleading or even arbitrary.

Kirmayer and Robbins (1991) investigated three "forms of somatization," determined by psychometric measures: high levels of medically unexplained symptoms, hypo-

chondriasis, and exclusively somatic presentations among patients with depression and anxiety. The overlap between these three forms was moderate: only 3 patients out of 180 (1.7%) met criteria for all three forms, 85% of the patients with somatization syndrome were not markedly hypochondriacal, and 68% of the hypochondriacal patients had no somatization syndrome. The results of Kirmayer and Robbins thus suggest that hypochondriasis is an aspect of somatoform symptomatology relatively independent from somatization syndrome.

The aim of the present study was to determine whether DSM-IV hypochondriasis and somatization syndrome are two distinct aspects of somatoform disorders justifying separate diagnoses, or whether hypochondriasis is only a secondary characteristic occurring in a subgroup of somatization patients. We focused on four different aspects of this question. First, we wanted to analyze the comorbidity between hypochondriasis and somatization in more detail. Second, we wanted to evaluate whether any differences exist between hypochondriacal and somatization patients concerning the comorbidity with other psychiatric disorders such as anxiety and personality disorders. Third, we wanted to address the question whether there is a difference in certain clinical characteristics between hypochondriacal and somatizing patients. Finally we assessed the relationship between hypochondriacal symptomatology, somatization symptoms, and other clinical characteristics on the level of psychometric measures.

Methods

We investigated a sample of 120 inpatients consecutively admitted to the Clinic Rose-neck Center for Behavioral Medicine in Prien, Germany. Hospitals of such a type in Germany are part of the general health care system and specialize in the psychotherapeutic treatment of inpatients with multiple diagnoses of severe and chronic mental disorders. One patient with very severe depression was excluded from the study. Age ranged between 19 and 69 years with a mean age of 44.5 years. Seventy-six (63.9%) of the patients were female and 43 (36.1%) were male. Two (1.7%) of the patients had been at school for 7 years, 59 (49.6%) for 9 years, 26 (21.8%) for 10 years, 13 (11.0%) for 13 years, and 18 (14.9%) were or had been at the university. When admitted to treatment, 64 (53.8%) of the patients had full-time jobs, 11 (9.2%) part-time jobs, 18 (15.1%) were unemployed, 8 (6.7%) were housewives, 1 (0.8%) was training on the job, and 13 (10.9%) were retired. Eighty-seven (73.1%) of the patients were married or had a partner; 32 (26.9%) had no or changing partners. Subjects with the principal diagnosis of eating disorder or chronic tinnitus were excluded from the study because these are treated on specialized wards. Patients with severe psychotic disorders, primary alcohol or substance abuse disorders are generally not admitted to treatment in the Klinik Roseneck. Included in our sample were 5 patients with lifetime eating disorders (1 Anorexia nervosa, 4 Bulimia nervosa) and 34 patients with secondary alcohol or substance abuse disorders that were partly or fully remitted by the time of diagnostic assessment. Informed consent was obtained from all subjects.

After admission, a diagnostic interview for complete DSM-IV Axis I and II (including all specific somatoform disorders mentioned in DSM-IV as well as affective, psychotic, anxiety, eating, substance abuse, and personality disorders) was conducted, and patients completed a battery of self-rating scales to measure different aspects of the general symptomatology. For the diagnostic assessments, two interviewers were trained using the International Diagnostic Checklists (IDCL; Hiller, Zaudig, & Mombour, 1996) and the International Diagnostic Checklists for Personality Disorders (IDCL-P; Bronisch, Hiller, Mombour, & Zaudig, 1996). The IDCL are interview checklists available for

DSM-IV and ICD-10 which are recommended by the World Health Organization to obtain reliable and valid diagnoses. They were used in all diagnostic interviews to simplify the diagnostic procedure and to guarantee a high level of diagnostic quality. For Axis I disorders kappa values from $\kappa = 0.65$ for OCD and $\kappa = 0.73$ for major depression to $\kappa = 0.85$ for bipolar disorder and $\kappa = 0.88$ for panic disorder (PD) are reported by the authors of the instrument. Regarding Axis II, kappa values range from $\kappa = 0.35$ for paranoid PD to $\kappa = 0.73$ for dependent PD, and $\kappa = 0.75$ for presence/absence of any PD. For the diagnostic concordance of the International Personality Disorder Examination (Loranger, Sartorius, Andreoli, Berner, Buchheim, Channabasavanna, Coid, Dahl, Diekstra, Jacobsberg, Mombour, Ono, Regier, Tyrer, & von Cranach, 1994) and the IDCL-P, a kappa value of 0.52 for the presence/absence of any PD is reported by the authors. All interviews were supervised by an experienced trainer (which was the first author of the IDCL) and discussed with the interviewers; due to organizational limitations interrater reliability in our sample was not checked by blind ratings of videotapes or life interviews. In order to control for severe depression and to reduce biasing effects of acute symptomatology on diagnosing personality disorders (Zimmerman, 1994), the diagnostic interviews of Axis II were not conducted until four weeks after admission to treatment, and depressive symptomatology was controlled for by the Depression Status Inventory (expert version, Zung, 1972). Self-rated somatoform symptoms were measured by the Screening for Somatization Symptoms (SOMS-7; Rief, Hiller, & Heuser, 1997), a 53-item scale including all somatoform complaints listed in DSM-IV and ICD-10. The patients also completed the Whiteley Index (Pilowsky, 1967), a 14-item scale to measure hypochondriasis, the Beck Depression Inventory (BDI; Beck & Steer, 1987), and the Symptom Checklist (SCL-90R; Derogatis, 1977). Furthermore, a newly developed self-rating scale, the Cognitions About Body and Health Questionnaire (CABAH, Rief, Hiller, & Margraf, 1998), was applied to the subjects to measure dysfunctional cognitions about body and health. It consists of five subscales measuring *catastrophizing cognitions*, *intolerance of bodily complaints*, *bodily weakness*, *autonomic sensations*, and *health habits*, with 48 items to be answered within five categories (0 = *completely wrong* to 4 = *completely right*). Cronbach's alpha for all items in a clinical sample of 493 inpatients is .90.

Definitions

In addition to the somatoform disorder categories provided by DSM-IV, the Somatic Symptom Index (SSI-4/6; Escobar, 1997; Escobar & Canino, 1989), comprising at least four somatoform symptoms for men and six for women, was applied as cut-off for severe somatoform symptomatology. The SSI-4/6 concept was developed as an abridged somatization construct in order to cover clinically relevant somatization syndromes below the threshold of somatization disorder, since these authors believe that the definition of somatization disorder is too narrow. Hiller, Rief, and Fichter (1995) found further evidence confirming the use of SSI-4/6 as cut-off for severe somatization. Rief et al. (1998) could show that patients with SSI-4/6 and somatization disorder are comparable with respect to certain clinical characteristics (such as cognitions about body and health), and clearly distinct from patients with other mental disorders. In the present study the term multiple somatoform symptoms (MSS) is used for all patients meeting diagnostic criteria for SSI-4/6 or somatization disorder (according to DSM-IV criteria).

Group Definition

Based on the IDCL interview diagnoses, the sample was subclassified into three groups: patients with DSM-IV hypochondriasis comprising all patients with a combination of

hypochondriasis and MSS (HYP), patients with multiple somatoform symptoms MSS (i.e., SSI-4/6 or DSM-IV somatization disorder) but without hypochondriasis (MSS), and clinical controls (CONTR). Patients with other somatoform disorders (pain disorder, conversion disorder, body dysmorphic disorder) who neither had MSS nor were hypochondriacal, were excluded from data analysis.

Data Analysis

For both somatoform groups and the clinical control group, comorbidity with anxiety and personality disorders was analyzed by χ^2 -tests. The three groups were compared statistically by analyses of variance (overall differences of means) and pairwise comparisons; all post hoc comparisons were Scheffé-corrected. Correlations between somatoform, hypochondriacal, and depressive symptomatology, cognitions about body and health, and further clinical features were investigated and statistically compared by Z -transformed effect sizes. In addition to that, a stepwise regression analysis was conducted to analyze the relationship between high levels of hypochondriasis and other clinical characteristics.

Results

We found no significant differences in age, gender, and further general clinical characteristics among the three subgroups (Table 1).

In the diagnostic interviews 31 patients met criteria for hypochondriasis and 86 patients met criteria for MSS; 19 patients did not meet criteria for any specific somatoform disorder and therefore served as a clinical control group. In our total sample 28 of 31 patients with the DSM-IV diagnosis of hypochondriasis also fulfilled diagnostic criteria for MSS, but only 28 of 86 patients with MSS fulfilled DSM-IV-criteria for hypochondriasis.

Comorbidity with other mental disorders was investigated to obtain further information about differences in the general psychopathology of the three subgroups. We also

Table 1
General Characteristics of the Three Subgroups

	Group I (HYP) <i>N</i> = 31, <i>M</i> (<i>SD</i>)	Group II (MSS) <i>N</i> = 58, <i>M</i> (<i>SD</i>)	Group III (CONTR) <i>N</i> = 19, <i>M</i> (<i>SD</i>)	ANOVA (<i>df</i> = 107)/ Chi-square-tests
Age	43.4 (10.1)	44.4 (11.0)	45.8 (12.5)	$F = 0.29$; n.s.
% female	58.1%	65.5%	63.2%	$\chi^2 = 0.18$; $df = 2$; n.s.
Prognosis (0 = very good to 4 = very bad)	1.6 (0.9)	1.7 (0.9)	1.5 (1.0)	$F = 0.33$; n.s.
Condition at the end of treatment (0 = healthy to 4 = very bad)	2.2 (0.7)	2.1 (0.7)	1.7 (0.9)	$F = 1.92$; n.s.
Number of days of inpatient treatment	61.0 (19.4)	62.2 (16.4)	58.7 (11.5)	$F = 0.32$; n.s.
Number of weeks unable to work before treatment	13.1 (23.2)	12.2 (17.6)	14.7 (17.2)	$F = 0.09$; n.s.
Number of years since first manifestation	10.4 (11.4)	11.1 (10.8)	6.0 (6.9)	$F = 1.73$; n.s.
Number of previous psychological inpatient treatments	0.7 (1.0)	0.8 (1.2)	0.7 (0.9)	$F = 0.03$; n.s.
Number of previous psychological outpatient treatments	0.8 (0.8)	0.8 (0.9)	0.9 (0.6)	$F = 0.22$; n.s.

wanted to know whether hypochondriasis is especially related to anxiety, depression, or personality disorders. However, we found no significant group differences in the χ^2 -test, which could be due to small group sizes, although comorbidity rates might be slightly higher in the HYP group than in the MSS group (Table 2).

The three groups were then compared with respect to differences in somatoform, hypochondriacal, and depressive symptomatology, cognitions about body and health, and general psychopathology (Table 3). We found significant general differences among the three subgroups on all measures applied. Regarding depressive symptomatology, the differences among the three groups are significant only at the 5% level, while differences on all other measures are significant on the 1% level. In the Scheffé-test a significant difference at the 5% level between the HYP and the MSS group was found only for the Whiteley-Index; HYP patients score clearly higher than the proposed cut-off (five to six positive items) for hypochondriasis (Barsky et al., 1986; Palsson, 1988), while patients with MSS and clinical controls are below this cut-off. However, all differences between the HYP group and the control group are significant on the 5% level, while there are no significant differences between the MSS group and the control group.

Correlations between hypochondriacal symptomatology, somatoform symptoms, and other clinical characteristics were analyzed to obtain further information about the comorbidity of hypochondriasis and somatization on the basis of psychometric measurement apart from the level of DSM-IV diagnoses. We found significant correlations between the SOMS-7 score and most of the other clinical measures applied, except the subscale *Health Habits* of the CABAH; the Whiteley-Index score is significantly correlated with all scales applied including the SOMS-7. The relationship between SOMS-7 and Whiteley-Index scores is not significantly stronger than the relationship between SOMS-7 score and BDI, SCL-90-R, and CABAH (total) scores. Differences between the correlations of SOMS-7 and Whiteley-Index scores with other scales were found only with respect to CABAH

Table 2
Comorbidity with Anxiety, Depressive, and Personality Disorders

	Group I (HYP) <i>N</i> = 31	Group II (MSS) <i>N</i> = 58	Group III (CONTR) <i>N</i> = 19	I vs. II	II vs. III	I vs. III
Panic disorder	<i>N</i> = 10 32.3%	<i>N</i> = 15 25.9%	<i>N</i> = 6 31.6%	$\chi^2 = 0.29$ n.s.	$\chi^2 = 0.17$ n.s.	$\chi^2 = 0.01$ n.s.
Social phobia	<i>N</i> = 11 42.9%	<i>N</i> = 24 41.4%	<i>N</i> = 4 21.1%	$\chi^2 = 0.04$ n.s.	$\chi^2 = 1.63$ n.s.	$\chi^2 = 1.15$ n.s.
Anxiety disorders (general)	77.4%	69.0%	58.9%	$\chi^2 = 0.20$ n.s.	$\chi^2 = 0.26$ n.s.	$\chi^2 = 0.64$ n.s.
Depression (Major depression/ Dysthymic disorder)	<i>N</i> = 28 90.3%	<i>N</i> = 51 88.0%	<i>N</i> = 16 84.2%	$\chi^2 = 0.01$ n.s.	$\chi^2 = 0.02$ n.s.	$\chi^2 = 0.05$ n.s.
Obsessive-Compulsive Personality Disorder	<i>N</i> = 12 38.7%	<i>N</i> = 13 22.4%	<i>N</i> = 7 36.8%	$\chi^2 = 1.91$ n.s.	$\chi^2 = 1.15$ n.s.	$\chi^2 = 0.01$ n.s.
Avoidant Personality Disorder	<i>N</i> = 11 35.5%	<i>N</i> = 22 37.9%	<i>N</i> = 6 31.6%	$\chi^2 = 0.00$ n.s.	$\chi^2 = 0.09$ n.s.	$\chi^2 = 0.05$ n.s.
Personality disorders (general)	61.3%	56.9%	47.4%	$\chi^2 = 0.07$ n.s.	$\chi^2 = 0.24$ n.s.	$\chi^2 = 0.41$ n.s.

Table 3
Comparison of HYP, MSS, and CONTR Groups on Psychopathology Indices

	Group I (HYP) <i>N</i> = 31, <i>M</i> (<i>SD</i>)	Group II (MSS) <i>N</i> = 58, <i>M</i> (<i>SD</i>)	Group III (CONTR) <i>N</i> = 19, <i>M</i> (<i>SD</i>)	ANOVA	I vs. II	II vs. III	I vs. III
SOMS-7	45.00 (29.01)	34.52 (19.85)	21.00 (13.39)	$F = 7.04^{**}$	n.s.	n.s.	*
Whiteley-Index	8.67 (2.99)	5.50 (2.79)	3.65 (2.57)	$F = 20.19^{**}$	*	n.s.	*
CABAH	64.30 (23.39)	53.74 (17.19)	42.67 (12.09)	$F = 6.74^{**}$	n.s.	n.s.	*
SCL-90R (GSI)	1.45 (0.73)	1.15 (0.62)	0.85 (0.51)	$F = 5.39^{**}$	n.s.	n.s.	*
BDI	23.64 (11.67)	21.50 (9.89)	15.75 (8.05)	$F = 3.50^*$	n.s.	n.s.	*

* $p < 0.05$.

** $p < 0.01$.

subscale *Intolerance of Bodily Complaints*, which is significantly more strongly related to the Whiteley-Index score (Table 4).

In order to obtain further information about the relationship between hypochondriacal symptomatology and other clinical characteristics, a (stepwise) multiple regression analysis was conducted. The Whiteley-Index score was defined as dependent variable; the SOMS-7, SCL-90R (GSI-score), BDI, and CABAH subscale scores were used as predictor variables.

Our results show that CABAH subscale *Intolerance of Bodily Complaints* ($\beta = 0.54$, $t = 6.57$, $p < 0.01$), the BDI score ($\beta = 0.22$, $t = 2.58$, $p < 0.05$), and CABAH subscale *Bodily Weakness* ($\beta = 0.18$, $t = 2.06$, $p < 0.05$) account for $r^2 = 0.55$ of the variance of the hypochondriasis score, while no significant impact of the somatization score (SOMS-7) and the other scales applied was detected.

Table 4
Correlations between Self-Rated Measures

<i>N</i> = 108	SOMS-7 <i>r</i>	Whiteley-Index <i>r</i>	Significance of Differences between Correlations
Whiteley-Index	.46**	—	—
CABAH (All Items)	.53**	.64**	n.s.
CABAH-1 (Catastrophizing Cognitions)	.39**	.50**	n.s.
CABAH-2 (Intolerance of Bodily Complaints)	.34**	.70**	**
CABAH-3 (Bodily Weakness)	.56**	.43**	n.s.
CABAH-4 (Autonomic Sensations)	.46**	.48**	n.s.
CABAH-5 (Health Habits)	.06; n.s.	.24*	n.s.
SCL-90R (GSI)	.59**	.43**	n.s.
BDI	.53**	.43**	n.s.

* $p < 0.05$, 2-tailed.

** $p < 0.01$, 2-tailed.

Discussion

In this study, we assessed overlap and boundaries between hypochondriasis and somatization on different levels of clinical description. Regarding the relationship between hypochondriasis and somatization on the level of diagnoses, the results of the present study suggest that hypochondriasis might be only a secondary phenomenon of somatization syndrome, since only three patients with MSS had no diagnosis of hypochondriasis. In contrast to the results of Kirmayer and Robbins (1991) in primary care patients, which were based on psychometric measurement, hypochondriasis might be seen rather as an additional feature of somatization syndrome, not as a markedly distinct disorder justifying a specific DSM-IV diagnosis. However, the subjects of the present study were all psychosomatic inpatients, characterized by high levels of chronicity and psychiatric comorbidity. Not only the overlap between the two investigated somatoform disorders but also with other disorder groups, especially depression, is very large. For that reason, the large diagnostic overlap is only a weak indicator to clarify the relationship between somatization and hypochondriasis.

We found no significant differences in comorbidity rates of depression, anxiety, and personality disorders among the three subgroups; however, a slight tendency towards higher comorbidity rates appears in the hypochondriacal group, which might indicate a more severe psychopathology. A clearer distinction between hypochondriasis and somatization may result from regarding different aspects of general symptomatology. One limitation to the conclusions of this study might result from the fact that interrater reliability of diagnoses was not demonstrated by blind ratings. However, results of the diagnostic expert ratings were partly confirmed by the self-rated measures of somatization and hypochondriasis applied. When compared to the clinical control group, hypochondriacal patients were found to have significantly higher levels of psychopathology on all measures applied, while no significant differences exist between the MSS group and the clinical controls. Moreover, a significant difference between both somatoform groups was found for the Whiteley-Index, while there is no marked difference in hypochondriacal tendencies between MSS patients and clinical controls, confirming that high levels of hypochondriacal pathology are specific for patients with DSM-IV diagnosis of hypochondriasis but not for patients with MSS.

Regarding the relationship between the clinical characteristics investigated, only a moderate correlation between somatization and hypochondriasis scores was found, which is not distinct from correlations with other clinical characteristics such as depression or general symptomatology; the hypochondriasis score is significantly more strongly related to intolerance of bodily complaints than the somatization score. Moreover, the results of the regression analysis suggest that only intolerance of bodily complaints and depression account markedly for the variance of the hypochondriasis score, while the somatization score does not seem to be related to hypochondriacal tendencies at all. These findings would be in contrast to a classification of hypochondriasis as a dependent part of somatization. The strong relationship between hypochondriasis and intolerance of bodily complaints is somewhat unexpected, since preoccupation with fear of having a serious disease (i.e., catastrophizing cognitions) is described as a core characteristic of hypochondriasis by DSM-IV. However, intolerance of bodily complaints could be an important trigger for catastrophizing cognitions, since it indicates a perceptual distortion of normal somatic sensations, which might result in misinterpretation of these sensations as threatening symptoms of disease.

One conclusion to be drawn from the results of the present study is that somatization and hypochondriasis are partially overlapping phenomena, but there is as well a substan-

tial part of the psychopathology specifically related to hypochondriasis. In consequence hypochondriasis has to be seen as a diagnostic entity clearly distinct from somatization disorder and subthreshold variants that should be diagnosed independently as comorbid disorder. The large comorbidity between hypochondriasis and MSS could be explained as an effect of criteria definition in DSM-IV. The part of the definition “. . . based on the person’s misinterpretation of bodily symptoms” in the A Criterion of hypochondriasis might result in an artificial overlap with somatization syndrome, which is defined by unexplained bodily symptoms. However, hypochondriacal fear is produced not only by serious and chronic complaints but also by normal “signs” or harmless bodily sensations, such as a red spot on the skin interpreted as cancer. The connection with physical symptoms is not conclusive. Until now, there is no exact evidence about phenomena triggering hypochondriasis; even a “mental hypochondriasis,” characterized by fear of mental disorder might exist. In the last 10 years, subclassifying hypochondriasis as an anxiety disorder has repeatedly been discussed (Schmidt, 1994), since its core feature is fear of disease or “illness phobia” (Wesner & Noyes, 1991). A subclassification of this kind, including a revision of DSM-IV criteria emphasizing the aspect of fear, would certainly be more adequate and useful to provide a better understanding of boundaries and overlap of hypochondriasis and somatization. Moreover, it might help to reduce the large and sometimes misleading comorbidity rate of both disorders.

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