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Hypochondriasis: A Clinical Study

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Introduction

The concept of hypochondriasis, and particularly its nosological position, is far from clear, and there is still a great deal of controversy as to whether or not there exists a condition of primary or essential hypochondriasis. Many of the historical and theoretical ramifications are reviewed in another paper (Kenyon, 1964). The object of the present paper is to give an account of the clinical findings in a large series of patients in order to evaluate some of the hypotheses put forward in the literature, and especially to determine if there is sufficient evidence to delineate a separate group suffering from primary hypochondriasis only. There is a dearth of well-documented case series published, although studies based on the investigation of a group of patients have been made by Gillespie (1928, 1929), Brown (1936), Katzenelbogen (1942), Alarcon (1956), Shirvaikar (1957), Greer (1961) and Ladee (1961). However, none of these attempt any sort of comparison with a "control" series, as is done in the present investigation, nor in most cases are numbers sufficiently large for drawing valid conclusions.

Material and Method

Case records of all patients attending the Bethlem Royal and Maudsley Hospitals over the 10-year period 1951–1960 were scrutinized, and all those in which a diagnosis of hypochondriasis had been recorded were abstracted for further study. The first time such a diagnosis was given during this period was taken as the point from which to start the investigation. Cases were then divided into two categories according to whether this was the only or primary diagnosis or whether secondary to some other category, and throughout the rest of this study these two groups will be referred to as the primary and secondary hypochondriasis groups or P.H.G. and S.H.G. respectively.

The main object was to compare these two groups on a number of different variables to see whether in fact there was any justification for a separate diagnostic group of hypochondriasis only, i.e. the cases designated primary hypochondriasis were compared with a control group, seen at the same hospitals and over the same period of time, but with some other primary diagnosis and hypochondriasis as a secondary feature. For certain variables, comparisons were also made with the Joint Hospital statistics concerning all patients seen over approximately the same interval and published as the Bethlem Royal and Maudsley Triennial Reports (Blacker and Gore, 1955; Blacker, 1957; Hare, 1959 and 1962).

Results

(*A*) All Patients with Hypochondriasis

The total number of patients was 512, and of these 295 were in-patients and 217 out-patients. There were 301 cases of primary hypochondriasis and 211 of secondary. Over the 10-year period this gives an incidence for primary hypochondriasis of 1 per cent. for in-patients and 0·9 per cent. for out-patients, which is approximately 11 new in-patients and 16 new out-patients a year.

Age and Sex Incidence

This is given for all patients, but shown separately under the two diagnostic headings (Table I).

For those diagnosed as primary hypochondriasis, there was no difference in total incidence between the sexes, but the peak age incidence was slightly different: for males it was the 30–39 age group and for females the 40—49

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TABLE I

Age and Sex Distribution

Age Groups	Primary Hypochondriasis			Secondary Hypochondriasis		
	Male	Female	Total	Male	Female	Total
10–19 ..	4 (2·7%)	2 (1·3%)	6 (2%)	—	—	—
20–29 ..	30 (20%)	12 (8%)	42 (14%)	14 (13%)	10 (9·6%)	24 (11·3%)
30–39 ..	46 (30·7%)	33 (21·8%)	79 (26·3%)	24 (22·4%)	26 (25%)	50 (23·7%)
40–49 ..	33 (22%)	37 (24·5%)	70 (23·3%)	23 (21·5%)	24 (23%)	47 (22·2%)
50–59 ..	17 (11·3%)	32 (21·2%)	49 (16·2%)	17 (15·8%)	18 (17·3%)	35 (16·5%)
60–69 ..	17 (11·3%)	23 (15·2%)	40 (13·2%)	26 (24·3%)	16 (15·5%)	42 (19·9%)
70+	3 (2%)	12 (8%)	15 (5%)	3 (3%)	10 (9·6%)	13 (6·4%)
Totals	150 (100%)	151 (100%)	301 (100%)	107 (100%)	104 (100%)	211 (100%)

group, although for the whole group it was 30–39. The findings for secondary hypochondriasis are similar and show the same overall peak age incidence.

Religion

This was classified under five headings and the percentage incidence for the two groups as well as the average for all patients calculated from the Joint Hospital statistics are shown in Table II.

The figures for the P.H.G. conform very closely to the average figures for the Joint Hospital, and do not show any great excess of Jewish patients, Similarly there are no striking differences when compared with the S.H.G.

Social Class

This was classified into the five groups on the basis of occupation, as used by the Registrar-General. Rather than try and compare the results with the population at large, the average figures from the Joint Hospital statistics are used instead (Table III).

Again there is a very close correspondence between the P.H.G. and S.H.G., and comparison with the Joint Hospital statistics does not show any preponderance of social classes IV and V amongst patients with hypochondriasis.

Civil Status and Nationality

Civil status was classified under four headings and comparisons for the three groups made as before (Table IV).

Again figures for the two hypochondriacal groups are very similar, but differ from the Joint Hospital figures in having relatively more married and less single patients.

TABLE II

Religion

Religion	Primary Hypochondriasis	Average for Joint Hospital	Secondary Hypochondriasis
Church of England	209 (69·5%)	71·6%	162 (76·7%)
Roman Catholic	42 (13·9%)	13·0%	22 (10·4%)
Jewish	13 (4·4%)	3·9%	6 (2·8%)
Nonconformist	20 (6·6%)	6·5%	18 (8·5%)
Other	17 (5·6%)	5·1%	3 (1·6%)

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TABLE III
Social Class Distribution

Social Class	Primary Hypochondriasis	Average for Joint Hospital	Secondary Hypochondriasis
I	10 (3·3%)	5·6%	6 (2·8%)
II	35 (11·6%)	15·3%	26 (12·3%)
III	149 (49·5%)	55·5%	114 (54%)
IV	37 (12·3%)	12·1%	19 (9·2%)
V	31 (10·4%)	11·5%	24 (11·3%)
Unemployed	9		2
Retired	16 (12·9%)		8 (10·4%)
Not known	14		12

TABLE IV
Civil Status

Civil Status	Primary Hypochondriasis	Average for Joint Hospital	Secondary Hypochondriasis
Single	78 (25·9%)	35·4%	46 (21·8%)
Married or cohabiting	190 (63·1%)	52·5%	143 (67·7%)
Separated or divorced	12 (4%)	3·2%	5 (2·5%)
Widowed	21 (7%)	5·1%	17 (8%)

The nationality of the patient, i.e. country of birth, was not always accurately recorded, but approximately 9·0 per cent. of the P.H.G. and 5·6 per cent. of the S.H.G. were foreign born.

Diagnosis

The multiplicity of diagnoses was reduced to 9 groups for ease of comparison, and the main object was to establish which was the most frequently associated condition as either the secondary or primary diagnosis with hypochondriasis, as well as to compare the primary and secondary groups on this variable. Results are given in Table V.

From this it can be seen that affective disorder, organic state, personality disorder and hysteria are the four most commonly associated conditions for both primary and secondary hypochondriasis. An affective disorder was the primary condition in no less than 82·4 per cent. of all cases of secondary hypochondriasis.

TABLE V
Diagnosis

Diagnosis	Primary Hypochondriasis	Secondary Hypochondriasis
Hypochondriasis only	194 (64·4%)	—
Affective	35 (11·6%)	175 (82·4%)
Organic state	35 (11·6%)	7 (3·4%)
Personality disorder	16 (5·3%)	12 (5·7%)
Hysteria	8 (2·7%)	6 (2·9%)
Mental subnormality	7 (2·3%)	1 (0·5%)
Schizophrenia	—	3 (1·7%)
Paranoid state	2 (0·7%)	—
Other	4 (1·4%)	7 (3·4%)

Specific Symptoms

From the history of the present illness the presence or absence of five symptoms was noted, and the frequency distribution (not mutually exclusive as more than one symptom can occur in one patient) is given in Table VI.

Pain and affective symptoms (anxiety and depression) were the commonest of these symptoms reported in the history, with pain being particularly frequent in the P.H.G.

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TABLE VI

Specific Symptoms in the History

Symptom	Primary Hypochondriasis	Secondary Hypochondriasis
Pain	226 (75%)	131 (62%)
Anxiety	123 (40·8%)	121 (57·3%)
Depression ..	121 (40·2%)	131 (62%)
Tiredness ..	42 (13·9%)	42 (20%)
Weakness ..	32 (10·6%)	25 (11·8%)

Classification of Somatic Complaints

All somatic complaints for each patient were noted, and whenever possible classified in three different ways, (*a*) by distribution in different parts of the body, (*b*) by system involved, and (*c*) whether unilateral or not.

(a) *Distribution of complaints*. For this purpose the body was divided into 8 regions, with two other categories added of "other" and "diffuse" for complaints which could not be fitted into these. The frequency distribution of these complaints, for both groups, is given in Table VII.

TABLE VII

Frequency Distribution of Complaints

Body Region	Primary Hypochondriasis	Secondary Hypochondraisis
Head and neck	171 (56·8%)	106 (50·2%)
Abdomen ..	124 (41·1%)	67 (31·7%)
Chest	91 (30·2%)	65 (30·8%)
Back	74 (24·5%)	24 (11·3%)
Lower limbs ..	73 (24·2%)	30 (14·2%)
Upper limbs ..	42 (13·9%)	31 (14·7%)
Anal	45 (14·9%)	21 (10%)
Genitalia ..	36 (11·9%)	19 (9%)
Other	98 (32·5%)	43 (20%)
Diffuse	54 (17·9%)	42 (10%)

It is interesting to note the close correspondence between the two groups and the fact that the three most highly represented regions (head and neck, abdomen and chest) are in exactly the same order in both.

(b) *Complaints by system*. The frequency distribution of complaints by system is given in Table VIII.

TABLE VIII

Frequency Distribution of Complaints by Body System Involved

System	Primary Hypochondriasis	Secondary Hypochondriasis
Musculo-skeletal	147 (48·8%)	75 (35·5%)
Gastro-intestinal	146 (48·5%)	79 (37·4%)
C.N.S.	125 (41·5%)	75 (35·5%)
E.N.T.	66 (21·9%)	30 (14·2%)
Genito-urinary ..	50 (16·6%)	21 (10%)
Cardio-vascular	41 (13·6%)	37 (17·5%)
Eyes	33 (10·9%)	18 (8·5%)
Respiratory ..	28 (9·3%)	21 (10%)
Skin	22 (7·3%)	8 (3·7%)
Dental	5 (1·6%)	2 (1%)

The three "systems" most frequently involved are the gastro-intestinal, musculo-skeletal and C.N.S. Included under the latter category are headaches.

(c) *Laterality*. In the P.H.G. 18·9 per cent. (57) had definite unilateral symptoms and of these 65 per cent. were referred to the left side of the body and 35 per cent. to the right. Corresponding figures for the S.H.G. were 12·3 per cent. with unilateral symptoms, 80·7 per cent. left-sided, and 19·3 per cent. right-sided.

The data given so far refer to all patients in the series, i.e. both out-patients and in-patients. As more information is available for in-patients, it was felt that more detailed analysis should be confined to this subgroup, comprising 118 patients with primary hypochondriasis and 177 in the secondary category.

(*B*) IN-PATIENTS ONLY

Length of History

This was calculated for the present illness or episode only and the time divided into four periods, with results shown in Table IX.

From this it can be seen that those with primary hypochondriasis had, on average, longer histories (for the present illness) before finally being hospitalized.

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TABLE IX

Length of History (Present Illness)

Time	Primary Hypochondriasis	Secondary Hypochondriasis
Less than 6 months	7 (5·9%)	37 (20·9%)
6 months–2 years	41 (34·8%)	73 (41·2%)
2–6 years	41 (34·8%)	44 (24·9%)
Over 6 years ..	29 (24·5%)	23 (13%)
Totals	118 (100%)	177 (100%)

Precipitating Factors

Any precipitating factors for the present illness were noted and put into one of four categories, as shown in Table X.

TABLE X

Precipitating Factors (Present Illness)

Factor	Primary Hypochondriasis	Secondary Hypochondriasis
None	63 (53·3%)	88 (50%)
Mainly physical ..	36 (30·5%)	44 (25%)
Mainly psychological ..	19 (16·2%)	43 (24%)
Other	—	2 (1%)
Totals	118 (100%)	177 (100%)

For approximately one-half of cases in both groups there were no precipitating factors noted.

Course of Illness

This was taken for the whole illness as far as possible and not just restricted to the episode leading to admission. The time since onset was also calculated, with the following results:

Primary Hypochondriasis—Onset-Admission, mean 8·1 years (range 3 months–42 years)

Secondary Hypochondriasis—Onset-Admission, mean 7·7 years (range 2 months–40 years)

The course of the illness, up to admission, was classified into four categories (Table XI).

The main difference between the two groups is for the last two categories, i.e. in half the cases of the secondary group the illness was phasic in character, but only in 34 per cent. of cases in the primary group.

TABLE XI

Course of Illness

Course	Primary Hypochondriasis	Secondary Hypochondriasis
Constant-worsening	29 (24·5%)	36 (20·3%)
Constant-static ..	7 (5·9%)	11 (6·7%)
Fluctuating ..	42 (35·6%)	42 (23%)
Phasic	40 (34%)	88 (50%)
Totals	118 (100%)	177 (100%)

Past Psychiatric History

When a positive psychiatric history was noted, an attempt to gauge its severity was made by subdividing into three groups on the basis of treatment, i.e. whether treated as an in-patient, out-patient or recovered without any special treatment. Results are shown in Table XII.

Slightly more of the S.H.G. had a positive psychiatric history with a higher proportion having received in-patient treatment.

It is also of interest to note that of the 118 patients diagnosed as primary hypochondriasis 36 or 30·5 per cent. had previously been diagnosed as suffering from an affective illness.

TABLE XII

Past Psychiatric History

History	Primary Hypochondriasis		Secondary Hypochondriasis	
None	51 (43·2%)		67 (37·8%)	
Mental hospital or in-patient ..	34 (28·8%)	(56·8%)	60 (33·8%)	(62·2%)
Out-patient only	17 (14·4%)		28 (15·8%)	
No special treatment	16 (13·6%)		22 (12·6%)	
Totals	118 (100%)		177 (100%)	

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Family Psychiatric History

This was restricted to parents and siblings only, when it was found that there was a positive family psychiatric history in 42·3 per cent. of the P.H.G. and 40·6 per cent. of the S.H.G., again demonstrating the similarities between the two groups.

School and Work Record

The mean age on leaving school was exactly the same for the two groups, viz. 14·5 years. The work record was classified under four headings and results are given in Table XIII.

TABLE XIII
Work Record

Work Record	Primary Hypo-chondriasis	Secondary Hypo-chondriasis
Good	50 (42·3%)	96 (53·6%)
Fair	32 (27·1%)	38 (21·4%)
Poor	27 (22·8%)	37 (20·9%)
Not known or not applicable ..	9 (7·8%)	6 (4·1%)
Totals	118 (100%)	177 (100%)

Considering that of necessity such a classification must be rather arbitrary, the two distributions show a very similar trend.

Sexual History

This was categorized under three (rather arbitrary) headings and the two groups compared. Figures for the P.H.G. were 34 per cent. well-adjusted, 54·2 per cent. poorly-adjusted and insufficient information 11·8 per cent.; the corresponding figures for the S.H.G. were 40 per cent., 49·1 per cent. and 10·9 per cent. respectively.

There was no difference in mean age at the menarche and menopause between the two groups, that for the P.H.G. being 13·9 years and 48·7 years and for the S.H.G. 13·8 years and 48·3 years.

Fertility was calculated on the basis of mean number of children per marriage and was found to be 2·1 for the P.H.G. and 1·7 for the S.H.G.

Findings in Hospital

(*a*) Mental State—the predominant feature of the mental state was tabulated as a frequency distribution and the three categories with the greatest incidence were found to be the same for the two groups, the figures in brackets indicating the incidence, with that for the P.H.G. given first:

Depression .. .. .. (44%, 62·7%)
Anxiety .. .. .. (17·8%, 20·3%)
Paranoid or other delusions (10%, 2·2%)

(*b*) Physical State—this is as recorded on admission, and as far as possible the abnormalities are classified under the body system affected. The results are shown in Table XIV, where it can be noted that exactly the same proportion in both groups showed no physical abnormality (47·4 per cent.).

TABLE XIV
Physical Abnormalities

Physical Abnormality	Primary Hypo-chondriasis	Secondary Hypo-chondriasis
None	56 (47·4%)	84 (47·4%)
Cardio-vascular ..	21 (17·8%)	44 (25%)
Musculo-skeletal ..	12 (10·2%)	13 (7·3%)
Skin	6 (5·1%)	7 (4%)
E.N.T.	6 (5·1%)	2 (1·1%)
Eyes	5 (4·2%)	4 (2·2%)
C.N.S.	4 (3·5%)	8 (4·5%)
Respiratory ..	3 (2·5%)	10 (5·6%)
Gastro-intestinal ..	1 (0·8%)	1 (0·7%)
Other	4 (3·5%)	4 (2·2%)
Totals	118 (100%)	177 (100%)

If more than one abnormality was present, the main one was taken for the purpose of classification and comparison. Abnormalities of the cardiovascular and musculo-skeletal systems have the highest incidence in both groups.

(*c*) Intelligence—only those completing the Mill Hill Vocabulary Test and the Progressive Matrices are included in this assessment, when mean verbal and non-verbal I.Q.s were calculated for the two groups. Results are given in Table XV, which shows that there is only

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approximately 3 points difference between the two groups on both mean scores.

TABLE XV
Results of Intelligence Tests

Test	Primary Hypochondriasis	Secondary Hypochondriasis
Mean verbal I.Q. ..	102·8 (N=42)	99·8 (N=78)
Mean non-verbal I.Q.	102·4 (N=49)	105·6 (N=81)
Totals	91	159

(*d*) Treatment—the main treatment given was classified under five headings and the numbers receiving this, for both groups, is shown in Table XVI.

TABLE XVI
Type of Treatment

Treatment	Primary Hypochondriasis	Secondary Hypochondriasis
Drugs	38 (32·2%)	38 (21·4%)
Supportive psychotherapy	22 (18·6%)	27 (15·2%)
E.C.T.	21 (17·8%)	75 (42·3%)
Other psychotherapy ..	15 (12·8%)	20 (11·3%)
Leucotomy ..	1 (0·8%)	1 (0·8%)
Other	21 (17·8%)	16 (9%)
Totals	118 (100%)	177 (100%)

A higher proportion of the S.H.G. received E.C.T. but fewer were treated predominantly with drugs when compared with the P.H.G.

(*e*) Condition at Discharge—this was classified into 3 groups, and results for the P.H.G., S.H.G. and average figures from the Joint Hospital Statistics are given in Table XVII.

Those for the S.H.G. are very similar for the average for all the Joint Hospital patients, but those for the P.H.G. show a marked deficit in the "recovered or much improved" category. Slightly more also took their own discharge against advice.

(*f*) Premorbid Personality—the predominant personality traits were classified under 9 headings and the frequency distribution for both groups is given in Table XVIII.

TABLE XVIII
Frequency Distribution of Personality Traits

Predominant Traits	Primary Hypochondriasis	Secondary Hypochondriasis
"Normal" well adjusted ..	29 (24·5%)	47 (26·5%)
Anxious	31 (26·2%)	60 (33·9%)
Obsessional ..	27 (22·8%)	50 (28·2%)
Hypochondriacal	15 (12·7%)	30 (17%)
Paranoid	14 (11·8%)	17 (9·6%)
Schizoid	10 (8·4%)	17 (9·6%)
Cyclothymic ..	8 (6·7%)	14 (7·9%)
Hysterical ..	5 (4·2%)	5 (2·8%)
Depressive ..	4 (3·3%)	9 (5%)
Hypomanic ..	2 (1·7%)	4 (2·2%)
Psychopathic ..	1 (0·8%)	9 (5%)

Approximately the same proportion of both groups were judged to be normally well adjusted and there is a very similar pattern shown in the other categories, with the four most frequently occurring traits being in the same order of frequency in both groups.

TABLE XVII
Condition at Discharge

Condition	Primary Hypochondriasis	Average for Joint Hospital	Secondary Hypochondriasis
Recovered or much improved ..	25 (21·2%)	48·6%	87 (49·1%)
Slightly improved	46 (38·9%)	30·1%	64 (36·1%)
No change or worse	47 (39·9%)	21·2%	26 (14·8%)
Discharged against advice	25 (21·2%)	13·6%	30 (17%)

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(*g*) Follow-up Data—the length of follow-up, from the time the diagnosis of hypochondriasis was made to the time of the present study, is shown in Table XIX.

TABLE XIX
Length of Follow-up

Follow-up Period	Primary Hypochondriasis	Secondary Hypochondriasis
Less than 6 months	32 (27·1%)	33 (18·6%)
6 months–2 years	24 (20·3%)	55 (31%)
2–6 years ..	24 (20·3%)	41 (23·1%)
Over 6 years ..	4 (3·5%)	12 (7%)
No follow-up ..	34 (28·8%)	36 (20·3%)
Totals	118 (100%)	177 (100%)

There was no follow-up in approximately the same proportion of each group. An assessment was then made, on the evidence recorded in the notes, on the condition of the patient when last seen. A simple classification of no symptoms-mild symptoms-severe symptoms was adopted for classifying the results which are given in Table XX.

TABLE XX
Condition at Last Follow-up

Condition	Primary Hypochondriasis	Secondary Hypochondriasis
No symptoms ..	6 (5·1%)	12 (7%)
Mild symptoms ..	45 (38·1%)	78 (44%)
Severe symptoms	33 (28%)	51 (28·7%)
No follow-up ..	34 (28·8%)	36 (20·3%)
Totals	118 (100%)	177 (100%)

The same proportion of both groups was judged to have severe symptoms, but slightly less of the P.H.G. had no symptoms; this is in marked contrast to the results obtained for "condition at discharge" (Table XVII) when it would seem that the P.H.G. was going to have by far the worse prognosis.

A note was also made of any change in diagnosis since the original one of hypochondriasis. For the S.H.G. this occurred in only 10 cases (5·6 per cent.), but in the P.H.G. in 25 (21·1 per cent.) and consisted of the following: depression (16), schizophrenia (5), paranoid state (2), cerebral arteriosclerosis (1) and hysterical reaction (1). During this follow-up period there were 2 suicides and 1 leucotomy in the P.H.G., but no suicides and 7 leucotomies in the S.H.G.

DISCUSSION

Some of the frequently stated assertions about hypochondriasis are not borne out by the present survey; for instance (primary) hypochondriasis is not found predominantly in old men, as the sex distribution was found to be equal and the peak age incidence to be 30–39. There was no excess of Jewish patients, nor was hypochondriasis diagnosed any more frequently in the two lowest social classes. Using those with secondary hypochondriasis as a control group, there were no striking differences between this group and the P.H.G. on age and sex incidence, religion, social class and civil status.

There was also a close correspondence between the two groups for associated psychiatric condition, with affective disorders (mainly depression, but including anxiety states) holding pride of place, and this has been the experience of others (Hopewell-Ash, 1934; Alarcon, 1956; Brown, 1936; Shirvaikar, 1957; Ladee, 1961). Indeed one author goes as far as to state: "Clinically, where hypochondriasis is not an anxiety state (psychoneurosis) it represents manic-depressive psychosis" (Hopewell-Ash, 1934). This association is further borne out by the high incidence of symptoms of both anxiety and depression found in the histories of both groups (Table VI). However, the most striking feature here was the high incidence of pain as a symptom; for instance headache, backache and other not so well localized aches and pains. How various psychiatric syndromes may present with pain has been the subject of recent comment (Ackner, 1957a). In another survey it is stated that: "Symptoms of hypochondriasis mostly comprise unpleasant sensations referred to different parts of the body" (Shirvaikar, 1957). In some cases the pattern corresponds closely to what has been

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called "psychogenic regional pain" (Walters, 1961). That facial and head pain may be closely associated with depression has already been made use of therapeutically (Webb and Lascelles, 1962) and further clarification of the part played by headache in psychiatric practice has been made by Gittleson (1961, 1962).

The combination of pain and the high proportion of symptoms referred to the musculoskeletal system (Table VIII) is in keeping with recent work on psychosomatic aspects of rheumatism (Halliday, 1937, 1941, 1942; Ross *et al.*, 1961) and backache (Paul, 1950). It has been pointed out that "rheumatism" accounts for 12 per cent. of all incapacitating sickness among industrial workers (Halliday, 1949), and in the light of present knowledge it is interesting to speculate as to how many of these would in fact be suffering from an emotional illness. Further, one general practitioner is quoted as stating that of the milder types of depression 40 per cent. presented with physical complaints as possible organic disease (Ackner, 1957b).

The body regions most affected by hypochondriacal complaints were head and neck and abdomen, but whether classified by region or system involved (Tables VII and VIII) there is a close correspondence between the primary and secondary hypochondriasis groups. That the head and neck has the highest area of cortical representation in terms of the body homunculus is of interest, and may also be important in connection with recent work on disorders of the body image. That the abdomen and gastro-intestinal tract should be highly represented is in keeping with the original idea of the pathology of hypochondriasis, and is reflected in descriptions given in the 19th century (e.g. Allbutt, 1884; Gull and Anstey, 1868). An extensive review of the concept of "visceroptosis" (Bedingfield, 1929) demonstrates the importance of constitutional and psychological factors, and a more recent study warns against indulging in extensive investigations and operations in cases of gastro-intestinal hypochondriasis (Alvarez, 1944). In his survey of 100 patients Shirvaikar (1957) also found complaints referred to the abdomen to be second in frequency to those in the head. Ladee (1961) on the basis of his clinical experience states that alteration of feeling in the region of the upper abdomen was more influential in certain types in producing hypochondriasis than operations and diseases elsewhere. Sir George Savage (1892), in his article in Hack Tuke's *Dictionary of Psychological Medicine*, discusses special types of hypochondriasis under the three headings of (1) Head Hypochondriasis, (2) Hypochondriasis of the Digestive Tract, and (3) Sexual Hypochondriasis. But it has been recently suggested that investigations of ". . . such fruitful correlations as probably exist . . . between hypochondriasis and non-gaseous abdominal bloating", would be worth while (Crawford, 1962). In a study of duodenal ulcer patients it was concluded that ". . . the hypochondriac significance of pain is one of several factors involved in the etiology of duodenal ulcer" (Stenbäck, 1961).

Of those in the P.H.G. with unilateral symptoms 65 per cent., and in the S.H.G. 80 per cent., experienced them on the left side of the body. This high proportion, particularly in the S.H.G. with its high incidence of depression, may reflect the symbolical associations of the left with sinister, evil, bad and irrational (e.g. Halliday, 1937; Mead, 1952; Cirlot, 1961) although the more mundane explanation is possible that it is due to the relatively less developed state of the right side of the cerebral hemisphere (Halliday, 1949).

There is little agreement in the literature over the previous personality of patients with hypochondriasis; for the present series predominant personality traits were assessed for in-patients only, with the result that the anxious-obsessional type was the most frequent, but this was non-specific, as it was also the predominant type in the S.H.G. This again demonstrates the similarities between the two groups. In the most recent enquiry into the personality characteristics of patients with hypochondriasis, no specific personality type was found except for ". . . their unusual, peculiar attitude towards health and sickness" (Katzenelbogen, 1942).

The rest of the data on the in-patients (Tables IX–XVII, IX and X) again confirms the similarities between the primary and

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secondary hypochondriasis groups, the only outstanding differences being the longer history of the present illness, less with a phasic course, a smaller proportion with overt affective features, fewer receiving E.C.T. and fewer recorded as recovered at discharge for the P.H.G. This (apparently) poorer short-term prognosis for the P.H.G. is later "made up" in the sense that at follow-up the two groups again approximate, but by this time 21 per cent. of the P.H.G. have had a change of diagnosis. There are very few follow-up studies in the literature; Brown (1936) gives the results of treatment in 41 patients after a follow-up period of 9 months, when 13 were recovered or much improved, 14 improved and 14 showed no change; Richards (1941) re-examined 22 children and adolescents 11 years after treatment and found 86 per cent. to be well adjusted and to have no somatic complaints; Greer (1961) followed up 175 psychoneurotic patients for 4–6 years and found no relationship between outcome at discharge or at follow-up and the presence or absence of somatic symptoms during time of admission.

In the past hypochondriasis has been compared and contrasted with hysteria, but more recent work on hysteria has tended to show that it is not a simple disease entity, as was once thought, but is used in different ways and can itself be symptomatic of different syndromes (Chodoff and Lyons, 1958; Slater, 1961; *Lancet*, 1962); and it is now suggested that hypochondriasis is in a similar position. It can be concluded that hypochondriasis, particularly when as rigidly defined as by Gillespie (1929), does not form a nosological entity, but is rather part of another syndrome, most commonly an affective one.

Summary

Data are presented on 512 patients seen at the Bethlem Royal and Maudsley Hospitals from 1951–1960, who were given a diagnosis of either primary or secondary hypochondriasis. These two groups are contrasted and compared and on some variables compared with all patients seen at the same hospitals over the same period.

The incidence of primary hypochondriasis was 1 per cent., with equal sex distribution and a peak age of 30–39. There was no excess of Jewish patients, nor of patients in the lowest two social classes. Using the secondary hypochondriasis group as a control group, there were no striking differences between the two groups on age and sex incidence, religion, social class and civil status. An affective disorder was the commonest of the associated diagnoses in both groups. The nature and distribution of the somatic complaints was also studied.

In a more detailed analysis of the 295 inpatients it was found that the primary hypochondriasis group had a longer history for the present illness, less with a phasic course, a smaller proportion with overt affective features, fewer received E.C.T. and fewer were regarded as recovered at discharge. At follow-up the groups again approximate on degree of recovery, but by now 21 per cent. of the primary group have had a change in diagnosis. There were no essential differences between the groups on precipitating factors, past psychiatric history, family psychiatric history, school and work records, sexual adjustment, predominant features of the mental state, physical disabilities, I.Q. and pre-morbid personality.

It is concluded that, on the available evidence, hypochondriasis is always part of another syndrome, most commonly an affective one.

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