A Reconceptualization of the Somatoform Disorders

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Since its introduction in DSM–III, the Somatoform Disorders category has been a subject of controversy. Critics of the grouping have claimed that it promotes dualism, assumes psychogenesis, and that it contains heterogeneous disorders that lack validity. The history of these disorders is one of shifting conceptualizations and disputes. A number of changes in the classification have been proposed, but few address problems that arise with the current formulation. The authors propose a dimensional reconceptualization based on marked and persistent somatic distress and care-eliciting behavior. This formulation is based on the interpersonal model of somatization. The authors propose testing of this conceptualization and indicate how this might be done.

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The framers of DSM–III took the “hysterical” and “hypochondriacal” neuroses from earlier versions and created a new category: the somatoform disorders. Many have regarded this new grouping as unsatisfactory and have offered various solutions to the problems they see, including elimination of the category altogether. As the time for DSM–V approaches, debate about these disorders is intensifying, and impetus for change is growing. In this article, we review problems with the classification of somatoform disorders in DSM–IV, the background and development of this classification, and solutions proposed for DSM–V. We then offer a reconceptualization and suggest how this new model might be tested.

Problems With the Current Classification

Critics claim that the Somatoform Disorders section of DSM promotes mind–body dualism. Defined in terms of physical symptoms, the somatoform disorders are regarded as psychological in nature because no organic disease explains them. Consistent with biomedical theory and practice, they are viewed as non-legitimate disturbances for which patients themselves are responsible. Hence, patients with such disorders are seen as the province of psychiatry, rather than general medicine.

Some claim that patients who are ill but without disease pose a threat to Western biomedicine. They say that, to maintain this system, it is necessary to devalue and stigmatize such patients. Although patients with psychiatric disorders generally are stigmatized, those with somatoform disorders are singled out because these disorders masquerade as physical conditions. Critics contend that such disorders do not assume recognizable form in cultures lacking this dualism. They see them as creations of dualistic thinking.

Somatoform Disorders in DSM–IV involve conceptual ambiguity. Individual disorders are conceptualized in terms not only of somatic distress but also an absence of organic disease and failure to respond to medical care. A diagnosis of hypochondriasis, for instance, requires a patient to have been evaluated by a physician, found to be
without physical explanation for their symptoms, and to have resisted appropriate reassurance.3

The somatoform disorder categories are criticized for lack of validity.14 Diagnostic categories are regarded as valid “if they have been shown to be discrete entities with natural boundaries that separate them from other disorders.”15 There have been few studies of clinical features, biological markers,16 family aggregation,17 longitudinal course, or treatment response.18 However, few psychiatric diagnoses are valid by the above criteria, so the somatoform disorders are not alone. Still, many diagnoses have high utility because they convey information about etiology, outcome, and treatment response.15 This kind of utility is generally lacking for the somatoform disorders. Such diagnoses are rejected by patients who see their problems as physical. Also, the rarity of these disorders, as currently defined, does not reflect the level of somatic distress encountered by clinicians.4,19

Finally, the somatoform disorders are heterogeneous and lack clear definition.4 All have extensive Axis I, Axis II, and Axis III comorbidity, and exclusionary rules regarding coexisting disorders are not clear. Also, the thresholds set for various disorders are either too low (e.g., Pain Disorder) or too high (e.g., Somatization Disorder).20,21

The classification of functional somatic syndromes (e.g., irritable bowel syndrome, fibromyalgia, and chronic fatigue syndrome) is an unsolved problem.22 These disturbances have “unexplained symptoms,” yet are classified by nonpsychiatric physicians according to a competing system that may have greater acceptance and utility.

These criticisms call for a reexamination of existing models and reclassification of the somatoform disorders. Before reviewing the proposed reconceptualization of the category, let us consider some historical background.

**Historical Background**

Hysteria and hypochondriasis have been recognized since antiquity. Both were ill-defined disorders, characterized by multiple physical as well as psychological symptoms, especially depression. They had little resemblance to present-day disorder classifications that only began to emerge in the eighteenth and nineteenth centuries as diseases with anatomical pathology were identified. Hysteria, the fore-runner of somatization disorder, was attributed to wanderings of the uterus.23 Hypochondriasis was related to disturbance of upper abdominal organs, especially the stomach and spleen.24

During the 19th century, hysteria and hypochondriasis, which had once been frequent diagnoses, all but disappeared as organic diseases were removed from the respective categories.25 For hysteria, these included tertiary syphilis and epilepsy, and, for hypochondriasis, they included gastrointestinal diseases. Toward the end of the century, hypochondriasis was subsumed under the broad category of neurasthenia, although it later reemerged as something distinct.26 At the same time, Hysteria was popularized by Charcot, and it became a concern of psychoanalysis. According to Breuer and Freud,27 mental distress might be converted into physical dysfunction symbolic of that distress. Consequently, such functional neurological disturbances became known as “conversion” symptoms.

Conversion reaction characterized by functional neurological symptoms was included in DSM–I,1 but hysterical and hypochondriacal neuroses did not appear until DSM–II.2 Hysterical neurosis, an acute reaction to stress, consisted of involuntary loss, or disorder of, function. Hypochondriacal neurosis was dominated by preoccupation with the body and fear of presumed disease of various organs.

DSM–III3 added a chronic form of hysteria, labeled Somatization Disorder. In DSM–III, explicit criteria were introduced, and a new group of somatoform disorders was created. The essential feature was physical symptoms suggestive of a physical disorder (hence somatoform) in the absence of organic disease and presence of psychological factors. Criteria for somatization disorder were based on the description of hysteria by Briquet28 and Purtell et al.29 These authors described a polysymptomatic syndrome in women that began early in life and was characterized by chronic ill health and complicated medical history, presented dramatically. Guze30 and others showed that this diagnosis was stable over time, that the disorder remained chronic, and that it occurred in female family members. Criteria for hypochondriasis were based on the description of Gillespie,31 who defined it as “a mental preoccupation with a real or supposititious physical or mental disorder.” Other disorders included in the somatoform category were conversion disorder and psychogenic pain disorder.

A number of modifications to the somatoform criteria were made in DSM–III–R and DSM–IV.2,32 First, several categories were added. Undifferentiated Somatoform Disorder is characterized by unexplained physical symptoms falling below the threshold for somatization disorder. Also, Body Dysmorphic Disorder was added, as was a residual category, Somatoform Disorder, Not Otherwise Specified. Because the DSM–III Somatization Disorder criteria were difficult to apply, they were simplified for DSM–IV, which
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now requires a combination of pain, gastrointestinal, sexual, and pseudoneurological symptoms. Conversion Disorder in DSM–IV is more narrowly defined as symptoms affecting voluntary motor and sensory functions, rather than any symptom suggestive of a physical disorder. The criteria for Pain Disorder were modified to include subtypes. These now include Pain Disorder 1) Associated With Psychological Factors; 2) Associated With Both Psychological Factors and a General Medical Condition; and 3) With a General Medical Condition alone. Several changes in the criteria for Hypochondriasis were also made. DSM–IV stipulates that the belief concerning serious disease is not delusional. The disturbance must have lasted 6 months and must not be due to an anxiety, depressive, or other somatoform disorder. Also, separate criteria for Specific Phobia, Other Type (illness) were introduced. Illness-phobic patients are said to fear contracting a serious illness, whereas hypochondriacal patients believe that such illness already exists.

The ICD–10 Somatoform Disorder criteria differ from those in DSM–IV in several important respects. In ICD–10, body dysmorphic disorder is incorporated in the criteria for Hypochondriasis. Also, the ICD–10 includes a category called Somatoform Autonomic Disorder. The criteria call for symptoms of autonomic arousal in the absence of any disturbance of structure or function. The criteria for somatization disorder are less restrictive, calling for at least 2 years of multiple and variable unexplained symptoms representing at least two organ systems. The ICD–10 criteria for Pain Disorder call for persistent, severe, and distressing pain (continuously for at least 6 months) that cannot be explained by a physical condition. DSM–IV, by contrast, specifies an important role for psychological factors, but has no duration requirement.

Alternatives to the Current DSM Classification

A number of authors, beginning with Mechanic, have focused on illness behavior. Such behavior is appropriate for a person with physical disease occupying the “sick role.” However, when such disease is lacking, it may be viewed as abnormal. According to Bass and Murphy, behavior of this kind may be a manifestation of disordered personality. As they see it, somatoform disorders are best conceptualized as personality disturbances. Consistent with their view, these disorders have an early onset and lifelong pattern of interpersonal difficulties with caregivers and attachment figures. Also, high rates of personality disorders have been observed among somatoform patients.

Along similar lines, Stuart and Noyes have proposed an interpersonal model for somatization. According to this model, somatic symptoms represent care-seeking behavior on the part of individuals with insecure attachment. They, like Bass and Murphy, point to the importance of developmental factors both for shaping personality and for directing attention toward somatic symptoms. Experience with illness in oneself or one’s family may be an important causal factor. These authors would also classify the somatoform disorders among the disorders of personality or attachment style.

Stress-diathesis modeling provides yet another conceptualization for somatization and somatoform disorders. According to this model, some patients are vulnerable to somatic distress by virtue of their psychological make-up; they deviate from the norm on one or more psychological dimensions. Pennebaker and Watson, in their review of the literature, found strong and consistent evidence linking symptom-reporting and hypochondriacal worry to neuroticism or negative affectivity. Neuroticism is the major personality dimension included in virtually all trait models. Persons who score high on this dimension experience and report negative emotions and overreact to stress. In their model of somatization, Kirmayer and Taillefer included such additional factors as attentional set, coping style, and autonomic reactivity. Along similar lines, Cloninger et al. see the development of a somatoform disorder “as part of a complex adaptive process involving nonlinear interactions among multiple contributing factors.” They note that patients with somatization disorder are likely to have borderline personality traits and be high on harm-avoidance and novelty-seeking.

McHugh and Slavney offer a different conceptualization. For them, hysteria (somatization disorder) is a disturbance of goal-directed behavior and should be classified as such. It is not something a person has but something a person does. It is an imitation of physical conditions by persons who believe they suffer from some disease. The goal of their behavior is to persuade others that they are ill. The factors that provoke this behavior are those that may find solution in adoption of the sick role or in publicly-acknowledged disability. McHugh proposed an idio- pathic classification of psychiatric conditions composed of four clusters of disorders. One of these clusters is made up of patients who adopt fixed, maladaptive behaviors (i.e., substance abuse, eating disorders, somatization disorder, etc.).

Another proposal calls for elimination of the Somatoform category in DSM–V. In addition to the problems
outlined earlier, proponents note that this heterogeneous grouping is based on clinical considerations (i.e., the need to exclude physical conditions), rather than on similarities between individual disorders or shared mechanisms.\textsuperscript{54} Once eliminated, the disorders within this category might be reassigned. For instance, Conversion Disorder appears to share essential features with the dissociative disorders and might be moved to that section.\textsuperscript{55} Hypochondriasis might be relocated to the anxiety disorders (health-anxiety disorder) or placed within an obsessive-compulsive spectrum.\textsuperscript{7,56} Body Dysmorphic Disorder might also be reclassified within such a spectrum, although the disorder remains ill-defined, and evidence for it is inconsistent.\textsuperscript{57} Somatization Disorder might be reclassified among the unstable (Cluster B) personality disorders.\textsuperscript{56}

Some advocate less-radical modifications to the existing classification. Rief and Sharpe,\textsuperscript{58} for instance, call for a broader conceptualization, especially of somatization disorder. This disorder is presently defined only by the type and number of somatic symptoms. Excluded from the criteria is any mention of emotions, beliefs, and behaviors that define most mental disorders. These authors call for adding such characteristics (e.g., illness attribution, attentional focus, symptom amplification, illness behavior) either within the present system or by modifying it to include new axes.\textsuperscript{59} Other proposals involve alternative definitions of individual disorders, especially somatization disorder. For example, Fava et al.,\textsuperscript{60,61} have offered diagnostic criteria for a series of psychosomatic syndromes occurring in association with medical conditions, not separate from them. Alternative definitions for several DSM and ICD somatoform disorders are included. Similarly, Martin\textsuperscript{64} proposed a diagnostic scheme linking somatoform disorders to psychosocial stressors. In different ways, these alternatives attempt to bridge the mind–body separation.

Efforts have also been made to redefine individual disorders, especially somatization disorder and hypochondriasis, so as to include more of the somatically distressed population.\textsuperscript{63} As defined in DSM–IV, they are rare. To address this concern, Escobar et al.,\textsuperscript{64} among others, have proposed criteria for an “abridged” somatization disorder category, based on fewer somatic symptoms than were required for the DSM–III Somatization Disorder diagnosis. Kroenke et al.\textsuperscript{21} developed criteria for “multisomatof orm disorder.” These require a number of unexplained symptoms, as well as at least 2 years of multiple somatoform symptoms. When these modified criteria have been applied, the prevalence of somatization or multisomatof orm disorders has substantially increased, whereas the extent of functional impairment and healthcare utilization have remained much the same. With respect to hypochondriasis, Guerje et al.\textsuperscript{65} observed that, if the criterion of failure to respond to reassurance were set aside, the prevalence would increase considerably, yet the patient characteristics would remain unchanged. Furthermore, Looper and Kirmayer\textsuperscript{66} found that persons who had persistent illness worry, but who did not meet criteria for hypochondriasis were, nevertheless, distressed and impaired.

\textbf{Proposed Reconceptualization}

We propose a reconceptualization of the somatoform disorders, as outlined in Table 1. This new framework has five features, the first two of which are specific for individual diagnoses. First, any formulation for the grouping must begin with somatic distress. Such distress may take varied forms. As indicated by Hiller and Rief,\textsuperscript{67} four types of clinical presentations should be covered by the generic term. Included are patients who 1) suffer from multiple symptoms in different parts of the body (polysymptomatic); 2) suffer from only one symptom in a single organ system (monosymptomatic); 3) experience health-anxiety or disease-conviction as the prominent feature (hypochondriasis); and 4) are excessively concerned about the appearance of their body (body dysmorphic disorder). All these types are included in the first item.

The second feature is related to the first. Somatic distress is associated with care-eliciting behaviors that are focused upon it. Such illness behaviors, which are prominent among somatoform disorders, may take a variety of forms that include persistent seeking of reassurance, sick-role privileges, and medical care. These behaviors are directed toward healthcare providers as well as others in the individual’s social network. They may or may not have their basis in recognized medical conditions, but it is their marked and persistent nature, not their origin, that characterizes them.

\begin{table}[h]
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\caption{Framework for a Reconceptualization of Somatoform Disorders}
\begin{tabular}{|l|}
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1. Marked and persistent distress related to, and preoccupation with, physical symptoms, illness, defect, or impairment. \\
2. Marked and persistent illness behavior related to physical symptoms, illness, defect, or impairment. \\
3. The somatic distress and illness behavior cause impairment in physical, occupational, or interpersonal functioning. \\
4. The disturbance is chronic. \\
5. The distress is not better accounted for by other psychiatric disorders. \\
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\end{tabular}
\end{table}
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The third feature makes specific mention of areas of dysfunction characteristic of somatoform disorders. Physical impairment often extends to work or employment (e.g., reduced efficiency, lost work-days), and interpersonal impairment may include interactions with medical professionals. The doctor–patient relationship is often strained, and “doctor-shopping” may occur.68

The fourth feature indicates that the disorders are chronic, and the fifth covers exclusionary criteria for other psychiatric disorders.

Some of the current somatoform disorders fit this conceptualization better than others. Conversion symptoms tend to be acute, and so may fall outside the framework of chronic disturbances outlined here.69 Hypochondriasis involves abnormal emotions and beliefs as well as prominent somatic distress.70 The focus of distress in body dysmorphic disorder is on perceived defects in appearance. Although our proposal specifically mentions defects, its inclusion would require empirical support.71 Pain disorder, as well as conversion disorder, represent monosymptomatic somatoform disorders.72

Table 2 displays proposed diagnostic criteria for hypochondriasis (health-anxiety disorder) and somatization disorder. They are, in many respects, contrasting conditions, and their criteria include contrasting clinical features: for hypochondriasis, persistent reassurance-seeking and, for somatization disorder, persistent care-rejection.73 Criteria for other disorders might be drafted by use of the same format.

The proposed criteria do not mention any response to medical care (i.e., failure to respond to reassurance) of the sort found in DSM–IV Hypochondriasis.33 As indicated, the current criteria have been criticized for this inclusion. Similarly, the proposed criteria do not state that symptoms are unexplained, as is the case in DSM–IV Somatization Disorder.33 There are several reasons for this. First, this is an unclear distinction, which has been found to have little significance or empirical support.74 Fink et al.75 have demonstrated that valid criteria for hypochondriasis do not require this kind of medical information. As these authors showed, characteristic forms of somatic distress and illness behavior appear sufficient for somatoform diagnoses even in the presence of organic disease. Second, disorders should be defined in terms of features that are present, not those that are absent. Third, saying that symptoms are unexplained implies a failure to conform to biomedical theory, according to which, illness must correspond to underlying disease.58 Such failure is not a satisfactory basis for classification.

The proposed conceptualization has several advantages. First, it reflects a biopsychosocial, rather than the more restrictive biomedical, model. The biopsychosocial formulation does not artificially separate mind from body, a division that has plagued conceptualization of the somatoform disorders. Second, the disorders are not defined by an absence of organic disease; similarly, they are not defined by inappropriate response to medical treatment. Instead, they are characterized by persistent health preoccupation and care-seeking behavior, irrespective of the “legitimacy” of the patient’s physical condition. Third, the proposed conceptualization appropriately emphasizes behavioral disturbances. Many have noted the prominence of personality and interpersonal problems among somatoform patients.40,41 These features make for more reliable and easily understood criteria. Finally, this conceptualization is dimensional; implied is the notion that somatic distress and illness behavior represent exaggerations of the normal. Somatoform disorders are, therefore, deviations of quantity, not quality.

Still another advantage is that our proposed conceptualization conforms to the interpersonal model of somatization. According to this etiologic model, individuals with somatoform disorders manifest care-eliciting behavior stemming from insecure attachment.43 Evidence for this

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<tr>
<th>TABLE 2. Proposed Criteria for Hypochondriasis and Somatization Disorder</th>
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<tr>
<td><strong>Hypochondriasis (Health Anxiety Disorder)</strong></td>
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<tr>
<td>1. Marked and persistent preoccupation with fear of having, or belief that one has, serious illness.</td>
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<tr>
<td>2. Marked and persistent reassurance-seeking or checking behavior.</td>
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<tr>
<td>3. The preoccupation with serious illness and reassurance-seeking behavior cause impairment in physical and interpersonal functioning.</td>
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<tr>
<td>4. The disturbance is chronic.</td>
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<tr>
<td>5. The preoccupation and reassurance-seeking are not better accounted for by other psychiatric disorders.</td>
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<tr>
<td><strong>Somatization Disorder</strong></td>
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<tr>
<td>1. Marked and persistent preoccupation with multiple somatic symptoms and physical disability.</td>
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<tr>
<td>2. Marked or persistent demands for, yet rejection of, health-related care and concern.</td>
</tr>
<tr>
<td>3. The preoccupation, as well as demands for, and rejection of, care cause impairment in physical and interpersonal functioning.</td>
</tr>
<tr>
<td>4. The disturbance is chronic.</td>
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<tr>
<td>5. The preoccupation, as well as demands for, and rejection of, care are not better accounted for by other psychiatric disorders.</td>
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model has been accumulating. Specifically, a number of recent studies have found associations between insecure attachment styles and reporting of somatic symptoms.76–79 Also, several studies have demonstrated relationships between various forms of insecure attachment and hypochondriacal concerns.78,80,81 Both clinical impression and investigation point to distinctive attachment styles associated with hypochondriasis and somatization disorder; that is, preoccupied and dismissive, respectively. This is a testable model for which evidence already exists, and it moves us closer to an etiologically-based classification.

Testing the Model

In testing the proposed model, there are several questions to be answered: First, do the somatoform disorders share combinations of somatic distress and care-seeking behavior as specified by this model? Care-seeking behavior is observed in insecurely attached individuals, especially when relationships are threatened by illness.82 Consequently, various attachment styles may be linked to one or another form of somatic distress, and such links might be demonstrated.83 Likewise, personality deviations, such as high neuroticism and low agreeableness, which are associated with interpersonal difficulties and unsatisfactory relationships with caregivers, may be closely related to somatic distress.84

Second, do the criteria distinguish individual somatoform disorders from each other?75,85,86 There is evidence that hypochondriasis is a multidimensional construct that includes illness-fear, illness-belief, somatic preoccupation, and interpersonal alienation.87 There is also evidence of associations with neuroticism and preoccupied attachment style.81 Somatization disorder, in contrast, appears to comprise multiple somatic symptoms and Cluster B (especially borderline) personality traits.88 Clinically, a dismissive attachment style has been observed in patients with this disorder. A review of the preliminary evidence suggests that, in many respects, these are contrasting disorders—one, externalizing and the other, internalizing.85 For example, Leibbrand et al.86 compared patients with DSM–IV Hypochondriasis and DSM–IV Somatization Disorder with respect to symptoms and personality traits. They found that, despite the overlap in these diagnoses, they were distinguishable on self-report measures.

Third, do instruments exist with which to assess the critical dimensions that define the somatoform disorders?89,90 Dimensions that appear most relevant to our proposed reformulation include somatic distress, attachment style, personality, illness behavior, cognitive dysfunction, and emotional disturbance. Within each of these, there are likely to be sub-dimensions. For instance, somatic distress may take a variety of forms, including pain symptoms, pseudoneurological (conversion) symptoms, autonomic symptoms, gastrointestinal symptoms, defects of appearance, functional impairment, and so on.91–93 Similarly, there are a number of attachment styles and personality dimensions that have been linked to somatic distress of one kind or another. However, in many instances, the available research offers little guidance. Because it will be important to distinguish somatoform from non-somatoform dimensions, measures of psychological symptoms and symptoms due to physical conditions also must be included.94

Some instruments for the various dimensions within our reconceptualization currently exist, whereas others may need to be developed. Hiller and Janca95 have reviewed the available measures for somatoform disorders. Many are multidimensional, especially those for the evaluation of hypochondriasis. In addition to the self-report instruments, there are a number of structured, observer-rated interviews and checklists that include, or are designed specifically for, somatoform disorders. Hiller and Janca95 note that available instruments are strongly influenced by the current DSM and ICD classifications, and, therefore, reflect many of the problems discussed earlier.

These problems highlight the need to develop a new generation of assessment instruments to measure the key components of our reformulation. A detailed discussion of this issue is beyond the scope of this article, but we note a few basic considerations here. First, no existing instrument contains all—or even most—of the basic elements in our reformulation. Indeed, we currently lack reliable and valid measures for several aspects of this model. Accordingly, there is need for a new assessment strategy that carefully assesses all of these elements within a single framework. This integrated approach would allow us to clarify the structure of this domain (e.g., the existence of subtypes of somatic distress) and to explicate the nature of associations among its various elements. Second, following established principles of instrument development,96 any new instrument should be over-inclusive. That is, it should not be restricted simply to the elements contained in our model, but also should include dimensions from other recently proposed reformulations of this domain.

Furthermore, we should acknowledge several basic challenges for assessment in this area. First, the reporting of various somatic symptoms, fears of illness, help-seeking behaviors, and so on, may be confounded by physical con-
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ditions. The validity of the Illness Behavior Questionnaire has been, for example, criticized on this basis. Among other things, this underscores the importance of including measures of current physical conditions in any comprehensive assessment. Similarly, somatoform dimensions are strongly influenced by psychological distress, in the form of depression and anxiety. Clearly, these types of psychopathology need to be modeled, as well. Moreover, it is not clear whether patients can determine which somatic symptoms are unexplained. Similarly, it is not clear how reliable somatoform patients may be when assessing their symptoms and behaviors. On the basis of these considerations, it seems unlikely that simple self-report measures will be able to assess all of the elements of our model. At the very least, these types of measures will need to be supplemented by interviews or other approaches.

CONCLUSION

Marked and persistent somatic distress, together with care-eliciting behavior, is prevalent and poses a challenge to the medical care system. The classification of patients with such distress remains problematic, and their treatment is still unsatisfactory. This situation calls for redoubled efforts to reexamine and test various conceptual models of these conditions.

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