
Abnormal Illness Behaviour: 25th Anniversary Update¹

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Abstract

This paper reviews in detail the concept of abnormal illness behaviour. Recent developments in relation to criteria for diagnosis are discussed and newer approaches to management are described.

INTRODUCTION

After I had agreed to review the concept of Abnormal Illness Behaviour (AIB) since it was first presented in 1969, I realised that it was a daunting task because so much has been written and so much research done in the areas falling under the rubric over the past 25 years, much of which I have covered in some detail in my book on Abnormal Illness Behaviour (Pilowsky 1997 & 1999). It soon became obvious that the review would have to be a selective one and

so I decided to cover the subject under the following headings:

1. Origins and beginnings.
2. The definition of AIB and its difficulties.
3. AIB in relation to Classification and Diagnosis (especially in ICD 10 and DSM IV).
4. Measurement and Research.
5. Treatment.

My main points are:

1. AIB is unique because it presents as a disturbance of the Doctor-Patient relationship.
2. AIB places an onus upon doctors to show that it results from an abnormality within the patient and not the doctor or doctors.
3. The DSM IV and ICD 10 have not grappled sufficiently with the issues involved.
4. Research has yielded some interesting findings but much more needs to be done as regards the description of adaptive and abnormal illness behaviours associated with various illnesses.
5. The therapeutic outlook has improved considerably. The need for a transition and a

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multimodal approach has been recognized.

BACKGROUND

When the term AIB was formulated the psychiatric world was a different place. "Behavioural Medicine" did not exist and there were no journals whose names were variations on that theme. Miller and Di Cara had not described biofeedback and only a few years had passed since Melzack and Wall described their gate control theory of pain. DSM IV and ICD 10 did not exist.

My own interest in the area began in 1961 when I was working as a psychiatric registrar in Sheffield under the mentorship of Erwin Stengel who had taken the chair after a period as a Reader at the Institute of Psychiatry – "The Maudsley." Although his main interest in the sixties was in the area of suicide and attempted suicide, he had always retained a fascination with psychobiological phenomena since his days in Vienna where he trained in the neuropsychiatric and psychoanalytic tradition and was especially influenced by the neuropsychiatrist Paul Schilder with whom he had coauthored a paper on "Pain asymbolia", i.e. congenital indifference to pain. Schilder's interest in the body image and abnormal disorders associated with it always remained in Stengel's mind, so that when appointed to a Chair in a department associated with a general hospital, he soon responded creatively to the challenge presented

by patients referred by his medical and surgical colleagues. He reacted to my interest in research by handing me a copy of Gillespie's monograph on Hypochondria suggesting that it might be a suitable topic for research towards an M.D. degree. I accepted this advice with some trepidation and the more I read of Gillespie's book (1929), the more worried I became, in particular because I did not see how I was going to measure hypochondriasis.

While I was preoccupied with this problem, I was having discussions with Harold Merskey who had joined the department as a lecturer and was engaged in the study of pain, as was Graham Spear. I also discussed my problems with Phil Seager who was particularly helpful, as was the late Max Hamilton then Professor of Psychiatry in the University of Leeds.

Now, on the basis of his work, Merskey came to the conclusion that chronic pain in psychiatric patients was a form of "hysteria" and this was a major finding of his M.D. thesis. Almost simultaneously Eliot Slater (1965) at Queen's Square, published work indicating that "hysteria" did not exist, indeed he maintained that it was "a snare and a delusion". Although others including Aubrey Lewis and Sir Francis Walshe disagreed with him, it was unfortunate that Oxford University appointed him as one of the examiners of Harold Merskey's M.D. thesis – which delayed its award for a little while. It is interesting to note that since then the International Association for the

Study of Pain has adopted a slightly modified version of Merskey's definition and continues to promulgate it, to the present time. In 1979 Merskey published a masterly exposition on the nature of hysteria.

While all of this was happening I could not avoid noticing that some of the patients diagnosed as showing "psychogenic pain" were finding their way into my study group of hypochondriacal patients and that there was clearly an overlap between the two disorders, or at least between the ways we were diagnosing them.

This led me to wonder about what they had in common and what distinguished them. At this point the concept of "illness behaviour" presented itself, formulated by two American medical sociologists: Mechanic and Volkart (1960). They defined Illness Behaviour as the various ways in which individuals perceived, evaluated and acted upon symptoms. Exploring this idea led me to the "sick role" as described by Talcott Parsons (1964) many years before. After much conjecture, I decided that hypochondriasis and hysteria could be regarded as abnormal forms of illness behaviour. What made the sick role concept important was that it underlined the salience of the doctor in the legitimation of illness and it did this by virtue of recognizing that the individual wishing to adopt a sick role was expected to seek medical help and cooperate with the person qualified to provide it. Thus, from Parsons's work and that of other

sociologists, it became obvious that "illness" was socially constructed (and biologically constrained) and was usefully defined as "an organismic state accepted for admission to the sick role by an appropriate reference group".

Thus at a crucial intersection of social forces stood the doctor who had to decide whether the sick role criteria were met, including those which required the individual to seek help from, and cooperate with an expert, designated as such by society. Resonating with this societal imperative was a criterion for the diagnosis of hypochondriasis which states that the preoccupation with disease "does not respond to medical reassurance." This criterion makes hypochondriasis quite unique in medicine, because it includes the doctor's behaviour as an integral part of the diagnostic process.

As I was examining patients in a general hospital psychiatric unit, it was not surprising that I would encounter some who were virtually deluded (or morbidly preoccupied) and therefore quite abnormal in their illness behaviour by virtue of what they believed; while others were obviously unconsciously motivated to adopt the sick role to a degree considered excessive, having regard to the amount of objective physical pathology which could be detected. These patients might not believe in the presence of a specific disease, but they behaved as though they were sicker and more disabled than health professionals expected them to be. Thus I therefore defined AIB with a

focus on the disagreement between patient and doctor over the sick role and after a number of intermediate stages arrived at the following formulation: Abnormal Illness Behaviour is defined as an inappropriate or maladaptive mode of experiencing, perceiving, evaluating or responding to one's own state of health which persists despite the fact that a doctor (or other appropriate social agent) has offered an accurate and reasonably lucid explanation of the nature of the person's health status and the appropriate course of management (if any), with provision of adequate opportunity for discussion, clarification and negotiation based on a thorough examination of all parameters of functioning (psychological, social and biological), and taking into account the individual's age, sex, educational and sociocultural background. Thus the concept of abnormal illness behaviour occupies a point of convergence for general medicine, psychiatry, psychology, psychoanalysis, sociology and anthropology, all of which disciplines have contributed to our understanding of illness and abnormal illness behaviour.

Society's stake in this concept cannot be overestimated, because of its relevance to issues such as health economics, invalidity pensions, and worker's compensation. For health services (and the legal profession which is so often involved), the concept of an illness characterised by a mistaken belief in the presence of illness is difficult to swallow and lurking in the wings is always the spectre of the malingerer. These

matters draw the psychiatrist into a societal arena where an individual's health is a contested commodity, and where employers and trade unions argue over the financial value of somatic symptoms and disabilities. It is also an arena where qualifications for the right to make pronouncements about illness are carefully and critically scrutinized by adversaries. In the early 60's in the U.K. the issue of worker's compensation did not impinge on the minds of researchers in this area, to the extent that it does now. Perhaps this was because the research was carried out in the U.K. within a National Health Service. However, in countries whose health services operate on a fee-for-service basis such as Australia and the USA, there is an even greater concern with "overservicing" on the part of doctors than there is with fraud on the part of the patient. How does a doctor convince an insurer that he is legitimately treating a patient for a condition in which the latter thinks he is sick when he isn't, or is sicker than he is supposed to be? Does he adopt the insurer's perspective and confront the patient? This can provoke a murderous response.

The concept of AIB was first presented in the 1969 paper (Pilowsky, 1969) and in greater detail in a paper entitled "A General Classification of Abnormal Illness Behaviours" (Pilowsky, 1978), the writing of which had been planned for some time, but was hastened when Richard Sternbach referred to AIB in his book on pain, implying that I had already pointed out that AIB

could involve denial of illness.

In writing "The General Classification of AIB" it became apparent that not only could illness be abnormally denied or affirmed but that the focus could be a somatic or a psychological condition. A search of the literature revealed examples of all such forms of AIB, although not all presentations were regarded as illnesses in their own right. However, it is interesting to note that it was recently proposed that the "Maladaptive Denial of Illness" be included in DSM IV.

The definition of AIB turned out to be a controversial one. For example, in 1984 the late and much missed, Heinz Wolf, at a plenary session on AIB during a London meeting of the European Society for Psychosomatic Research called AIB "a dangerous idea". I was grateful to have the opportunity later to convince him that not only was I not offended (as he thought I might be) by his very public statement but that I agreed with him completely and that was why the criteria for attaching the AIB label to a clinical presentation had to be so carefully and precisely delineated.

It is of considerable interest to dwell on the aspect of the definition of AIB which made it most dangerous. It will be recalled that a key part of the definition ran as follows: "despite the fact that a doctor has accurate and reasonably lucid explanation of the nature of the person's health status and the appropriate course of management (if any) this was the part of the definition which caused most concern". Often

the question was (and still is) posed - "What if the doctor is wrong?" (I recall George Engel asking this question when I presented a seminar on AIB to his consultation-liaison group in Rochester in 1976).

This is, of course, a very pertinent question, indeed it is a crucial one. Why, one may ask, was it rarely, if ever, asked about the definition of hypochondriasis before or after DSM IV, given that non-response to medical reassurance has always been explanation is found and to use the term when patients with physical symptoms manifest anxiety, depression or unattractive personality traits.

The irony of this is that the term AIB (which was meant to militate against the inappropriate and pejorative use of labels such as "hysteric" and "hypochondriac") can itself be used as a pejorative term. One can only hope that the more precise definition offered by AIB will at least provide a basis for questioning the use of the term more confidently.

Interestingly, there is some evidence that, although we all know that these pejorative labels may be bandied about in ordinary conversation, doctors probably never document such opinions in patients' casenotes (Beaber and Rodney 1984). Most GP's will, if asked, admit to some anxiety about doing so.

CLASSIFICATION AND DIAGNOSIS

Since 1969 there have been major developments in the classification of

psychiatric illness, foreshadowed by the WHO commissioned monograph on the subject by Erwin Stengel published in 1960, in which he urged the setting up of a pilot study with the ultimate goal of achieving a generally acceptable basis for psychiatric diagnosis (this was the year I joined his Department in Sheffield and remember being puzzled by his interest in what seemed such a dry topic). While this process evolved, the American Psychiatric Association mounted a massive initiative to produce a criterion-based diagnostic system which culminated in the publication of the 3rd Diagnostic and Statistical Manual in 1977 – better known as DSM III. This is not the time to describe this system in any detail. However, one of its most important guiding principles was that it be based on clinical phenomenology rather than on any aetiological theory, especially not psychoanalytic theory.

Two features of DSM III are relevant in this context. The first is that an entirely new term sprang fully grown from the heads of its creators: Somatoform disorders. These were described as psychiatric disorders which present with symptoms which suggest the presence of a physical disorder. Among these were to be found conversion disorders, hypochondriasis and for the first time "psychogenic pain disorder". Also "somatization disorders" (Briquet's hysteria) was described. The locus of abnormality varied from condition to condition. Thus, in hypochondriasis

it resided in the ideation, and in conversion in the behaviour.

Since then we have had DSM III Revised, and now DSM IV. In these versions, the diagnosis of hypochondriasis has remained essentially the same, with the lack of response to "medical reassurance" always a key criterion.

The second significant feature of DSM III and now DSM IV was that in the case of the somatoform disorders the principle of adhering to descriptive phenomenology only was abandoned, and the assumption of the presence of "conflicts or other stressors" was considered to be part of the diagnosis of these conditions. For example the criteria for conversion disorder are as follows:

Diagnostic criteria for 300.11 Conversion Disorder

- A. One or more symptoms or deficits affecting voluntary motor or sensory function that suggests a neurological or other general medical condition.
- B. Psychological factors are judged to be associated with the symptom or deficit because the initiation or exacerbation of the symptoms or deficit is preceded by conflicts or other stressors.
- C. The symptoms or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).
- D. The symptom or deficit cannot, after appropriate investigation,

be fully explained by a general medical condition, or by the direct effects of a substance, or as a culturally sanctioned behaviour or experience.

- E. The symptom or deficit causes clinically significant distress or impairment in social, occupational or other important areas of functioning or warrants medical evaluation.
- F. The symptom or deficit is not limited to pain or sexual dysfunction, does not occur exclusively during the course of Somatization Disorder, and is not better accounted for by another mental disorder.

Specify type of symptom or deficit: With Motor Symptom or Deficit with Sensory Symptom or Deficit, with Seizures or Convulsions, with Mixed Presentation.

Diagnostic criteria for Pain Disorder

- A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.

Diagnostic criteria for 300.7 Hypochondriasis

- A. Preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.

Somatoform disorders takes into account the points mentioned above. Thus the text states: "Even when the onset and continuation of the symptoms bear a close relationship with unpleasant life events or with difficulties or conflicts, the patient usually resists attempts to discuss the possibility of psychological causation; this may even be the case in the presence of obvious depressive and anxiety symptoms. The degree of understanding, either physical or psychological, that can be achieved about the cause of the symptoms is often disappointing and frustrating for both patient and doctors".

The actual diagnostic guidelines for Hypochondriasis (ICD 10) read as follows – for a definite diagnosis, both of the following should be present:

1. Persistent belief in the presence of at least one serious physical illness underlying the presenting symptom or symptoms, even though repeated investigations and examinations have identified no adequate physical explanation, or a persistent preoccupation with a presumed deformity or disfigurement;
2. Persistent refusal to accept the advice and reassurance of several different doctors that there is no physical illness or abnormality underlying the symptoms.

It seems to me however that we

would do better by describing some of these guidelines more explicitly from the patient's viewpoint, bearing in mind that patients with somatoform and more specifically hypochondriacal disorders can be shown to have considerable insight. My suggestions for hypochondriasis are as follows. Firstly, from the patient's perspective, the patient may be able to say: "I worry about my health all the time. I notice things in my body such as pains or palpitations and I think I might have cancer or I'm going to have a heart attack or a stroke. Sometimes I think I'm silly, but I still go on worrying. Even though my doctor has investigated everything very thoroughly, I can't accept what he says about there being nothing to worry about – at least not for long. When he says it may be a mental problem and that we should talk about some of the difficulties in my life, with my family or job, I get very upset and worry about my health even more". Secondly, from the doctor's perspective, the following criteria could be used – The patient manifests: 1) An uncomfortable awareness of bodily events most of the time. 2) Fears and concerns about health and disease which are present most of the time. 3) An inability to accept reassurance from doctors who have offered clear information, associated with the concern that doctors have not done everything possible to detect disease or are withholding information and/or treatment which could be helpful. 4) An inability to accept the sugges-

tion that non physical, i.e. psychosocial factors may be relevant to one's condition, and marked emotional discomfort when this possibility is raised.

In the case of conversion disorders the criteria could be enumerated as follows:

1. The patient presents with physical symptoms which may involve a loss or disturbance of function such as paralysis, blindness or vomiting, for which no objective somatic explanation can be found.
2. The patient is not aware of any life stresses which might be contributing to the physical problems.
3. The patient is almost constantly aware of the symptom and associated disability.
4. If dysphoria such as anxiety or depression are described, these affects are attributed to the physical problem.
5. If it is suggested that psychosocial factors may have a role to play in the illness, the patient rejects the possibility, may become angry and even break off contact.

For somatoform pain disorder the criteria are as above except that pain is the predominant or only complaint.

For somatization disorder, the criteria are again similar with the additional criteria that the patient feels driven to seek medical advice, welcomes any suggestion that surge-

ry be undertaken, and at times may even demand it.

Clinical experience indicates that many patients can provide such a description of their experiences if allowed to, and are not offended by an initial question such as: "Do you suffer from hypochondriasis or have your symptoms (pain, etc.) made you hypochondriacal?" The common response is to ask for an explanation of the word hypochondriasis, which can then be given in terms of the aforementioned criteria. Interestingly, whether or not patients agree that they are hypochondriacal, almost all seem to know someone else who is.

Finally let us bear in mind that these conditions present as problems in the doctor-patient relationship, and that it is incumbent on the doctor to show convincingly that the source of these difficulties are to be found in the psychopathology of the patient and not in the doctor. Furthermore, we conceptualise the diagnosis emerging from a sequence of interactions during which the patient's inability to negotiate towards an intersubjective understanding of the presenting problem in any other than a somatic way becomes increasingly apparent:

1. Adaptive Illness Behaviour. Here the doctor and patient reach agreement at an early stage.
2. Somatic Misattribution. Here the doctor spends time explaining to the patient that emotions are accompanied by somatic changes and the patient is able to reattribute the symptoms.

3. Abnormal Illness Behaviour. Here the patient cannot accept medical explanations and is fixed on a personal and inaccurate view of his health status.

Now the doctor needs to decide how to diagnose the AIB on the basis of the phenomenology.

1. The AIB may be psychotic, i.e. a delusional belief is present.
2. The AIB may be non-psychotic (neurotic) and most likely one of the somatoform disorders or a dissociative conversion disorder (ICD 10).

MEASUREMENT AND RESEARCH

Measuring AIB is not easy. One approach has been to construct questionnaires. In the mid sixties I constructed a Hypochondriasis questionnaire, named the Whiteley Index after the Whiteley Woods Clinic of the Department of Psychiatry in Sheffield where the work was carried out. A factor analysis revealed three dimensions: disease conviction, illness phobia and somatic awareness. This instrument was constructed because of dissatisfaction with the MMPI Hypochondriasis Scale which consisted essentially of a symptom list and neglected attitudes to illness. Later the Whiteley Index was expanded into the Illness Behaviour Questionnaire – IBQ (Pilowsky and Spence, 1994) and applied mainly to the assessment and study of patients attending a pain clinic, many of whom met DSM III criteria for a

diagnosis of "Idiopathic pain disorders", in DSM III R "Somatoform pain disorder", and in DSM IV "Pain disorder".

The IBQ has been used in a number of ways:

1. As a basis for dissecting out the dimensions of illness behaviour in various clinical populations, with the application of statistical techniques such as principal component analysis and numerical taxonomy.
2. To delineate predictors of treatment outcome.
3. To delineate predictors of health care utilisation.
4. As a measure of various aspects of illness behaviour in particular clinical populations.

Using principal component analysis on the responses of pain clinic patients, the following factors were generated which formed the basis for seven scales and two second order scales named "Disease Affirmation" and "Affective State".

A discriminant function analysis produced an equation which separated Pain Clinic and General Practice patients. This is now used as a measure of the likelihood of a patient having a somatoform pain disorder.

In a recent replication of the original factor analytic study, involving a much larger number of pain clinic patients, new factors emerged which have yet to be evaluated as measures.

PREDICTING RESPONSE TO TREATMENT AND LONG TERM OUTCOME

The IBQ has been used to predict response to treatment. For example, it has been found to correlate with the long term outcome in the Chronic Fatigue Syndrome (Wilson A et al, 1994). In both cases the important predictor was the score on the Disease Conviction Scale (either on its own or as part of the "Disease Affirmation", second order scale). In the case of the Chronic Fatigue Syndrome (CFS) the "Disease Conviction" scale was the only variable significantly correlated with: 1) The Global Outcome Rating, 2) The delayed hypersensitivity skin test and 3) The Karnofsky Quality of Life Index. In a previous study by this group (*British Journal of Psychiatry* 1990; 156: 534) "Disease Conviction" and "Denial" were found to be significant characteristics of CFS compared to a GP population (Deutscher et al have essentially confirmed this finding).

As mentioned earlier, a similar role for "Disease Affirmation" as a predictor of response to treatment was found in a study of surgery for low back pain reported from Glasgow by Waddell et al (1989). Here "Disease Affirmation" predicted significantly even after allowance was made for physical factors and degree of distress.

In a recent BMJ editorial commenting on Wilson, Hickie et al's work referred to earlier, Lawrie and Pelosi called for research to demonstrate

whether psychological treatment might have a role in modifying the attitude measured by the "Disease Conviction" scale. The recent reports on the treatment of hypochondriasis offer reason for optimism in this regard (Barsky, House, Goldberg, Creed). The BMJ, CFS article evoked a flurry of correspondence: reflecting the controversial nature of the topic, and if CFS can be considered an example of a controversial area into which the AIB idea and the IBQ have been drawn. Another even more heatedly debated condition was the one named Repetitive Strain Injury (RSI) in Australia, a syndrome encountered in the workplace and very similar to "Writer's Cramp." Here compensation was a major issue and so heated did the argument over the legitimacy of this diagnosis become, a few years ago, with claims and counter claims in the medical and lay press, that at one stage trade unions issued a warning to their members not to accept administration of the MMPI or the IBQ, because psychiatrists were trying to prove that the condition was a psychological one, i.e. that they were malingering. This was reported on the front page of the highly respected daily newspaper – the Sydney Morning Herald – where examples were given of "outlandish" questions – all of which were taken from the MMPI, I am relieved to say. Further information about the IBQ is provided in the Manual for the IBQ obtainable from the Department of Psychiatry of the University of Adelaide, South Australia (4th Edition, 1994).

The IBQ has been used to predict GP utilisation in a prospective study. Once again "Disease Conviction" scale predicted attendances over a six month period, but what was particularly interesting were the differences found between males and females. These findings suggest that gender differences will need to be taken into account to a far greater degree in future studies.

The IBQ has been widely used in a variety of settings to generate characteristic profiles for particular populations: e.g., a pain clinic population compared to a private physical therapy group in Seattle; a dental group in Adelaide; and, thirdly, a dental group in Göteborg.

An attempt has been made to use the IBQ to detect malingering by the development of a "Conscious Exaggeration" scale. This strikes me as entirely misguided for a number of reasons which cannot be discussed here but should, I think, be fairly obvious.

TREATMENT

A particularly heartening development over the past 25 years has been a change in the attitude to the treatment of AIB in its various manifestations.

Proeminent among those who have contributed to these advances are the names G.R. Smiths, Goldberg and Bridges (Somatisation in General Practice), H. Warwick and I.M. Marks, Robert Kellner, Arthur Barsky (Mass. General) and A. House (in the area of Hypochondriasis), and W. Fordyce,

D.C. Turk and D. Meichenbaum, J. Turner, I. Pilowsky, D. Bassett, G. Barrow and E. Tunks (in the area of Somatoform pain) and many others.

What is particularly striking is the change in the attitude to these disorders, perhaps especially hypochondriasis and chronic pain which were previously regarded most pessimistically from a therapeutic viewpoint unless they were secondary to depressive or anxiety disorders. There are many reasons for the change, but among them is doubtless the presence of psychiatric units in general hospitals actively engaged in consultation-liaison activities, the involvement of clinical psychologists within the orbit of such units, who bring their knowledge of cognitive and behavioural psychotherapies, and finally the emergence of multidisciplinary collaborative units as exemplified by the "Pain Clinic" movement.

What has been learned from all these activities is the need for flexibility on the part of clinicians wishing to enter this therapeutic area. If ever purism was out of place, it is in the management of somatoform disorders. Equally, if ever collaboration was essential it is also in the management of these conditions.

Another common theme to be discerned in the approach to treatment is the preparedness to educate patients and to arrive at a mutually acceptable "Explanatory Model" (Kleinman) for the illness.

In addition, it is now obvious that all treatments involve a transitional

phase during which the patient is helped to make a shift from viewing the illness as purely physical to accepting that psychosocial factors are worthy of consideration as contributors to the problem. Achieving this transition requires the acquisition of new skills by clinicians and a preparedness to tolerate the blurring of system boundaries.

Least we imagine this to be a new discovery, we may recall that Freud's management of Elizabeth von R (one of the cases described in "Studies in Hysteria") proceeded very much along these lines. Indeed he describes providing a period of physical therapy before introducing the "new" treatment to the patient. The transition included electrical stimulation to the patient's painful legs administered by Freud himself "in order to keep in touch with her". And in the case of Frau Emmy von N he reports, "I ordered her to be given warm baths and I shall massage her whole body twice a day".

Finally it should be said that while the transition to the psychosocial domain is important, it does not entail a complete abandonment of the somatic domain which must always be kept in mind. Nor does the transition entail a move from the care of a physician or GP to that of a psychiatrist. Patients who somatize can be managed perfectly well by GP's or others who are trained to detect and deal with psychosocial issues – *something that should be regarded as an integral part of being a doctor* – no matter what the primary diagnosis may be.

CONCLUDING COMMENT

The concept of AIB has now been around long enough to be a part of psychiatry's intellectual furniture – virtually taken for granted.

In 1969 I sent a proof copy to Sir Francis Walshe – the eminent neurologist who had defended hysteria against Slater's onslaught. He wrote back saying that he liked the idea of abnormal illness behaviour. I wonder now, in retrospect, whether he really grasped what I was getting at. Heinz Wolf, you will recall, said it was "a dangerous" idea. I think he got the message.

When all is said and done, we know that patients with AIB suffer from their condition but unfortunately the nature of their presentation tends to drive others, including doctors away from them, when they need them most.

Their contribution to medicine is to force us all to think deeply about the doctor-patient relationship and constantly to review our standards for medical behaviour.

The implications for undergraduate and postgraduate medical educators are self evident.

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