Supplementary Table 1. *Characteristics of DCPR syndromes*

Abnormal Illness Behavior	
Health anxiety	Worries about illness and bodily preoccupations of <6 months' duration that readily respond to appropriate medical reassurance even though new worries may ensue after some time.
Disease phobia	Persistent unfounded fear of suffering from a specific disease (that does not change with time) and that tend to present in attacks rather than in chronic worries as in hypochondria.
Illness denial	Persistent denial of having a physical disorder (lack of compliance, delayed seeking of medical attention for serious and persistent symptoms, counterphobic behavior), though the individual is aware of being ill.
Thanatophobia	Sense of impending death (without objective medical reason) and avoidance of death-related situations (funerals, obituary notices, etc.).
Somatization	
Persistent somatization	Functional medical disorder of >6 months' duration with symptoms of autonomic arousal involving other organ systems and exaggerated side effects from medical therapy.
Functional somatic symptoms secondary to a psychiatric disorder	Symptoms of autonomic arousal or functional medical disorder included in a psychiatric disorder that preceded the onset of functional somatic symptoms.
Conversion symptoms	Non-organic somatosensory symptoms coupled with ambivalent symptom reporting, histrionic personality features, and association with stressors.
Anniversary reaction	Somatic symptoms that began when the patient reached the age or on the occasion of a meaningful anniversary in the patient's life, even though s/he is not aware of such association.
Irritability	
Irritable mood	Episodes or a chronic state of irritable mood for which overt anger behavior lacks the usual cathartic effect.
Type A behavior	Steady and pervasive sense of time urgency, rapid and explosive speech, abrupt body movements, cynicism, irritable mood; speeding up physical and mental activities; high competitiveness.
Psychological factors affecting medical condition	
Demoralization	A prolonged feeling state of personal failure, inability to to cope with some pressing problem, feelings of helplessness and hopelessness, and subjective

	incompetence.
Alexithymia	Difficulties in identifying and describing emotions, poor fantasy life, thought contents associated more with external events than emotions, unawareness of the common somatic reactions that accompany the experience of a variety of feelings.

Note

For the 12 detailed diagnostic DCPR criteria, see the free online table at http://www.karger.com/ProdukteDB/katalogteile/isbn3_8055/_98/_53/suppmat/p109-Appendix-A.pdf.

For the DCPR Structured Interview (DCPR-SI), see the free online DCPR-SI form at http://www.karger.com/ProdukteDB/katalogteile/isbn3_8055/_98/_53/suppmat/p109-Appendix-B.pdf.

Supplementary Table 2. *DCPR and DSM-5 Somatic Symptom Disorder (SSD) criteria in two clinical cases*

	Patient 1	**Patient 2**
	Female, 32 years-old, employee, separated since 2 years, one son aged 3	Male, 56 years-old, business company executive, married, 2 adolescent sons
SSD criteria		
A) ≥1 somatic symptoms	Fatigue, loss of appetite, headache, functional abdominal pain. No medical explanation.	Tinnitus, dizziness, frequent episodes of elevated blood pressure. Autoimmune thyroiditis (?)
B) Health-related worries	Frequent medical visits, 2 hospitalizations in the prior year, frequent sick day leaves from work	Food avoidance, body checking, disease phobia, no sick leave (hard worker, 'workaholic')
C) Duration ≥6 months	12 months	10 years
DCPR	Demoralization (feelings of inability to cope with the personal sense of failure in life, anger and guilt for separation from husband, helplessness and hopelessness)	Type A behavior (excessive involvement in work, need for achievement and recognition, sense of time urgency and time pressing, irritable mood, tendency to speed up physical and mental activities, exaggerated physical activity)
	Health anxiety (worry about illness, tendency to somatic amplification, selective attention to her body sensations)	Disease phobia (periodic fears for having a serious CV disease or infarction, obsessive checking of bodily functions, compulsory avoidance of 'dangerous' food)

Patient 1 is a woman aged 32 who works as a part-time secretary at a small lawyer office. She has been on intermittent and frequent sick day leaves in the past 12 months. Her husband had left home 2 years before, leaving her alone with their 3 years-old son. She has a passive and dependent personality and has always needed to rely on someone to solve her problems. In the previous year, the patient increasingly experienced fatigue, loss of appetite, weight loss, frequent headache, and highly recurrent pain in her abdomen, though medical examinations revealed no organic abnormalities. Even if she does not meet criteria for major depression, she showed subthreshold depression, mood changes in reaction to the marital loss, and a general feeling of hopelessness and helplessness of failure in her life. She has been visited many times by her primary care physician in the previous year and has been also hospitalized twice because of her symptoms.

Patient 2 is a very active and assertive man aged 56 who works with hardiness and success as an executive manager at a pharma company. Continuatively, even if not constantly, he has been suffering from tinnitus, dizziness and frequent episodes of elevated blood pressure in the last 10 years. He suffers from Hashimoto's immune thyroiditis that is adequately treated but it is not clear if and how this disease is related to his somatic symptoms. He shows clear traits of type A behavior and probably a subthreshold bipolar disorder with rapid mood shifting even in the same day. He is very concerned about his health and, even not a frequent attender of physicians, tends to control continuously his body shape and functioning through exercise, blood pressure and heart rate checking, blood examinations, avoidance of certain food he thinks may be dangerous for him, and phobic anxiety of becoming ill for a serious disease.

These two persons are very different to each other but, nonetheless, can be diagnosed with the same psychiatric category by using DSM-5 criteria for SSD. However, these criteria seem unable to detect their underlying psychological condition beyond their symptom reporting and cannot help in the planning of tailored treatment for them. Conversely, the SSD criteria are based on the false presumption that individuals artificially falling into these categories are truly homogeneous, thus biasing any further research on prevalence and prognosis. Patient 1 is a young woman with

prevalent medically unexplained somatic symptoms due to the combination of severe demoralization (not reaching criteria for major depression) and health anxiety (because of high selective focus on bodily sensations). Patient 2 shows quite the opposite psychological profile of a middle-aged man, deeply involved in his work, with clear symptoms of type A behavior (close to hypomania but not meeting diagnostic criteria) alternated with periods of disease phobia (including patterns of obsessive thinking and compulsory behaviors). Based on the micro-analysis of symptom formation, different psychotherapeutic plans should be designed for affective demoralization in Patient 1 and cognitive restructuration in Patient 2.