

Hypochondriasis – Is it an Anxiety Disorder? “Health Anxiety Disorder”

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Key Issues

- What is hypochondriasis?
- What is wrong with the current understanding of hypochondriasis?
- Where is the concept heading?
 - Is it a somatoform disorder, a mood disorder or an anxiety disorder?
- What are the implications of re-conceptualising hypochondriasis as an anxiety disorder?

Hypochondriasis in DSM IV

- Preoccupation with fears of having, or the idea that one has, a serious disease based on the misinterpretation of bodily symptoms
- The preoccupation exists despite appropriate evaluation and reassurance
- 6 months + significant distress

- Various caveats: not delusional (delusional disorder), not just appearance (BDD), not “better accounted for” by GAD, OCD, Panic, MDE, separation anxiety, or another somatoform disorder.

Somatoform Disorders – DSM IV

- Somatization disorder
- Undifferentiated somatoform disorder
- Conversion disorder
- Pain disorder
- Hypochondriasis
- Body dysmorphic disorder
- Somatoform disorder NOS

Classification of Psychosomatic Disorders

- Problematic since classification began – shifting conceptualizations and disputes
- All ‘physical’ illness have psychological manifestations
- All “psychological’ processes have physical (somatic) manifestations
- Depression and anxiety in particular have many somatic symptoms
- Unexplained somatic symptoms have multiple possible causes, both psychological and physical.

- Should there be a category for ‘psychosomatic disorders’ at all?

The typical clinical scenario.....

- Patient presents with symptoms that sound serious
- Doctor does a series of test, and maybe some referrals for specialist opinions
- Doctor is unable to find a cause, and attention turns to containing the help-seeking behaviour
- Erosion of the doctor-patient relationship
- Patient terminates care, and seeks other opinions.
- Patient becomes frustrated with the health system, and seeks help elsewhere – Internet, alternative health industry.
- Sometimes vindication (that something is wrong) becomes as important as treatment.

Hart & Bjorgvinsson, 2010.

Problems for the doctor

- Relies on excluding medical illness (unexplained medical symptoms), which is difficult, especially given many illnesses develop slowly over time e.g. multiple sclerosis
 - Note - misdiagnosis rates in somatoform disorders are approximately 5 – 10%, which is consistent with misdiagnosis rates in other physical and mental disorders.
- Doctors are confused about the somatoform terminology
- Hypochondriasis requires the preoccupation persists despite appropriate reassurance – when does a concern become a preoccupation, and what is appropriate reassurance?

Hypochondriasis - Epidemiology

- We rarely see it in psychiatry. Is it really a major issue?
- Lifetime prevalence – 1 to 5%
- M:F = 1:1
- 4 to 7 % of all GP visits
- 10 to 13 times the health care costs of the average person

Problems with hypochondriasis

- Stigma – possibly psychiatry’s worst diagnosis
- Poor acceptance by patients
- Too much overlap with other disorders
- Fits far better in dimensional models than categorical models
- Somatoform disorders are often seen as dead ends with respect to treatment – the diagnosis of hypochondriasis is perceived to block people from receiving legitimate help
- Clinicians are confused
- Researchers are disinterested: Too hard basket?

Problems with the diagnosis

- The key terms – Fear or idea that one has a serious illness based on the misinterpretation of bodily symptoms:
 - Fear overlaps with anxiety
 - Ideas overlap with delusions
 - Bodily symptoms overlap with other somatoform disorders
 - Somatic symptoms are common in all psychiatric disorders, esp depression.
 - Comorbidity:
 - 40% have problems with depression
 - 15 % have panic attacks
 - 10% have other obsessive compulsive symptoms suggesting OCD
- (Barsky 2001)

Anxiety

- Patients with hypochondriasis suffer significant anxiety
 - Triggered in many ways, for example by bodily sensations, or learning about illnesses (TV, internet, friends & family)
 - Catastrophic thoughts, reassurance seeking
 - Hours spent worrying

Plans for DSM 5

Task force identified key problems with all somatoform disorders:

- Reliance on ‘medically unexplained symptoms’ is problematic
- The diagnoses are not used by clinicians
- Patients find the diagnoses objectionable
- Clinicians find the diagnoses unclear
- Prevalence estimates are highly discrepant, depending on criteria used

Justification of Criteria – Somatic Symptoms APA 2010 (www.dsm5.org)

Recommendations for DSM 5

- Change name to 'Somatic Symptoms Disorders' and include PFAMC and Factitious Disorders
- De-emphasize medically unexplained symptoms
- Combine somatization disorder, hypochondriasis, undifferentiated somatoform disorder, and pain disorder into a new category entitled 'Complex Somatic Symptoms Disorder.' Also a simpler form of shorter duration and less symptoms – Simple Somatic Symptoms Disorder.
- Illness Anxiety Disorder
- Conversion disorder becomes Functional Neurological Disorder

Illness Anxiety Disorder

- Analysis suggests hypochondriasis encompasses a spectrum of clinical presentations:

somatic symptoms and bodily distress



minimal somatic symptoms but highly anxious about the possibility of illness

Illness Anxiety Disorder

- DSM believes ('based on studies') that 75% of those previously diagnosed with hypochondriasis will be diagnosed CSSD, and the remaining 25% who have high levels of anxiety but minimal somatic symptoms will be diagnosed Illness Anxiety Disorder

DSM 5 – Illness Anxiety Disorder

The following 6 criteria must be met:

- A. Somatic symptoms are not present or, if present, are only mild in intensity.
- B. Preoccupation with having or acquiring a serious illness. If a general medical condition or high risk for developing a general medical condition is present, the illness concerns are clearly excessive or disproportionate. The individual's concern is focused not on any physical distress per se, but rather on a suspected, underlying medical diagnosis.
- C. High level of anxiety about health or having or acquiring a serious illness. These individuals have a low threshold for considering themselves to be sick and a low threshold for becoming alarmed about their health.

- D. The person performs related excessive behaviors (e.g. checking one's body for signs of illness, repeatedly seeking information and reassurance from the internet or other sources), or exhibits maladaptive avoidance (e.g., avoiding doctors' appointments and hospitals, avoiding visiting sick friends or relatives, avoiding triggers of illness fears such as exercise).
- E. Although the preoccupation may not be continuously present, the state of being preoccupied is chronic (at least 6 months).
- F. The illness-related preoccupation is not better accounted for by the symptoms of another mental disorder such as complex somatic symptom disorder, panic disorder, generalized anxiety disorder, or obsessive compulsive disorder.

Implications of change

- Renewed interest in the disorder
- Change reduces stigma
- Anxiety as a concept is well understood by the community
- Creates more options for treatment

Treatment Implications for Health Anxiety Disorder

Assessment of Health Anxiety

- Thorough attention to medical symptoms
 - Detailed history of symptoms and investigations
- Attention to psychiatric comorbidity: depression, panic, OCD
- Assess key symptoms to direct treatment: Depression V Anxiety V Somatic
- Rating scales e.g. Health Anxiety Inventory

Treatment

- Engagement is the problem since individuals with Health Anxiety oppose the notion that their condition is caused by anything other than disease
- Need to develop a discourse that acknowledges the role of psychological factors whilst not diminishing the role of possible disease
- Options:
 - Psychoeducation
 - Psychological approaches
 - Pharmacotherapy

Psychoeducation

- Information about symptoms/investigation/treatment
 - Learning real and appropriate medical facts and the role of stress
- Information about anxiety/depression and psychological responses to illness (real or perceived)
- Relaxation training

Psychological approaches

- Cognitive behaviour therapy
 - Incorporates psychoeducation, exposure and response prevention, cognitive restructuring and behavioural exercises.
 - 3 controlled (wait list) trials for individual CBT
 - 2 trials for group CBT
 - Many uncontrolled trials
- Exposure and response prevention are also used in isolation
- Behavioural stress management strategies are also used in isolation

Pharmacotherapy

- Various anti-depressants have been reported to be effective in case studies and small trials. Usually claimed to be effective for all symptoms: anxiety, somatic symptoms, avoidance, reassurance seeking.
- One successful study of fluoxetine for 12 weeks has been reported but not published

Asmundson, Abramowitz, Richter, Whedon, Curr Psychiatry Rep, 2010

Conclusions

- Hypochondriasis as a term has little clinical utility in current medical practice
- The term has gained too much stigma
- Classification of psychosomatic disorders is a work in progress
- A significant part of hypochondriasis appears to be anxiety related
- Re-classifying the anxiety-related part as Illness (or health) Anxiety Disorder may open the doors to greater research interest and more treatment options.