Hypochondriacal Concerns: Management Through Understanding

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The medically unexplained complaint is often a symptom of hypochondriacal concerns. Patients with hypochondriasis may be managed with either naive realism or consideration of morbid categorization or via dimensional assessment of illness beliefs and behaviors. Naive realism will foster focus somatization and promote regression as well as lead to needless tests and treatments. Attention to categorical entities such a major depression or anxiety disorders will alert the clinician to comorbid psychiatric disorders that respond to traditional psychiatric treatments. Finally, by assessing the domains of illness behaviors such as disease conviction, beliefs in organic versus psychological causes, and denial, the clinician can document and then confront abnormal cognitive schema that revolve around somatic concerns that are a proxy for psychosocial difficulties.

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Primary care physicians are familiar with patients who seek medical help for physical symptoms that are either lacking objective findings or determined to be in excess of any detectable pathologic findings. Those patients whose symptoms have no demonstrable organic etiology may be labeled as "hypochondriacal worriers," "somatizers," or "crocks." Nevertheless, such somatic complaints and euphemistic or pejorative labels may indicate the presence of a psychiatric disorder.

The terms *hypochondriasis* and *somatization* are often used interchangeably, but they have different meanings. *Hypochondriasis* denotes a psychiatric disorder involving a preoccupation with fears of having, or the idea that one has, a serious disease based on the misinterpretation of bodily symptoms despite appropriate medical evaluation and reassurance. *Somatization*, on the other hand, is a common phenomenon in all cultures for which there are many meanings. In some cultures, it does not signify a psychiatric disorder but a cultural-coded expression of distress, a metaphor for experience, or a medium of social positioning, and as such may not constitute a medical or psychiatric problem.[1] For example, in Nigeria, *brain fag* is a syndrome involving sensations of heaviness or heat in the head associated with the efforts of studying. Commonly, it has been noted among students who are the first to be formally educated and, in the process, have been psychologically and physically separated from their families and communities of origin. Thus, somatization is a phenomena that is best understood as a somatic idiom of psychosocial distress[2] and occurs in a variety of psychiatric disorders such as anxiety, depression, and a variety of somatoform disorders (Table 1), which include hypochondriasis.

The comorbidity between hypochondriasis and somatization is high,[3] and the relationship between the two is not well understood. However, it is useful to conceptualize hypochondriasis as a discrete categorical designation rather than as a dimension of somatizing. Another way of identifying the difference is to define hypochondriasis in terms of cognitive and emotional symptoms, whereas the definition of somatization emphasizes somatic symptoms. It is imperative for the primary care physician to better recognize and understand somatization and hypochondriasis since they are more likely to be found among patients presenting to general medical clinics.

Epidemiologic studies estimate a prevalence of hypochondriasis in primary care settings from 0.4% to 14%, depending on the population surveyed and the methods used.[4–6] Gerdes et al.[7] found that the identification of hypochondriasis by physicians occurs at a subdiagnostic level despite their awareness of their patients' concerns and fears of disease and bodily preoccupations. It has been assumed that primary care physicians are likely to ignore hypochondriasis because the label leads to pejorative views and confusion among clinicians when communicating among themselves and with the patient.

Despite these issues, it is important that primary care physicians identify somatizers and those with hypochondriasis. Such patients are excessive utilizers of medical resources. In the current era of medical cost containment, the somatically preoccupied or hypochondriacal patients can clearly overtax limited medical capacity. Compared with non–somatically preoccupied patients, they have a greater number of outpatient visits, more frequent hospitalizations, and greater overall health care expenditures. It

Table 1. Somatoform Disorders[a]

Somatization disorder	Many physical complaints occurring over a period of several years before the age of 30 years and resulting in treatment being sought; all of the following physical complaints occurring at any time during the disturbance: (1) history of pain related to at least 4 sites or functions, (2) 2 gastrointestinal symptoms, (3) 1 sexual function, and (4) 1 pseudoneurologic symptom
Undifferentiated somatoform disorder	One or more physical complaints lasting at least 6 months
Conversion disorder	One or more symptoms or deficits affecting voluntary motor or sensory function that suggest a neurologic or other general medical condition associated with psychological factors
Pain disorder	Pain in 1 or more anatomical sites as the predominant focus of the clinical presentation; psychological factors judged to have an important role
Hypochondriasis	Preoccupation with fear of having a serious disease based on misinterpretation of symptoms for at least 6 months; the patient not reassured by a negative medical evaluation
Body dysmorphic disorder	An excessive preoccupation with an imagined deficit in appearance
Somatoform disorder not otherwise specified	Somatoform symptoms not meeting criteria for other somatoform disorders, including unexplained complaints of less than 6 months duration

[a]Adapted from American Psychiatric Association.[13]

has been estimated that 10% to 20% of the United States medical budget is spent on patients who somatize or have hypochondriacal concerns.[8]

This article will provide an overview of hypochondriasis along with a guide to understanding, identifying, and treating this condition. The primary goal of this review is to demonstrate the link between psychiatry and primary care by using the hypochondriacal patient to illustrate the interface between the two disciplines.

MODELS TO UNDERSTANDING THE HYPOCHONDRIAC

Costa and McCrea[9] suggested 3 conceptual models to understand the phenomena of somatic distress without objective findings (such as physical examinations and laboratory and imaging studies) and thereby provided guidance for treatment. *Naive realism* suggests that each patient's complaints be considered real physical problems and as a result dismisses the concept that the patient's somatic complaints are an expression of psychosocial concerns. In this model, the physician does not search for causes other than the concrete cause of the physical complaint. This approach will also remind the physician of the patient's subjective distress. Research in neurobiology and cognitive sciences has proposed neural mechanisms to explain simultaneous origin and dynamic interaction of somatic and psychological experiences.[10–12] Thus, emotions are simultaneously experienced in the emotional and somatic processing areas of the brain. Aggressive medical investigation, rather than helping the patient understand the genesis of his or her fears, may only serve to reinforce such fears.

The *categorical* or *disease model* organizes clusters of symptoms into categorical syndromes, thereby allowing such entities to be formulated reliably so that research into pathophysiologic causes can be pursued in an attempt to achieve reliability. It is necessary to employ the disease model in treating the somatically preoccupied patient since bodily complaints must be evaluated first so that treatable organic etiologies can be identified and treated. When unexplained physical symptoms are not supported by diagnostic evidence, the disease model as presented in the Somatoform Disorders section in DSM-IV[13] allows the reliable diagnosis of psychiatric disorders. The categorical model also alerts the physician to comorbid disorders (such as anxiety and depressive disorders). Categorical labeling also serves for reimbursement from second-party payers.

The third approach to understanding hypochondriasis is to view this phenomenon from a *dimensional perspective*. Somatization as a variable can be studied along a measurable dimension. Thus, somatization can be viewed within the context of a distribution along a range derived from a larger population. Tyrer et al.[14] have suggested that hypochondriasis is a personality disorder, which leads to the conceptualization of illness worry as a dimension rather than a category. The utility of the dimensional approach is that it provides a strategy for personality assessment so that a patient's characteristic style and response to stressors can be described and measured along a continuum. There are a variety of dimensional approaches embodied in psychometric instruments to measure somatizing phenomena (Table 2). These instruments allow the physician to identify individuals who tend to be somatizers.

The first task of the physician is to establish trust with the patient and to empathically acknowledge the patient's symptom as real and then ascertain the most accurate etiology of the problem. Such an approach may reduce health care costs, limit iatrogenic harm, and reduce the patient's illness worry.

MANIFESTATIONS OF BODILY CONCERNS

Persons with hypochondriasis are more likely to be found among patients in primary care offices rather than in mental health clinics. In such settings, these patients can be elusive since many primary care physicians are trained in the identification and treatment of only physical illness. As hypochondriasis is defined in terms of psychological symptoms, the somatic presentation by such patients may be confusing. In primary care, there is usually a shortened time frame in which to gather data. Nevertheless, obtaining an accurate history is paramount. At the

Table 2. Psychometric Approaches to Measuring Somatization

Primary Care Evaluation of Mental Disorders (PRIME-MD)	This instrument was designed to identify mental disorders that are common in primary care. It consists of 2 components: a 1-page Patient Questionnaire (26 items) and a 12-page Clinician Evaluation Guide or structured interview to follow up positive responses.
Whiteley Index	A 14-item yes/no questionnaire that screens for hypochondriasis. This measure, developed by Pilowsky, distinguishes hypochondriacal from nonhypochondriacal patients.
Illness Worry Scale	A 9-item questionnaire that asks for yes/no responses. This modification of the Whiteley Index eliminates items influenced by symptoms of physical illness.
Somatosensory Amplification Scale	A 10-item, self-report inventory that measures an individual's sensitivity to bodily sensations that do not denote serious disease.
Health Attitude Survey	A 27-item questionnaire that assesses somatization. It differs from other somatization screening instruments in that it avoids mention of physical symptoms and instead focuses on dissatisfaction with health and distress-related health problems.

first session with the somatically preoccupied patient, the physician should undertake a careful evaluation based on a historical understanding of the evolution of the patient's illness and health-related experiences to understand the process whereby the patient's illness has been organized. The way symptoms are disclosed to physicians is shaped by the social context within which the symptoms are experienced and to whom they are disclosed. An illness is organized through an evolving interaction between physician and patient.[15]

Information obtained from the history will assist in the recognition of patients with unreasonable fear of illness. The somatically preoccupied patient may present with a history of a greater number of outpatient visits,[16] more frequent hospitalization,[17] and repetitive subspecialty referrals[18] than patients without these preoccupations. A medical record release may result in a "thick" medical record revealing multiple medications and a greater-than-average number of diagnoses and diagnostic studies. This type of record is a concrete manifestation of the somatically preoccupied patient who demonstrates a high utilization pattern.

A past medical history of the following symptoms or syndromes has been associated with somatic preoccupation: chronic fatigue syndrome, fibromyalgia, irritable bowel syndrome, atypical chest pain, hyperventilation, pelvic pain, abdominal pain, low back pain, headache, dizziness, insomnia, and nonulcer dyspepsia.[19–21] A history of multiple drug allergies including extreme sensitivity to medication side effects may also indicate somatic preoccupation.

A family history of anxiety and/or depressive disorders might be another clue from the patient's history to indicate an excessive fear of illness. Noyes et al.[22] observed a trend toward greater frequency of anxiety disorders among hypochondriacal relatives. Among current disorders, generalized anxiety disorder and any anxiety disorder were more frequent in hypochondriacal than control relatives. Anxiety disorders were especially prevalent among female relatives of hypochondriacal probands. Their findings suggested that hypochondriasis was not familial and that there is an association between hypochondriasis and somatization disorder.

The patient's social history might also provide clues. Social risk factors identified in the somatically preoccupied patient include being a single parent, social isolation, unemployment, urban living, and substance abuse.[23] Tien et al.[24] reported that multiple somatic symptoms are associated with alcohol abuse and that somatic symptoms might evidence a high risk for alcohol abuse. Additional associations include childhood exposure to models of illness behavior such as a parent with chronic illness and exposure to physical or sexual abuse.[25]

THERAPEUTIC MANAGEMENT

The management of the hypochondriacal patient usually takes place within the primary care setting. Such patients are often resistant to referral to a mental health professional and view such a suggestion as a rejection of the validity of their suffering. Thus, the physician must be sensitive to the "meaning" of considering the unexplained medical complaints as a somatization phenomenon. Nevertheless, difficult and treatment-resistant cases are referred to psychiatrists. In such instances, various perspectives discussed above need to be included in the treatment approach. The following case demonstrates this.

Case example. A 43-year-old attorney was referred to a psychiatric physician from his gastroenterologist after repeated evaluations for abdominal cramping and alternating bowel habits. The patient continued to believe he had a serious gastrointestinal disorder, "either an occult malignancy or ulcerative colitis" that had not been discovered. He reported that he tended to worry about everything and had sought evaluations at a number of major diagnostic centers. Each of these evaluations ended in the similar conclusion that he suffered from irritable bowel syndrome. He admitted that this seemed reasonable, but shortly after each medical encounter, he began to worry that the physicians might have missed something or a negative laboratory result was in error. He openly admitted to a depressed mood, difficulty sleeping since he worried about having a serious illness, and other symptoms suggestive of a major mood disorder. His wife reported that being married to him "was like having another child" because he was constantly identifying new maladies and staying home from work. His law partners were always joking about his many complaints, and his children

viewed their father as "the world's greatest hypochondriac." He complained that his internist did not believe him and thus sent him to a psychiatrist as a "punishment."

Thus, the first task of treatment was to discuss his anger at physicians as well as his family who did not believe his suffering. Both the patient and psychiatrist were able to agree that he indeed experienced "real symptoms" that provoked both pain as well as great anxiety. In this context, he admitted that his anxiety and subsequent demoralization including depressed mood were symptoms that needed treatment. He begrudgingly agreed to psychiatric treatment utilizing both psychopharmacology and cognitive-behavioral therapy. He started sertraline treatment, but complained about the gastrointestinal symptoms, which abated after 4 days. He also began to keep a diary of his symptoms and when they occurred. After 6 sessions, he began to recognize that his abdominal cramping was temporally linked to meetings with his law partners wherein he needed to repress much anger. Other situations involving anger also seemed to promote his symptoms. These data allowed a rational psychotherapy treatment that focused on managing his hostility. The medication also proved to alleviate his depression, and both the patient and his wife reported improvement in his mood, irritability, and somatic preoccupation.

This case illustrates the stages of treatment. They include building a therapeutic alliance with the patient who generally feels health professionals do not believe or understand his or her suffering. Most somatizing patients will agree that they are very anxious or "worried" about the significance of their somatic complaints. Attention to anxiety and depression is often the first link with the physician. Use of a behavioral diary and concurrent psychopharmacology reinforces this working alliance.

In the primary care setting, the most difficult task in managing somatization is to "switch the agenda" from a focus upon an organic etiology that has not been discovered to a psychosocial issue. This transition is complicated by the limited time frame inherent in managed care. To best accomplish this, the patient has to consider the goal of coping with, not curing, the somatic preoccupation and lessening the patient's fear and discomfort. The somatic complaint may not totally vanish, but the patient can learn to adapt to it. Some of the therapeutic work can be placed on the patient by having him/her keep a detailed record of the problem to achieve this goal.

The patient and physician can ally to become "somatic detectives" and begin to chart the patient's symptoms in detail via behavioral analysis.[26] Asking the patient to keep this record suggests that the complaint is serious and mandates such a detailed investigation. Behavioral analysis involves having the patient keep a daily record of when, where, and with whom the symptoms occur and the result of the specific complaint or various complaints that are troubling the patient. Such a record can be easily and flexibly developed for each patient. Such behavioral analysis can be done during or after the diagnostic evaluation when tests and procedures have been completed. The data gathered by such a diary can reveal patterns that link psychosocial issues to the complaint. For example, if a headache is worse in the evening after a disagreement with an adolescent child, the association can reveal to both patient and physician that stress is temporally related to the head pain. If irritable bowel symptoms are related to a stressful element of work, such as a weekly but disagreeable meeting, a link is established. This can abet an agenda change and allow the concept of stress management to emerge.

A second element is to actively treat the comorbid conditions of anxiety and or depression.[27] Such disorders are common in hypochondriasis. Barsky et al., in a study of 60 medical outpatients meeting DSM-III-R criteria for hypochondriasis, found that 43% had lifetime major depression, 45% had dysthymia, and 17% had panic disorder.[28] Barsky also found that generalized anxiety was the most frequent diagnosed disorder in 71% of hypochondriacal patients. The reliability of this diagnosis remains unclear since distinguishing between hypochondriacal worry and the excessive worry of generalized anxiety disorder may have been difficult. Being anxious may lead an individual to worry about health, and hypochondriacal concerns coupled with somatic distress may give rise to anxiety. Both cognitive and behavioral formats are essential.

In a randomized controlled trial, Clark et al.[29] studied the effectiveness of cognitive therapy and compared it with behavioral stress management, an equally credible, alternative treatment for the treatment of hypochondriasis. The comparison showed that cognitive therapy was more effective than behavioral stress management on measures of hypochondriasis, but not general mood disturbance at midtreatment and at posttreatment. One year after treatment, patients who had received either treatment remained significantly better than before treatment.

Finally, through psychological interventions, the patient can recognize that his or her personality style may lead to a characteristic set of responses when stresses identified by the behavioral analysis occur. This recognition may allow the patient to "dampen down" an extreme response such as excessive worry in the individual with high neuroticism or the tendency of the introvert to retreat into a solitary mode.

The use of psychotropic medications is often beneficial to treat the marked comorbidity of anxious and depressive symptoms. However, the most difficult challenge for the prescribing physician is the introduction of their use. The use of psychotropic medications might be interpreted by the patient as an attempt to dismiss his or her unexplained symptoms as "all in the mind." In addition, psychotropic medications pose special problems, since side effects are

often immediate while benefit is delayed. The physician must bear in mind that a successful management of the hypochondriacal patient is a longitudinal trusting relationship. It is also important to reassure the patient that, although there is no categorical diagnosis for the unexplained symptoms, the symptoms are not fatal or catastrophic. Barsky et al.,[28] in a 4- to 5-year prospective follow-up of patients with DSM-III-R hypochondriasis, found a considerable decline in symptoms and improvement in function, but two thirds of his subjects still met diagnostic criteria for hypochondriasis. Risk factors for poor outcome included greater somatization, more amplification of bodily sensations, and a greater number of ambiguous symptoms. Hypochondriasis, therefore, may carry a very substantial long-term burden of morbidity, functional impairment, and personal distress.

CONCLUSION

In our cost-conscious era of medical care, it is imperative to correctly identify and manage the somatizing patient. By naively accepting the patient's complaints needs, the physician will increase health care utilization and reinforce the patient's abnormal illness beliefs. Instead, the clinician should ascertain the comorbid psychiatric disorders that commonly present with hypochondriasis, such as mood and anxiety disorders. Vigorous treatment should be directed at these accompanying syndromes. Concurrently, the clinician must delineate the personality dimensions of the patient and the abnormal illness beliefs that propel the somatization. By careful behavioral analysis, the patient and physician can "change the agenda" and focus on the psychosocial problems instead of the somatic concerns that were a proxy for such psychological difficulties. In this manner, the hypochondriacal patient can be effectively treated.

Drug name: sertraline (Zoloft).

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