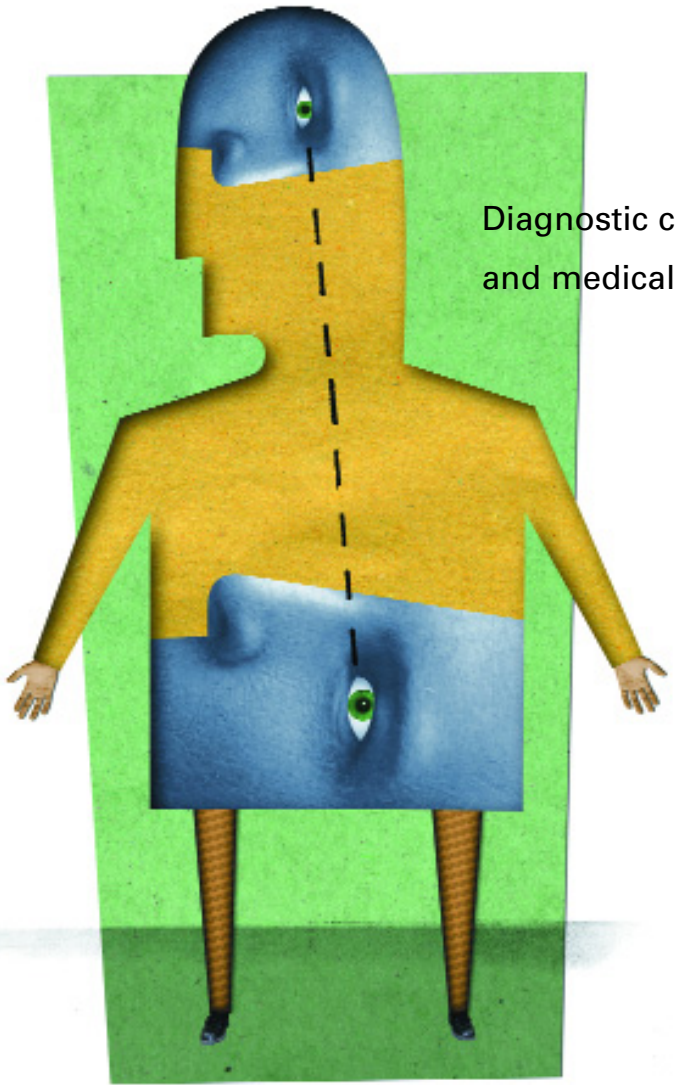
Current PSYCHIATRY

Don't be fooled by hypochondria



Diagnostic checklist helps rule out psychiatric and medical disorders and avoid treatment errors

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A hypochondria "checklist" can help you sort through many overlapping medical and psychiatric disorders and increase your chances of making an accurate diagnosis. Then—by addressing hypochondria's cognitive dysfunction—you can help patients achieve partial or full remission and change their distressing behaviors.

We offer a checklist that is useful in our practice and suggest behavioral therapies and medications that can help calm these patients' excessive, unwarranted fears.

WORKING AS A TEAM

Ideal approach. Because hypochondriasis has features of medical and mental illness, working with the patient's primary care physician is ideal. Physicians often consider these patients difficult because they demand a lot of time, support, and reassurance. Together, you can:

- offer the patient a healthy level of compassion and empathy to establish a positive therapeutic alliance
- set appropriate time limits and guidelines for the patient's care

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Box

Hypochondriasis: Persistent, unwarranted distress

Hypochondriasis is an excessive and persistent fear or belief that one has a serious illness, despite medical reassurance and lack of diagnostic findings that would warrant the health concern. If a medical disorder is present, the distress and preoccupation exceed what the patient's physician considers reasonable. Illness preoccupation is intense enough to cause great distress or to interfere with daily functioning and may cause the person to miss work or cancel social engagements.[1]

DSM-IV criteria. A patient's fear or conviction that he or she has a serious health threat must persist at least 6 months and may be accompanied by specific somatic symptoms, vague symptoms,[1] or no symptoms.[2] Hypochondriacal preoccupation may be stable over time, where one illness concern dominates, or it may shift—from fear of AIDS to fear of a heart attack.

A common disorder. Hypochondriasis occurs in 4 to 6% of the general medical population. In psychiatric or medical clinics, women are identified as having hypochondriasis three to four times more often than men. Average age of onset is in the early 20s.[3]

- dissuade patients from "doctor shopping"
- set limits on how often patients may visit their doctors and request reassurance.

For example, you may indicate to the patient, "I will reassure you only at office visits (not by phone), the office visits will be limited to once a month, and during each visit I will reassure you no more than once."

A doctor-patient relationship based on mutual trust and respect is vital when you treat a patient with hypochondriasis. You can help primary care physicians provide more empathic treatment by explaining that patients do not feign or desire this distressing condition.

DIAGNOSTIC FEATURES

Patients with hypochondriasis tend to be hypervigilant about normal physiologic fluctuations and bodily sensations, often misinterpreting them as life-threatening or serious enough to require immediate medical attention. This excessive focus on benign symptoms (such as an accelerated heart rate, sweating, or a bump on the skin) and the cognitive distortion of their significance result in increased anxiety, bodily checking, and doctor visits (*Box*).[1-4]

Presentations. Hypochondriasis has three common presentations: disease conviction, disease fear, and bodily preoccupation (*Table 1*).[5] Psychiatrists are most likely to see disease fear, as patients with this predominant symptom tend to realize that fear plays too prominent a role in their lives. Physicians in medical practice are more likely to encounter patients with high levels of disease conviction or somatic preoccupation.

Psychiatric comorbidity. Hypochondriasis is highly comorbid with Axis I and Axis II disorders, which complicate treatment. Nearly one-half of patients with hypochondriasis also have dysthymia (45%) or major depression (43%). Other comorbidities include phobias (38%), somatization disorder (21%), panic disorder (17%), and obsessive-compulsive disorder (8%).[6] Patients with hypochondriasis are three times more likely than the general population to have personality disorders;[6,7] the prognosis is believed to be more promising for patients without personality disorders.

Distinguishing between primary and secondary hypochondriasis is important. Treating a primary psychiatric disorder often alleviates the symptoms of secondary hypochondriasis, particularly when hypochondriasis masks depression.

HYPOCHONDRIASIS CHECKLIST

☑ **Underlying medical disorder?** Before diagnosing hypochondriasis, review the medical workup for underlying disease or illness. Medical conditions

Table 1

Three common presentations of hypochondriasis

Predominant symptom	Characterization
Disease conviction	Patient may appear delusional in believing he or she has a disease and in persistent efforts to find a doctor who will make the "accurate" diagnosis
Disease fear	Patient may avoid doctors because of fear associated with confirmation of a dreaded disease
Bodily preoccupation	Patient may complain of multiple somatic symptoms, which mask underlying fear or belief of having a serious disease

sometimes go undetected when physicians assume that complaints are an expression of long-standing hypochondriasis.

Sometimes a patient may become anxious when mild or vague signs and symptoms do not yet meet established diagnostic criteria for a medical disorder. An effective approach is to provide ongoing support, avoid excessive diagnostic tests, and help the patient make the best use of his or her functional capacities while living with uncertainty.

Patients with generalized anxiety disorder may worry about illness, but they also worry about other life issues

Functional somatic syndrome? Fibromyalgia and chronic fatigue syndrome do not represent hypochondriasis,[8] although they may be exacerbated by comorbid psychiatric disorders. Both disorders have diagnostic criteria and specified courses and have been studied to identify psychiatric comorbidity.

Transient or sustained? After it is clear that the patient is not suffering from a medical problem, determine whether hypochondriasis is transient or fully diagnostic:

- If transient, the patient may only need to be educated about how overattention may amplify symptoms; reassure him or her that a full medical workup has been negative.
- If fully diagnostic, reassurance may work for only a few days or weeks; the return of the fear or conviction helps establish the diagnosis.

Somatoform disorder? Distinguish hypochondriasis from other somatoform disorders (*Table 2*). In practice, the terms "hypochondriac" and "somatizer" are commonly used interchangeably, but the distinction needs to be clear. Hypochondriasis is primarily a disorder of abnormal cognition, in which symptom meaning is of greatest concern. Somatization is primarily a disorder of abnormal sensation, in which the symptoms themselves are the overwhelming focus of attention.

Anxiety disorder? Patients with generalized anxiety disorder may worry about illness, but they also worry about other life issues. Patients with panic disorder may have intense hypochondriacal concerns (such as having a heart attack), but these worries tend to be related to panic symptoms and resolve when the panic disorder is treated.

Obsessive compulsive disorder? Like obsessive-compulsive disorder (OCD), hypochondriasis is characterized by recurrent intrusive thoughts that create heightened anxiety and distress. To relieve their anxiety, patients with hypochondriasis engage in compulsions, such as:

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Table 2

How to distinguish somatoform disorders

Disorder	Patient focuses on...
Hypochondriasis	physical symptoms' meaning (abnormal cognition)
Somatization disorder	multiple unexplained physical symptoms (abnormal sensation)
Body dysmorphic disorder	perceived abnormal bodily appearance
Conversion disorder	motor or sensory function abnormalities that develop soon after life stressors or conflict
Pain disorder	intense pain, in which psychological factors contribute to pain onset, severity, or maintenance

- undergoing extensive medical tests
- seeking habitual reassurance from doctors and family
- consulting medical literature
- performing repeated body checks for perceived lumps or bumps
- avoiding activities that trigger their health-related stress.[9]

OCD and hypochondriasis also may share the diagnostic feature of pathologic doubt; patients' uncertainty in appraising a situation leads to additional checking and reassurance-seeking behaviors. The immediate relief gained by these compulsions reinforces the patient's urge to engage in more maladaptive behaviors and sends a stronger message to the brain that these behaviors are needed to prevent harm.

Ironically, the emergence of a real medical ailment—despite hypochondriacal worry—may force the patient to re-evaluate the usefulness of behaviors motivated by trying to avoid harm. A hypochondriacal patient who was diagnosed with optic neuritis and possible multiple sclerosis recently said to these authors, "I had always thought that by being vigilant I could keep illnesses away. Now I know that's not true."

Although hypochondriasis and OCD have similarities, certain clinical distinctions exist. Patients with hypochondriasis worry about having an illness, whereas OCD patients with somatic obsessions fear developing or transmitting an illness. A hypochondriacal patient might fear having AIDS or cancer despite reassurance from doctors, while an OCD patient more typically would fear contracting or transmitting the disease (a contamination obsession) and would engage in excessive behaviors to reduce the risk of developing the disease.

Hypochondriasis is worry about having an illness; somatic OCD is worry about developing or transmitting illness

Depressive disorder? Unlike the anxious-worrying version of hypochondriasis, the depressive version is more fatalistic. Patients may be convinced they are dying of a dreaded disease, often believing it to be punishment for an indiscretion, such as marital infidelity. Or they may suddenly become hypochondriacal with mild depressive features, unaware that the actual problem is unresolved bereavement (hypochondriasis with secondary depression). The appropriate diagnosis is primary depressive disorder with secondary hypochondriacal features when depression

Table 3

Recommended dosages for treating primary hypochondriasis

Drug	Starting dosage	Maximum dosage
Fluoxetine	10 mg/d if panic symptoms are present; 20 mg/d otherwise	80 mg/d
Fluvoxamine	50 mg at bedtime	150 mg bid
Nefazodone	100 mg bid	300 mg bid
Paroxetine	20 mg once daily	50 mg once daily

dominates the presentation and preceded the illness fears.

Delusional disorder? To distinguish hypochondriasis from delusional disorder (somatic type), consider the patient's pattern of insight:

- Hypochondriacal patients often vacillate between poor and excellent insight, depending on their distress level.[10] They may acknowledge the irrationality of their fears, then later be convinced they have a disease.
- Patients with delusional disorder are convinced they have a serious health threat, despite the absence of medical confirmation. These patients are considered to have a primary psychotic disorder that requires antipsychotic treatment.

Bottom Line

Hypochondriasis' cognitive dysfunction is treatable, once an accurate diagnosis is made. Using a checklist can help you differentiate hypochondriasis from other medical and psychiatric disorders. A trusting doctor-patient relationship enhances outcome.

TREATING PRIMARY SYMPTOMS

Drug therapy. When hypochondriasis is secondary—such as to depression or panic disorder—treat the primary condition first.[11,12] For primary hypochondriasis, selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine, paroxetine, or fluvoxamine have shown benefit, mostly in open-label studies. An uncontrolled case series suggests that nefazodone—with mixed serotonin reuptake inhibition and agonist properties—also may help patients with hypochondriasis.[13] In the only published controlled study, fluoxetine was more effective than placebo for treating hypochondriasis.[10]

Continue drug therapy, when used, for at least 8 weeks, with each dosage maintained for at least 4 weeks. If patients do not respond to lower SSRI dosages, increase to the higher dosages reported to be more effective for OCD (*Table 3*).[14]

Except for primary illness phobia, hypochondriasis has not been shown to respond to tricyclics, benzodiazepines, or dopaminergic blockers. In our experience, electroconvulsive therapy—although inadequately studied—may help treat patients with severe, treatment-refractory hypochondriasis with marked somatization.

Psychotherapy. Cognitive-behavioral therapy (CBT)—challenging patients' irrational fears about illness and teaching them problem-solving tools—is effective in treating hypochondriasis.[15] CBT can help patients understand that distorted thoughts lead to their sad or anxious moods.

Instructing patients to keep thought diaries can help them identify irrational fears and use cognitive restructuring to correct their faulty schemas. Tailor your cognitive therapy tech-

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niques to target the patient's level of insight at the time of therapy.

Effective behavioral techniques may include setting limits on doctor visits, checking behaviors, reassurance seeking, etc. Repeated exposure to feared stimuli such as needles, white lab coats, blood pressure cuffs, medical dialogue, or hospital wards can help the patient habituate to the anxiety.

Relaxation techniques, a healthy diet, and exercise are also useful. Relaxation exercises—such as diaphragmatic breathing, progressive muscle relaxation, and visual imagery—may help patients manage anxiety by reducing CNS and autonomic nervous system arousal.

Related resources

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DRUG BRAND NAMES

Fluoxetine • Prozac
Fluvoxamine • Luvox
Nefazodone • Serzone
Paroxetine • Paxil

DISCLOSURE

Dr. Feinstein and Dr. Fallon report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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