HYPOCHONDRIACAL DISORDERS

OVERVIEW

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INTRODUCTION

A psychiatric disorder involving preoccupation with fears of having or idea that one has serious disease based on misinterpretation of bodily symptoms despite appropriate medical evaluation and reassurance.

ETYMOLOGY

- Hypokhondrios (Greek)-
  hypo (under) + khondros (Cartilage)

- Hypochondria (late Latin)- "the abdomen"

HISTORY

- Hippocrates- below the cartilage
- 17th century- excess black bile
- The Anatomy of Melancholy (1621) - Burton's description of hypochondriacal melancholy
- Thomas Sydenham- male equivalent of hysteria

HISTORY

- 18th century- neurasthenic concept
- 1799- Sims- first modern definition
- 19th century- neurosis
- 1822- Falret- first to identify as mental disorder
- 1928- Gillespie- ‘a mental preoccupation with a real or supposititious physical or mental disorder'.

EPIDEMIOLOGY

PREVALENCE

- Studies in Italy and USA- 5%
- WHO multi-centre study- 0.8% (2.2%)
- Primary care prevalence- 3 to 7 %
- More prevalent among medical patients
- Higher in those with functional illness

EPIDEMIOLOGY

RISK FACTORS

- Women- 1.5 to 2 time more
- No age barrier
- Barsky *et al*- no difference in medical morbidity between hypochondriacal and non-hypochondriacal outpatients.

EPIDEMIOLOGY

FAMILY AND TWIN STUDY

- 1 Family study:
- Proband relatives- somatization and anxiety disorder more frequent
- Proband relatives- more somatic symptoms, more hostility, and poorer social adjustment.
- Twin studies- no to modest correlation, environmental than genetic

EPIDEMIOLOGY

Co-morbid conditions

1) Depression (40%)
2) Panic disorder (10 to 20 %)
3) OCD and GAD (5 to 10 %)

ETIOLOGY

- **Unknown**

- **Personality-**

1. Neuroticism
2. Negative affectivity
3. Narcissism
4. Angry, mistrustful, resentful

ETIOLOGY

- **Childhood environment-**

1. Adverse early environment
2. Illness in childhood
3. Parental attention and overprotection

- **Life events**

1. Illness events
2. Events of death
3. Difficulty in expressing emotions

ETIOLOGY

- **Perceptual amplification**

1. Somatosensory amplification
2. Heightened self-scrutiny

- **Cognitive factors**

1. Faulty cognitive appraisal of bodily sensations
2. Attribution of sensations to pathological processes
3. Attribution- attention- amplification

ETIOLOGY

- **Social and cultural factors**

1. Caretaking behavior
2. Sick role

- **Google syndrome**

1. Search engines
2. Google weird feelings- linked to disease
3. Behaviour reinforced

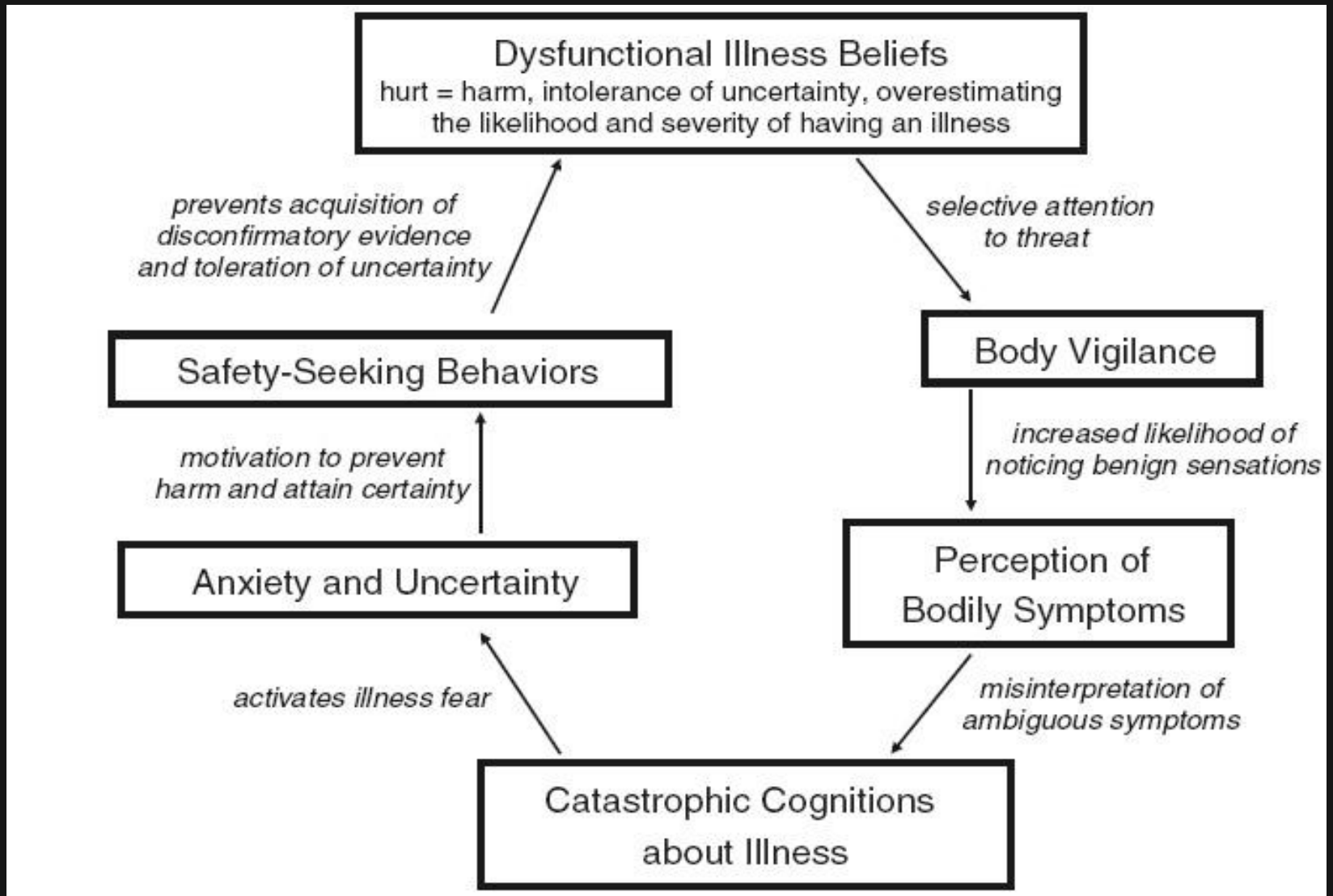


Fig. 1 Cognitive-behavioral model of hypochondriasis

CLINICAL FEATURES

- Morbid preoccupation with bodily functions, minor abnormalities and complaints
- Long-term intense fear or anxiety about having a serious disease
- Thoughts intrusive and overvalued
- Seeing doctors and repeated investigations

CLINICAL FEATURES

- Doctor shopping
- Health research
- Checking body and vital signs
- Thinking presence of a disease after reading or hearing about it
- Others find them preoccupied with health concerns.

CLINICAL FEATURES

DISEASE PHOBIA	DISEASE CONVICTION
• Anxious • Less symptoms • More insight	• Depressive • Somatic symptoms • No insight • Antagonism towards physicians

SOME EXAMPLES OF COMMON OBSESSIONS SEEN IN HYPOCHONDRIA ARE

- Thinking that a headache is indicative of a brain tumor
- Believing that a cough must be sign of lung cancer
- Assuming that a minor chest pain is a heart attack
- Thinking that a minor sore is a sign of AIDS

SOME COMMON EXAMPLES OF COMPULSIONS SEEN IN HYPOCHONDRIA INCLUDE

- Multiple doctor visits, sometimes “doctor-shopping” on the same day
- Multiple medical tests, often for the same alleged condition
- Repetitive checking of the body for symptoms of an alleged medical condition

SOME COMMON EXAMPLES OF COMPULSIONS SEEN IN HYPOCHONDRIA INCLUDE

- Repeatedly avoiding contact with objects or situations for fear of exposure to diseases

- Habitual internet searching for information about illnesses and their symptoms ("Cyberchondria")

DIAGNOSTIC CRITERIA

ICD-10

- Category- somatoform disorders
- Name- hypochondriacal disorder
- Diagnostic criteria:

A) Persistent belief or preoccupation with at least one presumed serious physical illness underlying symptoms despite repetitive lack of clinical or investigative finding

B) Persistent refusal to accept reassurance

DIAGNOSTIC CRITERIA

DSM-5

- Category- Somatic symptom and related disorders
- Name- Illness anxiety disorder
- Diagnostic criteria:

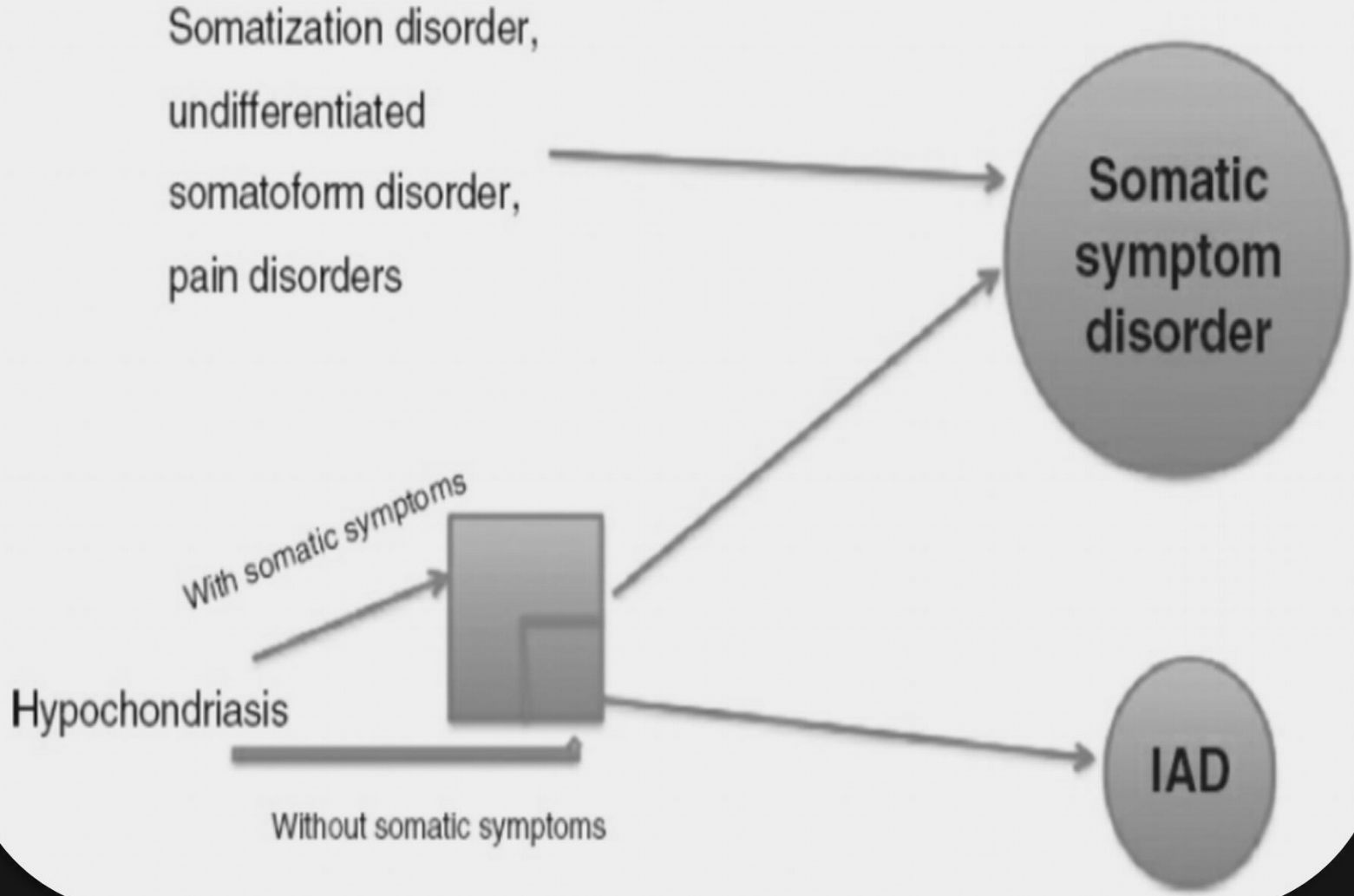
A) Preoccupation with having/acquiring serious illness for 6 months or more

B) Somatic symptoms mild or absent or disproportionate

C) High level of anxiety with excessive health related behaviors or maladaptive avoidance

- Specifier- care-seeking or care-avoidant

Coalescing and differentiating



DIAGNOSTIC CRITERIA

DSM-5	ICD-10
Somatic symptom disorder	Somatization disorder, undifferentiated somatoform disorder, persistent somatoform pain disorder
Conversion disorder (functional neurological symptom disorder)	Dissociative (conversion)
Illness anxiety disorder	Hypochondriacal disorder
Factitious disorder	
Somatoform disorder NEC	Somatoform autonomic dysfunction, other somatoform disorders, somatoform disorder unspecified, neurasthenia (neurotic disorders category)
Psychological factors affecting another medical condition	

DIAGNOSTIC DILEMMA

4 main domains of dysfunction:

- Preoccupation and misinterpretation (cognitive component)
- fear/anxiety(affective component)
- hypervigilance to bodily symptom(attentional component)
- avoidance and repetitive behaviors (behavioral component).

DIAGNOSTIC DILEMMA

Overlap with

- GAD
- OCD
- Panic Disorder
- Somatoform disorder

- Cognitive (preoccupation) and behavioral (compulsive checking) repetitive characteristics
- Overlap with OCD and BDD
- ICD-11 as OCRD

DIAGNOSTIC CRITERIA

ICD-11 (PROPOSAL)

- Category- ORCD, secondary- anxiety disorders
- Name- hypochondriasis
- Diagnostic criteria:

A) Persistent proccupation with serious or life-threatening disease

B) Catastrophic misinterpretation of bodily sensations or symptoms

C) Disproportionate to context and persists despite reassurance

DIAGNOSTIC CRITERIA

D) Avoidance, checking, information seeking and/or reassurance seeking

E) Distress and impaired functioning

F) Includes those with no insight or delusional beliefs

- Specifier- insight

DEVELOPMENT & COURSE

- A chronic & relapsing condition with an age at onset in early & middle adulthood.
- 65% show a chronic but fluctuating course
- 10% recover
- 25% -do poorly

PROGNOSIS

Good prognostic indicators:

- Acute onset
- Brief duration
- Mild hypochondriacal symptoms
- Absence of co-morbid mental disorder
- Absence of secondary gain
- Presence of a general medical condition

PROGNOSIS

Unfavorable prognostic indicators

- Longer duration of illness
- Psychiatric comorbidity
- Stressful life events
- Lack of serious medical comorbidity

FUNCTIONAL CONSEQUENCES OF HYPOCHONDRIASIS

- Substantial role impairment
- Decrements in physical function & health related quality of life.
- Interference with interpersonal relationships, disrupt family life & damage occupational performance.

DIFFERENTIAL DIAGNOSES

- Physical Disorders
- Neurological conditions- Multiple sclerosis, myasthenia gravis
- Endocrine conditions- thyroid or parathyroid disorders
- Multisystem diseases- SLE
- Occult malignancies
- Because of such possibilities, a physical cause warrants continuing consideration

DIFFERENTIAL DIAGNOSES

Other medical conditions

- Concerns and distress proportionate to its severity.
- A co-morbid diagnosis of Hypochondriasis if the health related anxiety- disproportionate to the seriousness of the medical condition.
- Transient preoccupations do not justify a diagnosis of Hypochondriasis.

SOMATIZATION

SOMATIZATION	HYPOCHONDRIASIS
Concerned with Symptoms	Concerned with Disease process
Multiple frequently changing Symptoms	One or two disease processes
Females/ Family etiology	Equal incidence/ No Family etiology
Asks for relief from Symptoms	Asks for investigations to diagnose the disease
Excessive use of drugs –abuse/dependence	Fear drugs- Frequent visits to various doctors

SPECIFIC PHOBIA, ILLNESS SUBTYPE

- Pts with hypochondriacal disorder are preoccupied with a disease they believe is already present.
- Illness phobic fear developing a disease they do not yet have.

GENERALIZED ANXIETY DISORDER

- Characterized by excessive worry about a number of areas.
- If worry is confined to illness, then a diagnosis of GAD shouldn't be made.
- Pts with GAD have worries about multiple events, situations, or activities, only one of which may involve health.
- Hypochondriasis involve specific diseases.

PANIC DISORDER

Panic disorder	Hypochondriacal Disorder
Fear immediate consequences of illness (eg. heart attack)	Fear long term consequences of illness (eg. Cancer)
Fear 'dying'	Fear 'death'
Misinterpret the symptoms of autonomic arousal	Misinterpret a range of bodily symptoms
Frequent unexpected panic attacks	- -

OBSESSIVE-COMPULSIVE DISORDER

	OCD	Hypochondriasis
Cognitions	Intrusive thoughts of contamination or disease. Irrational Resistance	Fear of illness Rational No resistance
Sensations	None	Somatic and visceral sensations
Other classic OCD obsessions	+++	---
Behaviors	Compulsions	Doctor shopping

BODY DYSMORPHIC DISORDER

	BDD	Hypochondriasis
Cognitions	Body parts	Body illness
Distress	Due to perceived deformity	Due to ↑ levels of health concerns

MAJOR DEPRESSIVE DISORDER

- Ruminations about health and excessive worry about illness, along with the symptoms of a MDD
- A separate diagnosis of hypochondriasis is not made if these concerns occur only during the major depressive episodes.

PSYCHOTIC DISORDER

- Characterized by somatic delusions (e.g., that an organ is rotting or dead) or delusional beliefs of having an illness.
- In Hypochondriasis the person can acknowledge the possibility that the feared disease is not present.

MEASURES

Self-rated questionnaires

- Whiteley Index
- Illness Attitude scales
- Illness worry scale
- Health anxiety questionnaire
- Health anxiety inventory
- Multidimensional inventory of hypochondriacal traits
- Psychiatric diagnostic screening questionnaire

MEASURES

Structured interviews

- Structured diagnostic interview for hypochondriasis (Barsky et al.)
- Structured clinical interview for DSM-IV (SCID)
- Composite international diagnostic interview (CIDI)
- Schedules for clinical assessment in psychiatry (SCAN)

MANAGEMENT

Strategies

1. Legitimize the pt's symptoms
2. Establish a regular schedule of visits
3. Base diagnostic evaluation on objective findings
4. Approach Rx of physical symptoms cautiously
5. Provide plausible explanations for symptoms
6. Establish a goal of improved functioning
7. Maintain a therapeutic relationship

PSYCHOLOGICAL THERAPIES

Explanatory therapy

- Involves- repeated physical examinations, reassurance, information
- In a controlled trial, this therapy yielded significant improvement as compared to no treatment. Gains maintained for 6 months.
- Additional controlled trials needed.

PSYCHOLOGICAL THERAPIES

Cognitive Behaviour therapies

- Cognitive procedures include identifying & challenging dysfunctional thoughts & formulating more realistic beliefs
- Behavioural procedures involve in vivo exposure with response prevention.
- Four RCTs have shown CBT to be superior to no treatment & gains sustained upto 12 months.
- A non-specific intervention, behavioural stress management, was effective as well

PSYCHOLOGICAL THERAPIES

- Barsky and ahern (2004)
- Brief, individual CBT intervention, developed specifically to alter hypochondriacal thinking and restructure hypochondriacal beliefs,
- Significant beneficial long-term effects on the symptoms of hypochondriasis.

PHARMACOLOGICAL THERAPIES

- No RCTs for hypochondriasis have been completed.
- Anecdotal and open-label studies suggest that serotonergic agents such as clomipramine and the SSRI fluoxetine may be effective (Fallon et al.,1993)
- SNRIs, Olanzapine and Pimozide (case reports)
- Pregabalin and Gabapentin

PHARMACOLOGICAL THERAPIES

- Pharmacotherapy for co-morbid psychiatric disorder.
- Tricyclics, SSRI, Nefazodone- associated depressive symptoms
- Antipsychotics- delusional syndromes
- Fallon et al- fluoxetine moderately effective in acute phase

PHARMACOLOGICAL THERAPIES

Inherent limitations of drugs

- Adverse effects
- Increased relapse rates following discontinuation
- Do not address the cognitive component

SUMMARY

- Hypochondriasis- a broad term regarding preoccupation with bodily illness
- Phenomenological overlap with anxiety and OCD
- Diagnostic and treatment quagmire
- Drain on medical resources
- Good therapeutic relationship, overcoming mistrust and addressing negative expectations and psychological therapies- treatment pillars

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