Don’t be fooled by hypochondria

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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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, 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 hyper-vigilant 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...
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

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

sometimes go undetected when physicians assume that complaints are an expression of longstanding 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.

**Functional somatic syndrome?** Fibromyalgia and chronic fatigue syndrome do not represent hypochondriasis, 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

<table>
<thead>
<tr>
<th>Predominant symptom</th>
<th>Characterization</th>
</tr>
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<tbody>
<tr>
<td>Disease conviction</td>
<td>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</td>
</tr>
<tr>
<td>Disease fear</td>
<td>Patient may avoid doctors because of fear associated with confirmation of a dreaded disease</td>
</tr>
<tr>
<td>Bodily preoccupation</td>
<td>Patient may complain of multiple somatic symptoms, which mask underlying fear or belief of having a serious disease</td>
</tr>
</tbody>
</table>

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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.

How to distinguish somatoform disorders

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

Ironically, the emergence of a real medical ailment—despite hypochondriacal worry—or 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.”

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

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. 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. In the only published controlled study, fluoxetine was more effective than placebo for treating hypochondriasis.

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).

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. 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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**Table 3**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Starting dosage</th>
<th>Maximum dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine</td>
<td>10 mg/d if panic symptoms are present; 20 mg/d otherwise</td>
<td>80 mg/d</td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>50 mg at bedtime</td>
<td>150 mg bid</td>
</tr>
<tr>
<td>Nefazodone</td>
<td>100 mg bid</td>
<td>300 mg bid</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>20 mg once daily</td>
<td>50 mg once daily</td>
</tr>
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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**


**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.

**References**