

Case Illustration

The patient is a 20-year-old, single, unemployed man who lives with his parents and younger sibling. He quit school when he was in the 10th grade due to depression and anxiety. At the time of admission to The Menninger Clinic, the patient was diagnosed with hypochondriasis, panic disorder with agoraphobia, and generalized anxiety disorder. The patient also presented with avoidant and dependent personality traits. He had been in psychiatric treatment since he was 15. The focus of this treatment had been on his personality traits and depression, with the assumption that his health anxiety and panic would abate if his dependency on his family could be resolved. His health anxiety primarily concerned a fear of dying of a heart attack. His fear grew more intense when he

had thoughts and worries that he would die alone and helpless. The patient's lesser fears involved stomach distress (he was under treatment for gastroesophageal reflux disease at the time of admission) and developing some type of disorder that would cause him to go blind. He had worked in the family business with his father but was unable to do so as his condition worsened. His social and recreational life, which had been reasonably active when he was younger, was now severely limited.

The patient had developed a number of safety and avoidance behaviors to neutralize health fears and reduce anxiety. He avoided any strenuous activities that might raise his heart rate because an elevated heart rate signaled cardiac arrest. He avoided being alone and made sure that someone was available for him to call by cell phone at all times. If he needed to drive somewhere by himself, he would be in constant contact via cell phone with a family member or a friend. If no one was available to be on the phone, he would not drive. The patient checked his pulse dozens of times per day and monitored his blood pressure with a home sphygmomanometer. He had visited various emergency rooms more than 500 hundreds times in the span of 4 years, piling up thousands of dollars in hospital costs. He had accumulated stacks of bills from numerous visits to doctors' offices and incurred costs of medications that his health insurance was no longer covering. The patient avoided spicy foods and kept a bland but unhealthy diet. Because of his fears of going blind, he wore sunglasses indoors to avoid fluorescent light. He compulsively sought reassurance from family members, which created significant tension in the home.

The patient entered the hospital seeking help with his anxiety. A case conceptualization was built with the help of the patient. He was asked to consider two explanations of his condition. The first was his own explanation that he was imminently vulnerable to catastrophic illness and death and that his current coping methods would be effective in protecting him from his fears. The alternative version hypothesized that he suffered from health anxiety and hypochondriasis and, while his distress was real and troubling, his coping strategies were contributing to his distress and ruining the quality of his life. The patient agreed to entertain the latter hypothesis and build a treatment plan around it.

He began to examine his beliefs about illness and anxiety. He met regularly with a physician to be educated about his feared illness as well as about normal bodily functioning and “body noise.” These meetings helped the patient practice accepting reasonable medical reassurance. He agreed to limit his reassurance-seeking behavior and discussions of his health to short daily talks with a nurse. The patient committed to attending all groups and activities despite his high level of anxiety and body noise. This portion of the plan was intended to extricate him from his sick role and to help him become more aware of the reinforcing power of such behaviors. The patient had been told in earlier treatments that he was receiving “secondary gain” from his anxiety and that his symptoms were caused by a motivation to avoid the responsibilities of adult life and unwillingness to individuate from his parents. The patient reported that he felt confused as well as accused by these interpretations. He related that he desperately wanted to be more independent, and he was extremely frustrated that he was unable to do the things in life that mattered to him. The treatment team explained to the patient that, although fears of independence and separation-individuation problems were likely relevant, they would be less of a focus in this treatment. The primary focus would be on psychoeducation and CBT aimed at treating his health anxiety and hypochondriasis.

The patient associated anxiety with catastrophic illness and death. Since death and catastrophic illness should be avoided, it had become axiomatic for the patient to avoid anxiety. It was called to his attention that if he drove by himself from point A to point B, there was only a minute chance that he would die of a heart attack, but that there was a 100% chance that he would be anxious. The patient began to challenge and modify his beliefs about his anxious arousal. He reflected on alternative meanings for his anxious experience and learned that since he perceived anxious arousal to be the cardinal sign of impending disaster, his anxiety became the primary target of his efforts to control through avoidance and safety behaviors. Eventually, the patient was able to understand the bidirectional nature of his cognitions and anxiety; thoughts and images of illness produced anxiety but anxious arousal triggered such thoughts and images. For instance, when on a treadmill, he had fears of having a heart attack after just a few minutes of

semivigorous walking. Continued use of the treadmill helped the patient reinterpret his anxious arousal as the physiological arousal associated with exercise that, in fact, promotes health.

A simple E-RP intervention, including repeated sessions on the treadmill, provided the patient opportunities to reinterpret the meaning of the situational, internal, and somatic cues associated with his health anxiety and hypochondriasis. The patient developed a hierarchy of feared situations to guide his exposure therapy. The most intense of these exposures was driving home for the weekend, which was several hours away, without using his cell phone. The patient's progress was not linear. On an initial attempt at driving home, he found himself in the parking lot of a hospital emergency room midway to his destination, but he was able to resist the urge to go into the hospital.

Another important aspect of the patient's treatment was the use of acceptance and mindfulness. He was able to realize that his worries, ruminations, and obsessions functioned to give him the perception of safety and to protect him from feelings of vulnerability. Furthermore, he realized that his health fears kept him from things that mattered to him. The patient agreed to experiment with not challenging his automatic thoughts to determine whether they were true or false, but rather to see them as inevitable thoughts, or "noise," that were not functionally relevant to the task at hand. This perception removed the need to avoid thoughts and images, such as dying alone of a heart attack. He learned that he could take a nonjudgmental observational stance toward the thoughts and images that he previously believed he had to avoid. Likewise, the patient was able to practice experiencing anxiety in a nonjudgmental way through understanding that anxiety, although a useful source of information, was not a direct reflection of reality. Through imaginal and in vivo exposure activities, the patient practiced taking a mindful stance toward previously avoided cognitions and affective states while refraining from the maladaptive action tendencies that had been habitually associated with these states. The patient began to accept that he would feel anxious while participating in these novel activities and needed to reassess the meaning of his anxiety in a more functional way without attempting to exercise direct control over his anxiety. As a result, the patient's goals shifted from

the primary directive of setting and pursuing goals about avoiding feared cognitions and uncomfortable affective states, and he began to pursue activities that had more functional value for him.

As the patient approached his discharge after 8 weeks of treatment, he began to make aftercare plans. He had been participating in weekly family therapy, with aftercare and planning as a major part of this process. Early in family therapy, the parents and patient learned the deleterious effects of constantly giving reassurance to his health fears. The parents and patient agreed that the parents would refrain from answering health questions pertaining to the patient's health anxiety. The patient agreed to wait until his regular monthly visits with his family physician, who had been made aware of the patient's health anxiety and hypochondriasis, in order to review his health concerns. Furthermore, the family was able to set up a contract concerning daily schedules, work and educational plans, and a timeline that moved the patient toward increased independent functioning. Because of the increased knowledge of the patient's health anxiety and hypochondriasis and a better sense of direction for their son, the parents felt more confidence in helping him hold the line against sick role behaviors and reinforcing independent functioning.

Upon returning to his home community, the patient began group and individual CBT with a therapist experienced in the treatment of anxiety disorders. The patient was able to return to work part-time and eventually began school. At last follow-up, 10 months posttreatment, he continued to follow his aftercare plan, work, and attend school part-time.

To objectively measure this patient's progress, we also administered the Whitley Index. It is a 14-item, true or false measure that was developed by Pilowsky (1967) to measure health-related worries or the core features of hypochondriasis. Most studies conducted using this measure indicate good reliability and validity (Barsky et al., 1992; Pilowsky, 1967). The patient's scores on the Whitley Index decreased from 11 on admission to 5 at discharge. His depression levels were monitored with the Beck Depression Inventory, which significantly reduced from 38 to 14 (63%). A general measure of anxiety, the Penn State Worry Questionnaire (Miller, Miller, Metzger, & Borkevec, 1990) was administered pre- and posttreatment, showing a decrease from 73 to 42 (31%).

Conclusion

Health anxiety and hypochondriasis are serious and debilitating conditions that are poorly understood by the general public as well as by the medical and psychiatric community. More research into clarifying the diagnostic issues concerning hypochondriasis is essential. Although CBT and pharmacology have demonstrated effectiveness, the goal of treatment should focus not only on symptom relief but also on improving quality of life. Further investigation into effective treatments for health anxiety and hypochondriasis will help determine the mechanisms of change for the varied components of these conditions. Hypothetically, disease phobia should respond to treatments known to be effective in treating anxiety, while disease conviction should respond to interventions known to be effective in treating depression.

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