Health Anxiety & Hypochondriasis

DANIEL ZIGMAN & OREN KRAJDEN

Objectives

By the end of this presentation participants should:

1) Understand the diagnostic criteria and clinical presentation of Illness Anxiety Disorder and Somatic Symptom Disorder

2) Have an approach to engaging these patients in appropriate treatment

3) Explain effective pharmacological and psychological treatments for these conditions

Disclosures

Neither of us have financial relationships with industry

We will be discussing off-label use of medications

Clinical Case

25 F, lives w/ M, works in call center, seen in OPD

RFC: I'm afraid I have cancer

No psych Hx. No ETOH, no drugs.

HPI: Had viral illness 4 months ago, then discomfort in neck, and worried she has cancer. Also diffuse aches and pains. Symptoms not really distressing. Father died 3 yrs ago of gastric ca.

Sometimes worried, sometimes convinced.

Seen GP and several other MDs who reassured her than no concern.

1 month worsening depressive symptoms. Came to ER with anxiety attacks, crying at work. Started on citalopram up to 40 mg without benefit.

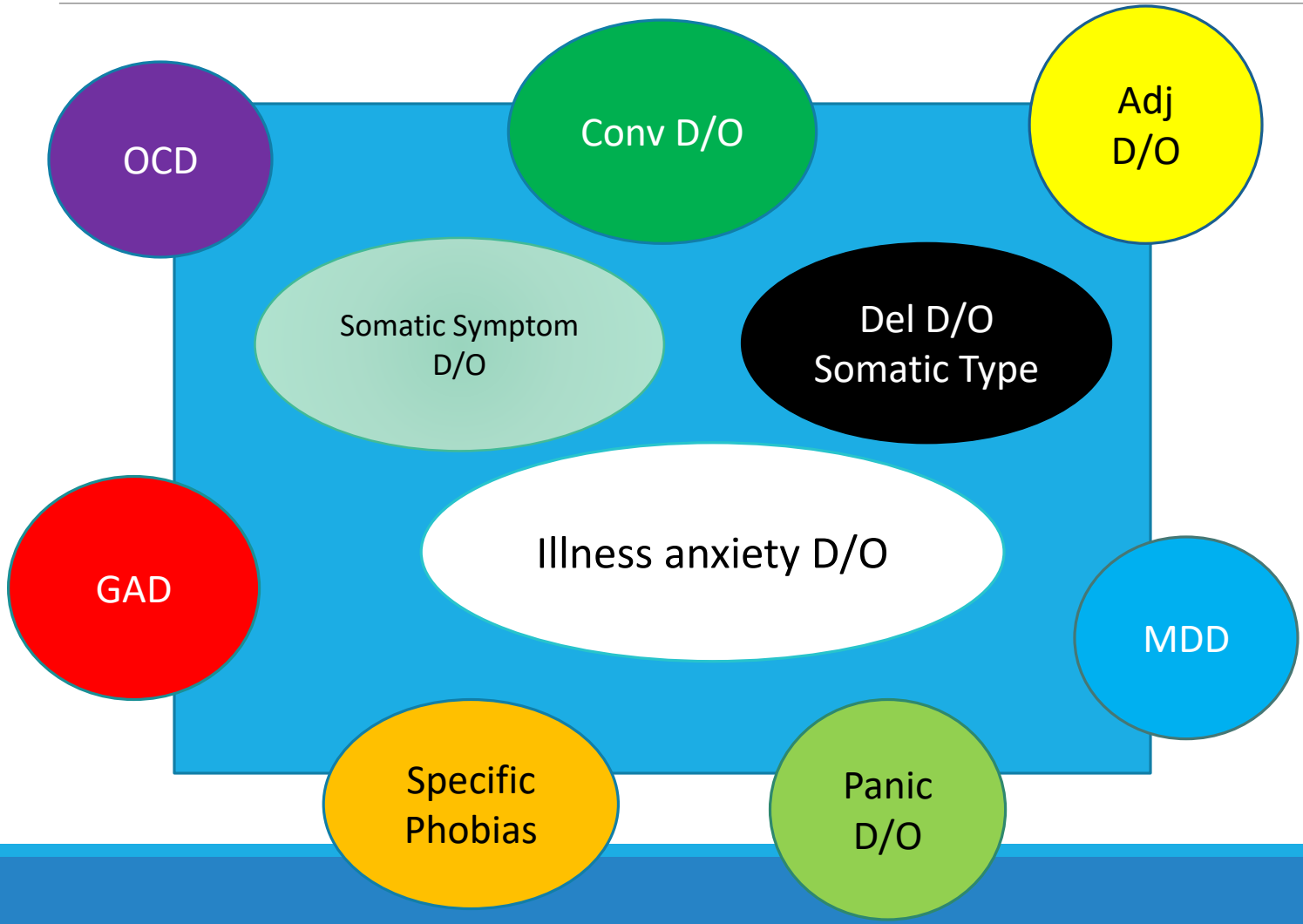
Saw internal medicine who provided 2nd opinion that all necessary investigations have been completed and no concern about ca.

Referred to psychiatric day hospital, started private therapy

Aripiprazole added up to 3 mg

Within 1 month, much improved, returning to work

Diagnostic Categories Associated with Health Anxiety



“Health Anxiety”

From psychological literature

Salkovskis 1989- A psychological problem consisting of catastrophic misinterpretations of sensations and signs that signal a *future* danger to one’s health

- Examples:
  - Recurrent headaches signal a brain tumor
  - Fatigue signals cancer
  - Concentration problems signal dementia

Vs. Panic disorder -> the danger is *imminent*

- Examples:
  - Palpitations signal an arrhythmia
  - Chest pain signals an MI

Rachman, Beh Res Ther, 2012

DSM-IV – Somatoform disorders

Hypochondriasis

Somatization disorder

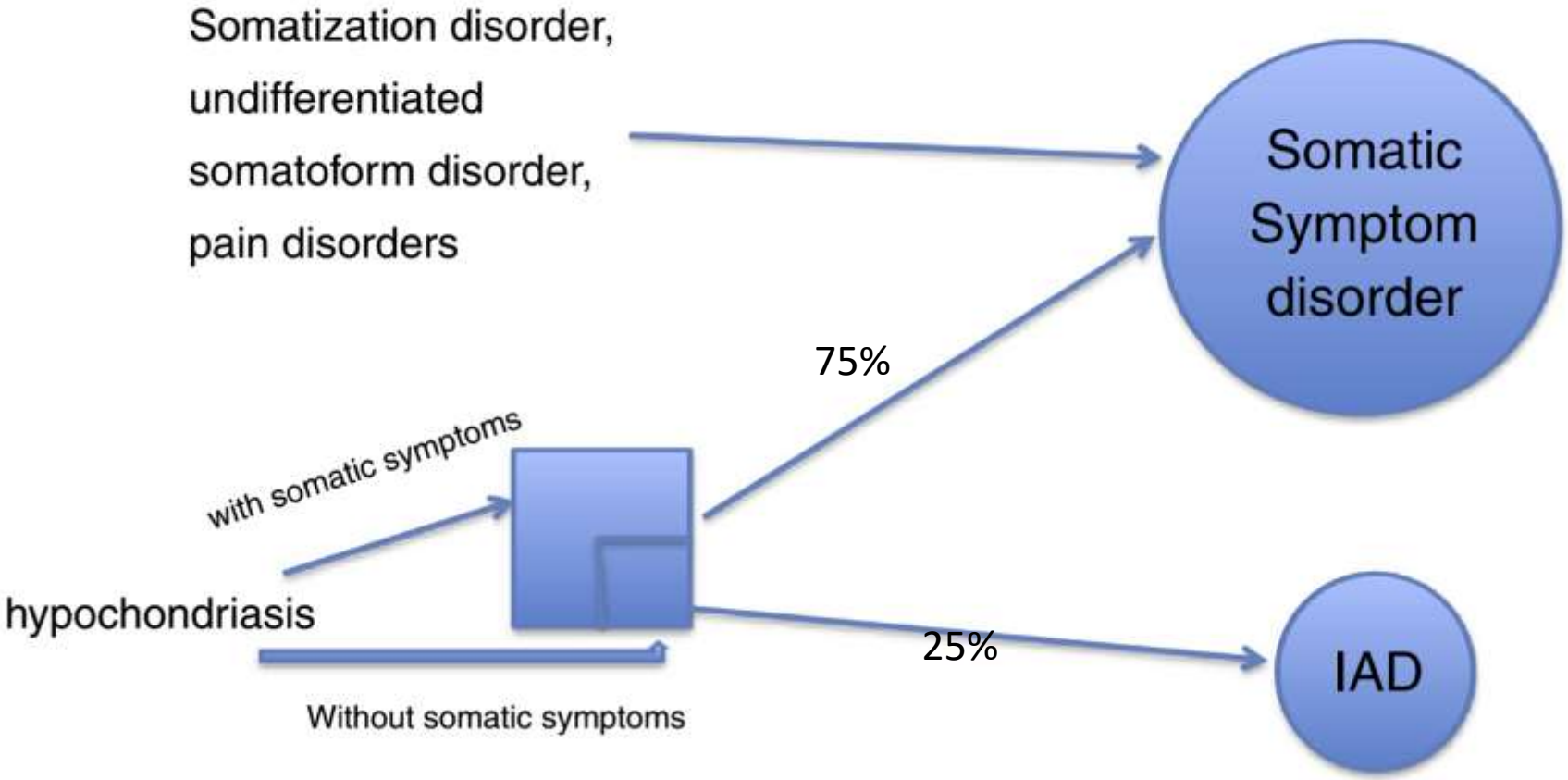
Undifferentiated somatoform disorder

Pain disorder

Conversion disorder

Concept of “medically unexplained” symptoms

Coalescing and differentiating



Dimsadale, J Psychosom Res, 2013

DSM-5: Somatic Symptom Disorder

One or more somatic symptoms that are distressing and/or result in significant disruption of daily life.

One of the following:

- (1) Disproportionate and persistent thoughts about the seriousness of one's symptoms.
- (2) High level of anxiety about health or symptoms
- (3) Excessive time and energy devoted to these symptoms or health concerns

Symptom duration >6 month

DSM-5: Illness Anxiety Disorder

Preoccupation with having or acquiring a serious illness - excessive or disproportionate

*Somatic symptoms not present or mild

High level of anxiety about health or having or acquiring a serious illness.

Excessive behaviors or maladaptive avoidance

Duration > 6 months

Epidemiology

Medically unexplained symptoms (fibromyalgia, IBS, chronic fatigue etc)

- ~80% of population
- ~75% of primary care patients
- 10% of all medical costs

Somatic symptom disorder –

- 4-6% lifetime prevalence
- 17% of primary care patients
- 25% of patients with fibromyalgia

Illness anxiety disorder –

- 0.1% lifetime prevalence
- 0.75% of medical outpatients

UpToDate 2018
Hauser, J Psychosom Res., 2015
Van Der Bergh, 2017, Neurosci & Beh Rev

Comorbidity

As with other anxiety disorders, “comorbidity is the rule”

- Other anxiety disorders
- Mood disorders
- Personality disorders

Explanatory Models for MUS

Freudian psychoanalytic – "top down" – **unresolved unconscious conflict** gets converted into symptoms

Cognitive behavioral – "bottom up" – **peripheral signals gets amplified** by stress and misattributed to disease

Perception model – **impairments in information processing in brain areas involving introception** (e.g. the insula, the anterior cingulate) influenced by expectations.

Henningsen 2018, APA Textbook of Psychosomatic Medicine

Etiology of Health Anxiety

Genetics:

- 30% heritability

Early life experiences:

- Parental conflict
- Traumatic sexual experiences
- Victim of Violence
- Poor health in childhood
- Phobias in childhood

Furer, 2008

Triggers for Health Anxiety

Family members with serious illnesses

Death of a family member or friend

Medical illness

Media reporting

CBT - Cognitive Biases

Emotional reasoning – “if I am anxious about the pain, it means there is danger”

Confirmatory bias – patients selectively notice and remember information consistent with their beliefs

Thought action fusion / magical thinking – “If I think about getting cancer, I am more likely to get it”

Rachman, Beh Res Ther, 2012

CBT - Rules

"I must take all symptoms and bodily changes seriously"

"I must be symptom free to be healthy"

"I must have a diagnosis so I can move forward"

"My doctor must be certain"

CBT - Assumptions

“If my doctor orders a test, then there must be something wrong”

“If my doctor doesn’t know exactly what the problem is, then it must be really serious”

“If I don’t get a clean bill of health from the doctor, then I must be ill”

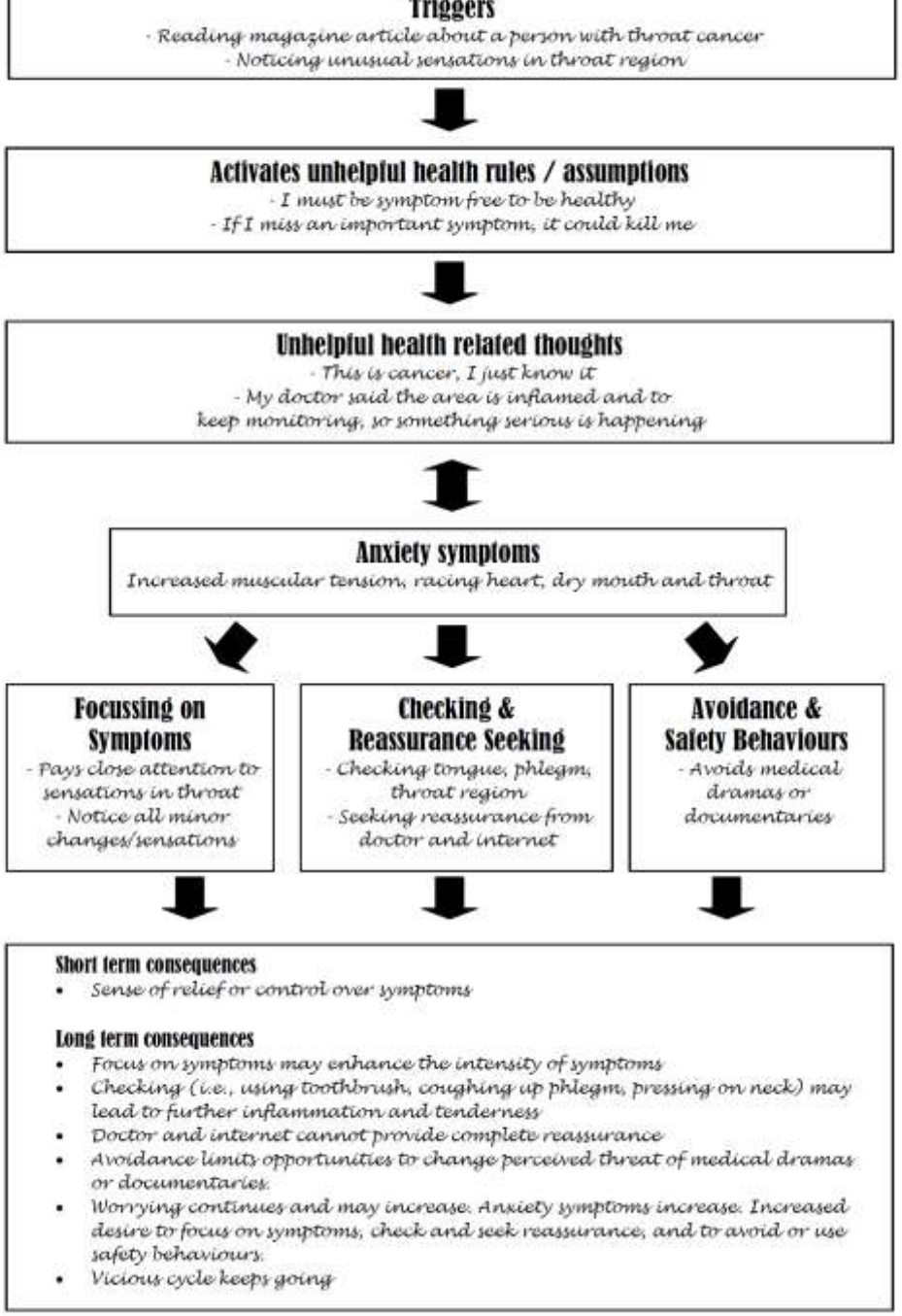
“If I don’t keep checking / having tests, I could miss something really important”

“If I don’t persist, my Doctor may miss something important”

“If I’m not vigilant, an underlying problem could be getting worse”

“Once you are sick, there are no second chances”

How Health Anxiety is maintained



But how do I discuss this with my patient?

The Elephant in the Room

Patient-Centred Approaches

Validation: First emphasize the impact and reality of the symptom

Summary reflection: Recap the investigations done thus far
"I have taken a careful history and I have examined you / done blood tests /other tests/ referral to sub-specialist without an explanation. What was this process like for you?"

Admitting our limitations as clinicians (The "one-down" position) :
"We are good at ruling out serious illnesses *but we are not so good* at finding out the cause of each symptom."

The curious stance: "What would it mean for you if we cannot find a cause for this symptom?" Explore.

The meaning of somatic symptoms: "We all experience stress but some people experience more of their stress in their bodies." Clinician can help normalize.

Communicating with patients

The number needed to offend:

"If you had leg weakness, your tests were normal, and a doctor said you had 'X' would he be suggesting that you were Y (or had Y)." Percentage responses among 86 new neurology outpatients, offence score, and "number needed to offend"—that is, number of patients who would have to be given this diagnostic label before one patient is "offended"

	Connotations (Y) (No (%) of patients)						
Diagnoses (X)	Putting it on (yes)	Mad (yes)	Imagining symptoms (yes)	Medical condition (no)	Good reason to be off sick from work (no)	Offence score (%)*	Number needed to offend (95% CI)†
Symptoms all in the mind	71 (83)	27 (31)	75 (87)	57 (66)	60 (70)	93	2 (2 to 2)
Hysterical weakness	39 (45)	21 (24)	39 (45)	28 (33)	36 (42)	52	2 (2 to 3)
Psychosomatic weakness	21 (24)	10 (12)	34 (40)	18 (21)	24 (28)	42	3 (2 to 4)
Medically unexplained weakness	21 (24)	10 (12)	27 (31)	32 (37)	35 (41)	35	3 (3 to 5)
Depression associated weakness	18 (21)	6 (7)	17 (20)	13 (15)	24 (28)	33	4 (3 to 5)
Stress related weakness	8 (9)	3 (6)	12 (14)	14 (16)	20 (23)	20	6 (4 to 9)
Chronic fatigue	8 (9)	1 (2)	9 (10)	16 (19)	12 (14)	15	7 (5 to 13)
Functional weakness	6 (7)	2 (2)	7 (8)	7 (8)	17 (20)	12	9 (5 to 21)
Stroke	2 (2)	4 (5)	4 (5)	5 (6)	10 (12)	12	9 (5 to 21)
Multiple sclerosis	0 (0)	1 (1)	3 (3)	3 (3)	7 (8)	5	22 (9 to ∞)

*Proportion of patients who responded "yes" to one or more of "putting it on," "mad," or "imagining symptoms."
†Calculated according to the offence score.

Stone, BMJ, 2002

Symptoms as “Functional”

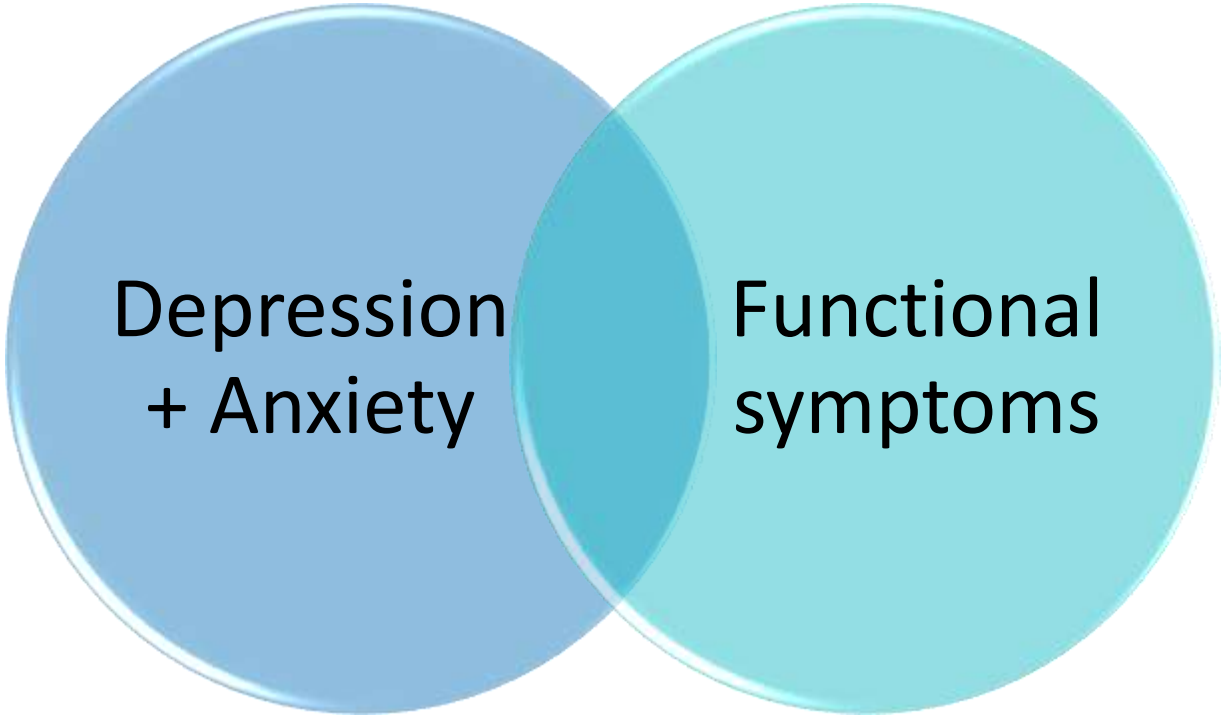
Unless symptoms are obviously due to anxiety/panic/depression, it is best not to focus on that as the “cause” of symptoms.

Instead explanation of functional vs. Structural problems (e.g. stroke, tumor)

Functional implies a problem with the “functioning” of the parts of the body.

- E.g. can mean that brain areas are not communicating properly with each other.

Overlap with mood and anxiety disorders suggests possible involvement of same brain areas.


Depression
+ Anxiety
Functional
symptoms

Dealing with refusal to accept diagnosis/treatment

Focus on the distress

- E.g. Maybe we can agree to disagree regarding the cause of your symptoms, but can we agree that the level of anxiety/avoidance/impairment/distress is taking over your life?

Theory A vs. Theory B

- *Theory A - the problem is that you have an undiagnosed medical illness. This means that you try very hard to research to find out what it could be. You need to undergo many tests and check your body repetitively. However, your solutions become your problem and cause you to become increasingly worried about your symptoms and have a poor quality of life*
- *Theory B - this is an emotional problem, which makes you excessively worried about your health. This may be linked to some of your early experiences (for example, of seeing your parents die at a young age). Have you noticed that solving it as a health problem (Theory A) actually makes your preoccupation and distress worse? Would you be willing to act as if it were Theory B for at least 3 months? If Theory B were true, what would this mean for how you cope?*

Role of medical tests

No effect of medical tests on illness worry or nonspecific anxiety either in the short term of long time

May slightly reduce office visits

-> Can be used a behavioral experiment, especially with respect to "getting a 2nd opinion"

Rolfe, JAMA internal Med. 2013

Role of medical tests and the “therapeutic consultation”

- Investigate and refer only as per usual practice and resist the urge to over-investigate or over-refer
- Clinicians advised to interrogate own anxiety: (fear of “missed” serious condition is common)
- Recommend early exploration with patients **in advance** to help **anticipate** the consequence and meaning of:
  - No finding of cause for symptoms
  - An incidental finding / ”incidentaloma” – can affect the doctor-patient relationship if patient is “surprised” or attributes symptoms to incidental finding

Good clinical management

Schedule regular visits

Acknowledge and legitimize symptoms

Communicate with other clinicians

Evaluate for and treat diagnosable medical disease

Limit diagnostic testing and referrals to specialists

Reassure that grave medical diseases have been ruled out

Assess and treat the patient for psychiatric disorders incl SUDs

Educate patients about coping with physical symptoms

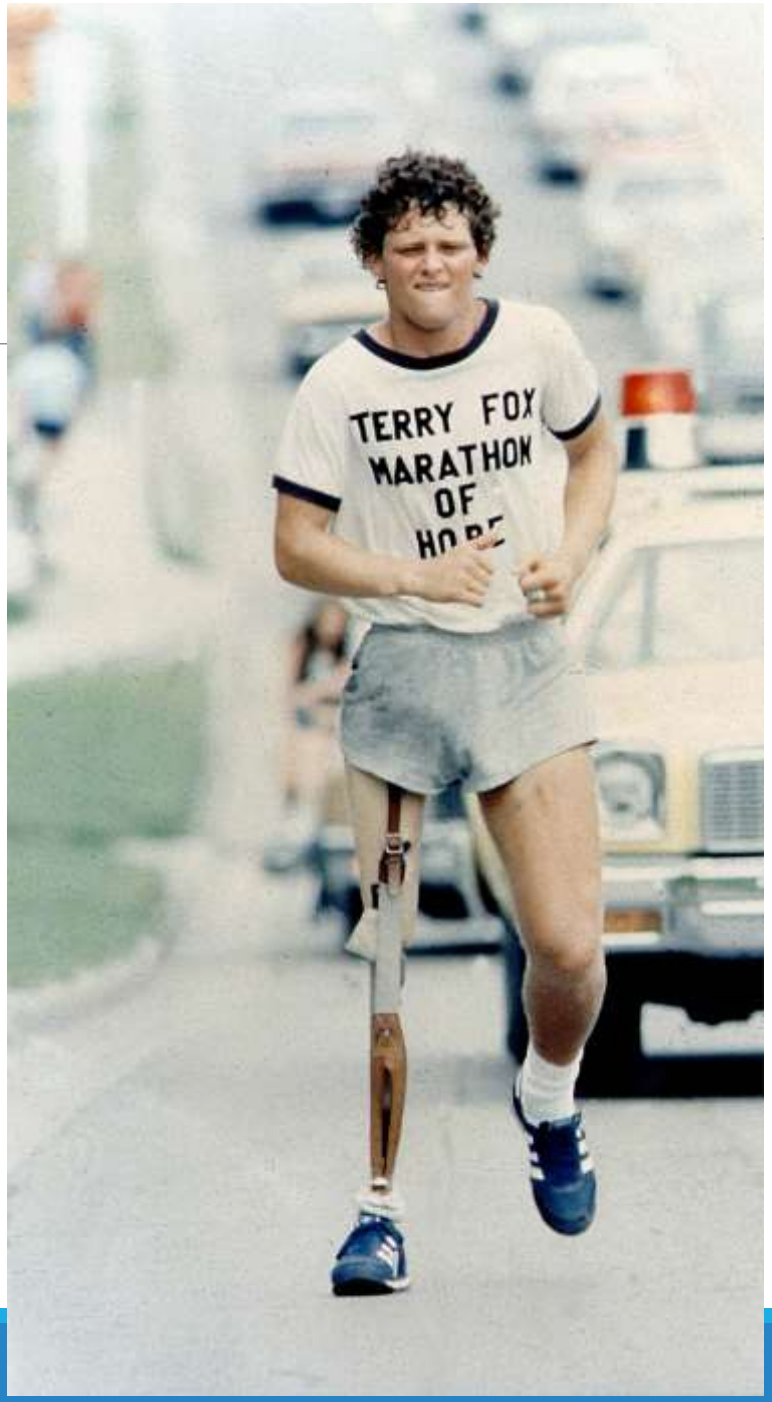
Explicitly set the goal of treatment as functional improvement

UpToDate

For somatising patients:

Focus on limitations of medicine to explain symptoms

Living a meaningful life despite symptoms and associated disability



Psychodynamic approaches

Focus on death anxiety and confronting mortality (see Yalom, Staring at the Sun)

- Fears of pain, dependency, loss of autonomy
- Life goals not accomplished
- Opportunities wasted
- Not being remembered

Psychotherapy

A Cochrane review confirmed that CBT is effective for reducing symptoms of hypochondriasis

Behavioral stress management also shown beneficial in an RCT

Psychodynamic therapy no better than waitlist and inferior to CBT

Psychoeducation alone is ineffective

UpToDate 2015
Thompson, *Cochrane Rev*, 2007
Sorensen, *Psycholo Med*, 2011

5 minute office-based CBT

- Educate the patient about the role of checking in maintaining health anxiety (i.e. short term relief, but difficulty tolerating uncertainty)

- Help patient make list of all the ways that they check their health

- Help patient understand red flag symptoms that actually warrant further investigations.

Pharmacotherapy

Hypochondriasis:

- 2 RCT showed SSRIs (fluoxetine, paroxetine) moderately effective
- Paroxetine similar effectiveness to CBT, no significant difference at 18 mo F/U
- Open studies and case reports suggest potential benefits for other SSRIs and pregabalin

Fallon, *J Clin Psychopharm*, 2008
Greeven, *AJP*, 2007
Greeven, *J Beh Ther Exper Psychitry*, 2009

2nd line treatments

In absence of evidence for guidance, most experts treat resistant illness anxiety and somatic symptom D/O similar to MDD or GAD

- Augmenting with SGA
- Adding pregabalin or BZD
- TCAs or SNRIs if pain is prominent.

Pharmacotherapy

- It is important to avoid the use of opioids in these conditions
- If asked, explicitly build common ground with patients around lack of evidence, potential for harm (dependence, substance use disorders) – many clinicians are afraid to do this!
- Patients may arrive into your practice already on long term opioid therapy (LTOT) with these underlying conditions, especially somatic symptom disorder

Summary

Health anxiety associated with many psych disorders, but primary focus of somatic symptoms disorder and illness anxiety disorder

CBT is the most effective first line treatment. Antidepressants can be used in more severe or treatment resistant cases.

Therapy focuses on helping patients challenge unhelpful assumptions about health and illness and learn to tolerate uncertainty.