

Psychotherapeutic management of hypochondriasis: a case study

Abstract

Objectives: The present study aims to explore the course of hypochondriasis and to assess the efficacy of psychotherapeutic management in alleviating the symptoms associated with hypochondriasis and to improve the client's overall functioning. **Research design:** Case study. **Sample and method:** This study was carried out in Delhi and 18 years old unmarried male was included. Treatment plan was formulated according to psychotherapeutic management wherein different management techniques were utilised to modify the client's hypochondriacal beliefs and the associated behaviours. **Result:** Findings of the assessment showed significant distress and impairment in overall functioning. Stressor activates his dysfunctional belief which shifts his attention to minor bodily perturbations and results in misinterpretation of these trivial variations. Psychotherapeutic management techniques successfully restructured his dysfunctional beliefs and remarkably improved his functioning. **Conclusion:** On the basis of results, it can be ascertained that psychotherapeutic management is an effective approach to treat hypochondriasis.

Keywords: Stressor. Beliefs. Functioning.

Shilpi Aggarwal¹, Prashant Srivastava²

¹*Clinical Psychologist, Child Development Centre, Department of Paediatrics, Maulana Azad Medical College and Associated Lok Nayak Hospital, New Delhi, India,* ²*Psychiatric Social Worker, Child Development Centre, Department of Paediatrics, Maulana Azad Medical College and Associated Lok Nayak Hospital and PhD Scholar, Department of Social Work, Jamia Millia Islamia, New Delhi, India*

Correspondence: Prashant Srivastava, Psychiatric Social Worker, Child Development Centre, Department of Paediatrics, Maulana Azad Medical College, New Delhi-110002, India. 21prashantsrivastava@gmail.com

Received: 27 September 2016

Revised: 7 December 2016

Accepted: 8 December 2016

Epub: 13 December 2016

Introduction

Hypochondriasis is an excessive disease belonging a morbid preoccupation with one's health. In general medical practice, hypochondriasis occurs in three to 14 per cent of patients, especially adolescents.[1] Hypochondriacal person's augment and amplify somatic sensations, and they have lower thresholds and tolerance of physical discomfort. Hypochondriacal patients are resistant to treatment; however, treatment helps a significant proportion of patients.[1]

Hypochondriasis has multiple meanings and has been widely used by both clinicians and the public with different apprehensions. Three common usages are: a) It can mean a morbid concern with health and with defending one's healthy position. Such persons may be engrossed with health foods and patent medicines to delay ageing. Many of them do not complain at all of ill health and in fact may complain their healthiness, connecting it to the measures they have taken to protect it. b) It can be used to define a group of individuals who seem to follow ill health as a way of life. They appear to enjoy bad health and collect new symptoms and shed old ones as they go through life. c) It can describe a belief of the actual disease or a fear of developing serious disease.

A common individual, as one can often learn by contemplation, is subject at all times to somatic feelings

slightly below the level required to claim the consideration of consciousness. These sensations, as a rule, pass unheard and do not form the subject of complaint. However, in hypochondriacal conditions these sensations seek mindful gratitude and are felt to be the cause of distress or malaise. These may go on to inhibit with normal action and hence become the signs of illness. Though there is the usual amount of normal variation in the liability to hypochondriasis, the tendency is adequately universal to incite misuse by manufacturers of laxatives, backache pills, patent medicines and remedies which are usually sold across the counter. This commercial exploitation itself rises the diffusion of this tendency through the population and has, for instance, led to what has been termed 'a national hypochondriacal neurosis centered on constipation.'[2]

The idea of illness behaviour was introduced by Mechanic,[3] and it mentions the ways in which symptoms may be differentially perceived, assessed, and represented upon by different kinds of persons. Pilowsky[4] further redefined the concept of "abnormal illness behaviour" in 1969 and in 1983,[5] projected that number of psychiatric syndromes (such as hypochondriasis, conversion reaction, malingering, somatoform disorder, etc.) may be seen as varying extents along the same spectrum of illness behaviour.

Somatoform disorders are considered by physical symptoms that suggest a medical condition but that are not

fully clarified by a medical condition. Patients presenting with somatoform disorders characterise a formidable challenge to the healthcare system. These patients tend to overuse healthcare services, derive little profit from treatment, and experience protracted impairment, long-lasting for many years.[6] Many patients with somatoform symptoms are displeased with the medical services they obtain and recurrently change physicians.[7] Likewise, physicians of these treatment-resistant patients often feel unsatisfied by patients' common complaints and disappointment with treatment.[7,8]

Differential diagnosis

The symptoms of hypochondriasis are similar to several other mental disorders. Such as both hypochondriasis and panic disorder involve fears related to bodily sensations, panic attacks can occur in both conditions. Panic attacks and panic disorder, however, are marked by the fear of imminent physical catastrophe (e.g. "I am having a heart attack, losing control, dying") that will occur before help can be obtained. In contrast, the fears in hypochondriasis often concern more latent threats (e.g. "I may have a brain tumour or lung cancer") that could be treated with appropriate and adequate medical attention and intervention. Similarly both hypochondriasis and generalized anxiety disorder can include worries about illness, but individuals who have generalized anxiety disorder evidence additional areas of worry (e.g. relationships, finances, world affairs) and the content of their health-related worries often shifts. In addition, patients who have generalized anxiety disorder tend to ruminate more and engage in less safety-seeking behaviour than those who have hypochondriasis.

A case report

Mr P, 18 years male Hindu, unmarried, intermediate passed belonging from upper middle class came with his father with the chief complaints of voice problem- "voice not coming out", breathing problem, communication problem, aggressive behaviour, and thought of "suffering" from throat cancer.

According to the patient till June 2011, he was functioning well. In June 2011, he suffered from throat pain and visited an Ear, Nose, and Throat (ENT) specialist. As his throat problem did not subside completely, he visited another ENT specialist after a month who diagnosed him as having infection. The patient started believing that he was suffering from throat cancer. Following which in past 13 months he visited five ENT specialists, three oncologists, and two psychiatrists. All medical investigations conducted by the doctors ruled out the possibility of cancer. According to the patient he had severe cough, swelling, burning sensation in the throat, and one incidence of bleeding which made his belief firm.

Since summer 2011, according to him, the relationship with family members was strained. In 2012 July, he joined B.Tech which he discontinued after three days of joining. According to him he had a romantic relationship with a relative, though he was not in regular touch with that girl or proposed each other. He also reported of having breathing problem when he was in closed space, climbs up the staircase, walks, and runs. He observed that he started feeling sad and difficulty in concentrating. He also mentioned of having decreased appetite since past one year. He was

admitted in a psychiatric hospital for ten days and was given electroconvulsive therapy (ECT) once. He was on amlodipine 5 mg, clonazepam 0.5 mg, olanzapine 10 mg, and pimozide 2 mg from November-December 2012. He had also taken blonanserin 2 mg and divalproex 500 mg.

Mr P was first issue of non-consanguineous parents. His developmental milestones were reported to be normal. He was good in studies till SSE but in first year inter he left his college. Father was 49 years old, BA pass, a journalist in a local newspaper. Mother was 39 year old, MA, BEd and teacher by profession. His elder brother was 20 years old, studying B.Tech third year. He had a younger sister who was 17 years old and studying in intermediate first year. His overall interpersonal relationship with family was strained on that time.

On mental state examination (MSE), speech was soft, not audible, unclear, goal directed, and coherent. Content of thought revealed preoccupation with his health condition. Subjectively client reported "I am ok" and objectively appeared sad and worried. His cognitive functions were intact. Personal and social judgement was impaired. Insight level was at IV.

Reason for taking for intervention

To reduce the preoccupation about the unexplained somatic pains, enhance the productive activities, quality of life, individual functioning, and to reduce the distress, doctor shopping, poor coping skills, give awareness regarding the manifestations of hypochondriasis, reduce his anxiety and worry about future.

Specific areas to be focused

Short-term objectives

- Establish a firm therapeutic alliance with the patient
- Educate the patient regarding the manifestations of somatoform disorder
- Offer consistent reassurance and make a behavioural contract
- Maintain regular, consistent contact with a single physician.

Long-term objectives

- Optimise the patient's ability to cope with the symptoms rather than trying to eliminate the symptoms
- Deal with coexisting disorders including persistent low mood and anxiety.

Types and techniques of intervention

Psychoeducation

The patient and family members were offered psychoeducation to make the client and his family aware about the nature of illness, course, treatment, prognosis, and to clear any misconceptions about the illness. This was done so that the client is in a better position to deal with the illness as the client had no hope of getting better. Directions to reduce repeated medical consultations and investigations also provided.

Supportive psychotherapy

Supportive psychotherapy was aimed at validating the distress the client is undergoing. The patient is given reassurance, support, and his ability to cope with distress is reinforced.

Jacobson's progressive muscular relaxation (JPMR)

JPMR is widely used to manage and reduce anxiety and autonomic arousal. The major steps involved in it are learning to identify excessive tension in certain muscles and learning to relax and if possible, eliminate that tension. This procedure is repeated with various muscle groups of the body.

Cognitive therapy

Cognitive restructuring

To find out erroneous, illogical cognitions, and to modify such maladaptive cognitions and replace them with more adaptive thoughts.

Cognitive distraction technique

By using various distraction strategies such as focusing on the environment or involving in specific tasks, instead of paying attention to the physical symptoms, and preoccupation about getting infected, death, and other negative thoughts.

Therapy process

Session 1

Psychoeducation was provided to the patient with the purpose of increasing awareness about the illness. This helped them in understanding how his symptoms began. Firstly therapist listened him with care and reassurance and empathy was given to him. And he was educated about the disease which he thought he harboured and then he was sent for physical investigation and a behavioural contract was made that he would not seek any investigation outside for his illness. Supportive psychotherapy was given to his father as he was very anxious and worried. Supportive measures such as reassurance and persuasions were used and were asked to support the patient. This helped him to develop trust and confidence. Ego strengthening was done to change his devalued self-esteem. JPMR was introduced to the patient. Therapist explained the JPMR components and its rationale. He was educated about his illness, JPMR, and its implications.

Session 2

Patient was seen. The client was given understanding regarding the importance of relaxation of his problem and also explained the rationale for the same. First session of JPMR was held. Before the session the therapist demonstrated to the patient how to tense and relax various group of muscles. He was asked to come consecutively for five days of relaxation training. After relaxation, the client was given opportunity to ventilate his feelings and reassurance was given to the client that the problems could be solved over a period of time.

Session 3

Patient was reviewed. Second session of JPMR was conducted. Towards the end of the relaxation, guided imagery was also given. Patient reported he was getting some relief for his anxiety from the relaxation procedure. Support in terms of building his confidence was provided. Cognitive restructuring was done to find out erroneous, illogical cognition that he

has; he was instructed to replace them with more adaptive thoughts.

Session 4

Patient was reviewed. Third session of JPMR was conducted with guided imagery. Patient seemed to be relaxed after the session. The client reported that he was able to observe calmness by working through the relaxation process and had showed confidence that he would participate in the rest of therapy with increased enthusiasm. He was motivated to think in positive way and was reassured that his condition was not as hopeless as he imagined and he could overcome all his problems.

Session 5

Patient was reviewed. Fourth session of JPMR was conducted with guided imagery. Patient seemed to be more comfortable and confident after the relaxation. Cognitive distraction technique was explained to the patient. By using various distraction strategies such as focusing on the environment or getting involved in specific tasks, instead of paying attention to the physical symptoms and preoccupation about getting infected, death, and other negative thoughts.

Session 6

Patient was reviewed. Fifth session of JPMR was conducted with guided imagery. During this session the patient practiced also and the therapist gave feedbacks and corrections during the process. After the session therapist explained about the importance of regular practice of relaxation and advised the client to practice it on daily basis at least for three weeks at home. For review, appointment was schedule after two weeks.

Conclusion and outcome

Six sessions were held with the patient. Later the patient ran up and reported the therapist considerable improvement (up to 50%) in terms of symptoms. He reported that his distress, health related worries, and taking unnecessary medicines reduced and felt confident. This was in agreement with the study conducted by Speckens *et al.*:[9] patients' therapy was taken from six to 16 individual sessions and cognitive behaviour therapy was administered, and result revealed significantly more improvement in their problem (psychosomatic concerns) than individuals with simple medical service. The other study with eight group sessions of cognitive behaviour therapy found greater to control situation in decreasing somatic indications and hypochondriacal concerns.[10] In both the studies, major improvements were observed after treatment as well as six months later.[9,10]

Future plans

In future we can suggest the relapse prevention and steps can be taken to enhance his coping strategies and restore his affected socio-occupational functioning; also the interpersonal relationships can be strengthened.

References

1. Kaplan HI, Sadock BJ. Synopsis of psychiatry. 6th ed. Baltimore: Williams & Wilkins; 1991.

2. Slater E, Roth M. Mayer Gross' clinical psychiatry. 3rd ed. London: Bailliere Tindall; 1977.
3. Mechanic D. The concept of illness behavior. *J Chronic Dis.* 1962;15:189-94.
4. Pilowsky I. Dimensions of hypochondriasis. *Br J Psychiatry.* 1967;113:89-93.
5. Pilowsky I, Spence ND. Manual for the Illness Behaviour Questionnaire (IBQ). University of Adelaide, Adelaide; 1981.
6. Smith GR Jr, Monson RA, Ray DC. Patients with multiple unexplained symptoms. Their characteristics, functional health, and health care utilization. *Arch Intern Med.* 1986;146:69-72.
7. Lin EH, Katon W, Von Korff M, Bush T, Lipscomb P, Russo J, *et al.* Frustrating patients: physician and patient perspectives among distressed high users of medical services. *J Gen Intern Med.* 1991;6:241-6.
8. Hahn SR. Physical symptoms and physician-experienced difficulty in the physician-patient relationship. *Ann Intern Med.* 2001;134:897-904.
9. Speckens AE, van Hemert AM, Spinhoven P, Hawton KE, Bolk JH, Rooijmans HG. Cognitive behavioural therapy for medically unexplained physical symptoms: a randomised controlled trial. *BMJ.* 1995;311:1328-32.
10. Lidbeck J. Group therapy for somatization disorders in general practice: effectiveness of a short cognitive-behavioural treatment model. *Acta Psychiatr Scand.* 1997;96:14-24.

Aggarwal S, Srivastava P. Psychotherapeutic management of hypochondriasis: a case study. *Open J Psychiatry Allied Sci.* 2016 Dec 13. [Epub ahead of print]

Source of support: Nil. **Declaration of interest:** None.