

THE HYPOCHONDRIACAL PATIENT

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ABSTRACT

Until recently, hypochondriasis received relatively little attention from clinical investigators. The epidemiology is largely unknown. The numerous theories on the aetiology cannot explain the psychopathology. Recent interest and attempts at operationally defining the syndrome have resulted in some progress in the recognition and treatment of the hypochondriacal patient. The physician's reaction is highlighted as an important factor that contributes to the initiation and maintenance of this difficult condition.

Keywords: Hypochondriasis, clinical features, diagnosis, treatment, physician's reaction.

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INTRODUCTION

The hypochondriacal patient has for centuries captured the imagination and interests of laymen and physicians alike. English writers in the 18th century were so preoccupied with bodily symptoms that hypochondriasis was then commonly known as the 'English Malady'. To clinicians however this malady has always been a source of confusion. Not only are the symptoms ambiguous but there has been a century-long argument whether hypochondriasis is a syndrome in its own right or merely a manifestation of depression, anxiety or other psychiatric condition. Kenyon⁽¹⁾, after a detailed review of the literature, lists eighteen different uses of the term ranging from a 'synonym for mad or senseless' to 'a form of schizophrenia'. This wide variability in the meaning and application of concept explains why to date the hypochondriacal patient has received relatively little attention from clinical investigators.

Present day interest in the condition was rekindled after the publication of Kenyon's⁽²⁾ extensive study of over 500 hypochondriacal patients at the Maudsley - Bethlem Royal Hospital from 1951 - 1960. Attempts were made to formulate an operational definition of the term on both sides of the Atlantic.

This resulted in a more consistent and uniform international criteria for the diagnosis of hypochondriasis. The Diagnostic and Statistical Manual of Mental Disorders, 3 ed., [DSM-3]⁽³⁾ published by the American Psychiatric Association in 1980, operationally defined the following diagnostic features:

1. The predominant disturbance is an unrealistic interpretation of physical signs or sensations as abnormal, leading to preoccupation with the fear or belief of having a serious disease.
2. Thorough physical evaluation does not support the diagnosis of any physical disorder that can account for the physical signs or sensations or for the individual's unrealistic interpretation of them.
3. The unrealistic fear or belief of having a disease persists despite medical reassurance and causes impairment in social or occupational functioning.

4. Not due to any other mental disorder, such as schizophrenia, affective disorder, or somatization disorder.

EPIDEMIOLOGY

There are no known firm epidemiological figures for hypochondriasis, but in medical settings a range from 3% to 13% of patients has been quoted⁽⁴⁾. We do not have any local statistics to date, but among Chinese psychiatric patients in Hong Kong, Chiu and Rimon⁽⁵⁾ found only 4 out of 150 acute consecutive patients met DSM-3 criteria for primary hypochondriasis. However, they point out that Chinese patients are likely to consult a psychiatrist if they believe they have a physical illness.

The incidence in the population at large is unknown but it is presumably larger than that among a group of psychiatric patients, because many individuals with hypochondriacal complaints are seen only by the internist or general practitioner and would not appear among the statistics collected by a psychiatric institution.

Hypochondriacal symptoms may occur at any age. In Kenyon's series, the peak incidence in men was during the fourth decade and women during the fifth decade. In a little more than half of Kenyon's patients, no precipitating factors could be found. In nearly a third of the patients, the hypochondriacal concern appeared to arise from a substrate of symptoms referable to bodily disease, and among the remainder, a variety of psychological stresses preceded the onset of the hypochondriasis.

AETIOLOGY

There are numerous theories in the literature to explain the hypochondriacal behaviour; from Freud's concepts of the actual neurosis, to ego-defensive theories and neuropsychologically based hypotheses of perceptual and cognitive abnormalities. These theories frequently come from investigators who are concerned with the symptoms, not the syndrome. The explanations have been derived from observations made on a small number of patients who were generally unreliable in revealing the kind of psychological introspections on which psychodynamic formulations must be based and tested.

Perhaps the most important contribution of these theoretical constructs is that they focus attention on the poorly understood phenomenon of narcissism which is at the root of the hypochondriacal patient's personality organisation⁽⁶⁾.

CLINICAL FEATURES

The hypochondriacal patient presents clinically in many forms

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but commonly involves pain, bodily appearance, smell, eye symptoms, sexual hypochondria, gastrointestinal, cardio-respiratory, and ear, nose and throat symptoms. It is well known that there can be hypochondriacal elements in depression, phobic and anxiety states and in hysteria. Hypochondriacal symptoms may reach delusional proportions in depressive and schizophrenic illness and there may be a hypochondriacal component in acute (eg amphetamine psychosis) or chronic (eg arteriosclerotic dementia) organic psychotic syndromes.

Despite its varied manifestations the salient clinical features are:

1. The symptoms are diffuse and variegated, involving many different areas of the body. The most common sites are the abdominal viscera, the chest, and head and neck, but the symptoms may be related to any part of the anatomy or may consist of a generalized bodily sense of fatigue or malaise. Less often, patients may complain of disturbances in mental functioning that lead them to believe they are losing their minds or going crazy.
2. There is often a curious mixture of the minutely specific and the diffusely vague in the quality of the patients' complaints. The hypochondriacal patient may for example, specify catarrh from his right nostril and an aching in his left knee and toe and, at the same time, talks of "a flooding of my whole system" and "a burning heat in my blood".
3. The symptoms often arise from patients' heightened awareness of a bodily sensation (a mild ache, pain, or discomfort), of a normal bodily function (bowel movements, heart beats, peristaltic action for example), or of a minor somatic abnormality (occasional mucus in the stools, a nasal discharge, a slightly enlarged lymph node).
4. To the trained medical observer, the symptoms have little pathological significance. Individually, they usually suggest no known or specific malfunction or pathological process in an organ system, and taken collectively, they form no pattern that is recognizable as being characteristic of physical disease.

DIAGNOSIS

In terms of its differential diagnosis, hypochondriasis should be carefully distinguished from other psychiatric disorders that may present with hypochondriacal and somatic symptoms, particularly anxiety and depression. Some depressions may present exclusively with somatic symptoms, with depressed mood essentially denied by the patient.

Great care should also be given to ruling out occult physical illness for the patients' somatic symptoms and pain. Even patients who may be formerly diagnosed with hypochondriasis should be checked for intercurrent medical illness. It is not unusual for doctors to devalue the complaints of a hypochondriacal patient only to discover later they are symptoms of an evolving organic illness.

There are certain behaviour characteristics commonly found in the hypochondriacal patient which are helpful in arriving at the diagnosis:

1. Patients complain at length, in detail, and with an urgent, insistent pressure of speech. If the doctor interrupts with a comment or question, it is usually ignored or brushed aside.
2. Patients, however, often interrupt their own continuous recitation of symptoms by showing the doctor the parts affected, often with aid of detailed anatomical diagrams or drawings. The structural lesion which greatly affected them is usually small and insignificant.
3. The content of patients' thought and speech centres entirely on their own bodily symptoms, their suffering and on the failures of other doctors to relieve or cure them.

4. Patients often use medical terms or jargons which they learned from frequent visits to doctors and from extensive reading of medical textbooks.
5. Patients are clearly and visibly anxious and worried and these are obvious as they recite their symptoms and elaborately express their fears that they have a serious illness.
6. The hypochondriacal complaints may be based on physiological sensations (eg dry mouth, bloating sensation over epigastrium) usually disregarded or overlooked by the normal person or on symptoms arising from minor physical conditions (eg constipation, palpitation, acne) that patients exaggerate out of all proportion to their medical significance.
7. Many patients develop a pattern of visiting doctors and clinics that becomes almost a way of life. Some become attached to a single physician, whom they consult repeatedly on the smallest pretext.
8. Many hypochondriacal patients arouse in their doctors feeling of therapeutic impotence, frustration and resentment. They are generally dissatisfied with the doctors' "explanation" and "reassurances" regarding their symptoms and may become argumentative and contentious as they demand for more tests and medications. In the end to avoid them, the angry and exasperated doctor may refer them away to another round of multiple specialty consultation.

TREATMENT

Of all somatoform disorders, hypochondriasis has probably had the worst reputation among doctors as a condition which was invariably unresponsive to treatment⁽⁷⁾. In recent years, however, attitudes have changed, as doctors have become more flexible, and multidisciplinary teams have been formed.

Unfortunately as most hypochondriacal patients are seen in primary care settings, they are averse to psychological interventions and are resistant to investigation; the treatment of hypochondriasis has not yet received systematic controlled investigation. The wide variation in definitions and use of the concept further compounds the problems.

Smith et al⁽⁸⁾ have advocated a useful model for cost-effective treatment of these patients with a structured plan. The essence of their care should involve:

1. Unified, consistent treatment by a primary physician; in this context, a psychiatrist is not necessary.
2. Supportive, regularly scheduled office visits that are not on an as needed basis or based on the development of new or exacerbated symptoms; the visits need not be lengthy.
3. Avoidance of hospitalizations, tests, and medications with addictive potential, and
4. The focusing of office visits initially on symptom reports and brief physical examinations but with guiding of the interview toward social or interpersonal problems in the patient's life.

If the hypochondriasis is related to an underlying psychiatric condition, appropriate treatment for the latter is indicated eg. antidepressant in cases of depression and antipsychotic if the symptoms are part of a psychotic illness. Even in the absence of a psychiatric condition, a trial of anti-depressant is useful because depressives do present exclusively with hypochondriacal symptoms.

It is important to work with patients' relatives, especially in the initial phases of treatment. They should be informed of the nature of the patients' complaints and be guided in providing the patients with a supportive relationship. With relatives' cooperation, the patients' compliance with regular visits and avoidance of "doctors-hopping" is further enhanced.

Gerrard and Riddell⁹'s concise report, with clinical vignettes, of a successful approach to the description and management of difficult patients in a group general practice, provides a very helpful perspective for treating the hypochondriacal patient. They examined 25 'difficult' patients and felt able to place them into ten categories: black hole, family complexity, primitive behaviour, personal links to the doctor's character, differences in culture and belief, disadvantage, poverty and deprivation, medical complexity, medical connections, wicked manipulative and playing games and, finally secrets. They were particularly impressed to find that many patients had family secrets which, once revealed, helped the doctors to understand the patients' behaviour. Most important of all, these doctors found that in the process of thinking carefully and objectively about these patients, they have learned to do more family interviews and have found their 'difficult' patients 'now seem less troubling'.

Finally a word of caution in the management of the hypochondriacal patient. There is growing evidence to suggest that thoughtless or inept communications by doctors about the symptoms or illnesses of patients may help to initiate or reinforce hypochondriacal symptoms. Confronting patients with statements like "it's all in your head" is a case in point.

CONCLUSION

Hypochondriasis is a syndrome which is operationally defined in DSM-3. Besides the clinical features, the hypochondriacal patient also exhibits behavioural characteristics which are helpful in the diagnosis. Physicians' reactions to the hypochondriacal patient can initiate, prolong or aggravate the illness. Results from recent studies on treatment strategies are encouraging.

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