

Editorial

Is hypochondriasis an anxiety disorder?

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**Summary**

Although hypochondriasis is currently classified as a somatoform disorder, the underlying cognitive processes may be more consistent with an anxiety disorder. This observation has important implications for treatment and

subsequent revisions of the diagnostic classification of hypochondriasis.

Declaration of interest

None.

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Cognitive and behavioural mechanisms shared with anxiety disorders

Overlaps between hypochondriasis and other disorders might be found on two levels. The first and least conceptually compelling is superficial similarity. Like obsessive–compulsive disorder, hypochondriasis involves intrusive, distressing thoughts and repetitive behaviours. Similarities have been noted between hypochondriasis and certain presentations of obsessive–compulsive disorder such as contamination fear, in terms of preoccupation with health and disease, and the repetitive and pervasive nature of such preoccupation.⁶ The prominent preoccupation with bodily symptoms in both hypochondriasis and panic disorder has also invited comparisons between these conditions.⁷ Like those with hypochondriasis, patients with panic disorder are hypervigilant to benign, arousal-related body sensations and often erroneously attribute them to organic causes such as heart attacks, strokes and other serious medical conditions.

The second level of overlap is more interesting. When behaviour is meaningfully linked to beliefs, a certain degree of convergence may be expected; consistent links are especially likely when the perception of threat (and therefore anxiety) is involved.⁸ For example, in both hypochondriasis and obsessive–compulsive disorder, dysfunctional beliefs (e.g. overestimation of the likelihood and severity of having an illness, intolerance of uncertainty about the meaning of feared stimuli) are associated with an increase in subjective anxiety and distress, and the efforts to check or seek reassurance about the symptoms are associated with an immediate reduction in anxiety.⁸ Put another way, compulsive rituals in obsessive–compulsive disorder and reassurance-seeking and checking in hypochondriasis serve as ‘safety behaviours’ which are designed to restore a sense of well-being and a degree of certainty about the future. Unfortunately, these behaviours paradoxically maintain the very concerns they are intended to alleviate by: (a) preventing the natural extinction of anxiety; (b) interfering with the correction of mistaken beliefs and interpretations of feared stimuli; and (c) increasing preoccupation with feared stimuli.⁸ Thus, the common psychological process in obsessive–compulsive disorder and hypochondriasis is the perception that some feared catastrophe will occur at some future time.

The cognitive and behavioural mechanisms that propel hypochondriasis are also similar to those that maintain panic disorder, with the exception that the feared catastrophe is foreseen as occurring somewhat immediately, resulting in the urge to immediately escape. Both panic disorder and hypochondriasis involve hypervigilance to bodily sensations and exquisite sensitivity to even benign (and unexplained) sensations.⁹ Moreover, the tendency to misinterpret innocuous bodily symptoms as

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According to DSM–IV–TR,¹ the central feature of hypochondriasis is the preoccupation with fears of having a serious medical illness based on misinterpretations of benign (or minor) bodily sensations. The DSM–IV–TR also emphasises a ‘disease conviction’ that persists despite appropriate medical evaluation and reassurance of good health. Preoccupation with medical illness in hypochondriasis might focus on specific signs or symptoms (e.g. sore throat), diseases (e.g. cancer) or vaguely defined somatic phenomena (e.g. ‘my aching veins’). Typically, the individual attributes unwanted bodily sensations to the possible disease (e.g. ‘this headache means I have a brain tumour’) and is highly concerned with their cause and authenticity. Perhaps the most readily observable sign is the persistent attempt to seek information and reassurance about the feared symptoms or illness. Individuals with this condition may repeatedly contact doctors, seek additional tests, scour internet sites and medical texts, and seek reassurance from significant others about bodily sensations which have been appropriately evaluated and judged to be benign. As a result of these emotional, cognitive and behavioural manifestations, hypochondriasis is often disruptive to social, occupational and family functioning, and its associated economic costs are substantial.²

Historically, hypochondriasis has been regarded as resistant to psychological treatment.³ This view may be partially attributable to the absence of a unified conceptual model of hypochondriasis. Indeed, some have argued that hypochondriasis is best viewed as a personality disorder,⁴ a result of psychic conflict or as secondary to depression. More recently, however, the development of a cognitive–behavioural model of hypochondriasis has led to an efficacious psychological treatment. The cognitive–behavioural approach is derived largely from the observation that symptoms – at both a topographical and functional level – overlap remarkably with certain anxiety disorders: namely, panic disorder and obsessive–compulsive disorder.⁵ These observations are supported by empirical findings which raise the question of whether hypochondriasis is best considered an anxiety disorder.

physically harmful (i.e. anxiety sensitivity) is associated with both panic disorder and hypochondriasis.¹⁰ The combination of excessive body vigilance and high anxiety sensitivity leads to the catastrophic misinterpretations of somatic cues ('this symptom means I have a tumour') which evokes hypochondriacal fear and panic attacks. The coping strategies, such as body checking and seeking medical reassurance,¹¹ that individuals with hypochondriasis and panic disorder use to manage their anxiety paradoxically maintain or even exacerbate the cognitive mechanisms that underlie these disorders.

Treating hypochondriasis as 'health anxiety'

For most of the 20th century, psychodynamic and psychoanalytic conceptualisations dominated the treatment of hypochondriasis. In this context, hypochondriasis was poorly understood and was considered resistant to psychotherapy. In the past two decades, however, a model of hypochondriasis as 'health anxiety' has been advanced that draws from the cognitive (i.e. dysfunctional beliefs, body vigilance, anxiety sensitivity, intolerance of uncertainty) and behavioural (i.e. avoidance, safety-seeking) processes implicated in the development of other anxiety disorders.¹² This conceptualisation has been translated into specific treatment techniques that: (a) help patients recognise and modify faulty beliefs about illness such as 'all bodily sensations are signs of serious illness'; and (b) eliminate behavioural responses that prevent the self-correction of faulty beliefs. Although in its early stages, research on the effects of cognitive-behavioural therapy (CBT) for hypochondriasis has produced encouraging results. In one study, CBT was found to be superior to no treatment in reducing health anxiety, the need for reassurance and the frequency of checking behaviour.¹³ A subsequent study also found that CBT was more effective than stress management in reducing illness fears and unnecessary medical visits in hypochondriasis.¹⁴ Compared with usual medical care, CBT has been shown to produce more improvement in health anxiety, hypochondriacal attitudes and beliefs, and quality of life;¹⁵ it has also been found to be more effective than pill placebo and as effective as the drug paroxetine.¹⁶ In a recent study, greater improvements in health anxiety and less use of health service consultations were observed in patients treated with CBT relative to a control group.¹⁷

Conclusions

Recent DSMs classify hypochondriasis as a somatoform disorder marked by a collection of signs and symptoms with a focus on the body. Unfortunately, the DSM's reliance on superficial phenomenological similarities to group hypochondriasis with the somatoform disorders obscures the important functional mechanisms hypochondriasis shares with anxiety disorders. It also ignores the fact that the cardinal feature of hypochondriasis is anxiety about one's health, and not the presence of abnormal or excessive somatic symptoms. As a result of this (mis)classification, there has been a noticeable delay in the development of theoretically grounded paradigms for understanding and treating hypochondriasis. The cognitive-behavioural view of hypochondriasis as health anxiety appears to hold substantial promise. Although this model is based largely on phenomenological and functional similarities between hypochondriasis, obsessive-compulsive disorder and panic disorder, it should be noted that

individuals with generalised anxiety disorder often display excessive and persistent worries about their health,⁵ and some types of specific phobias (i.e. illness phobia) also involve irrational fear and avoidance of particular health contexts that are reminders of illnesses. In light of these considerations, categorising hypochondriasis in DSM-V as an anxiety disorder is most consistent with empirical and clinical observations about the nature and treatment of this disorder.

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