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A CASE STUDY OF HYPOCHONDRIASIS: COGNITIVE BEHAVIORAL APPROACH

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ABSTRACT

Objectives: *The present study aims to explore the course of hypochondriasis and to assess the efficacy of cognitive behavioral approach in alleviating the symptoms associated with hypochondriasis and to improve the client's overall functioning.*
Research Design: *Case study*
Place and Duration of Study: *This study was carried out in Institute of Clinical Psychology, University of Karachi, Pakistan, 2012.*
Sample and Method: *40 years old married male engineer. Besides interview sessions, standardized psychological assessment tools were used to aid the assessment process. Treatment plan was formulated according to Cognitive Behavior Therapy wherein different cognitive and behavioral techniques were utilized to modify the client's hypochondriacal beliefs and the associated behaviors.*
Result: *Findings of the assessment showed significant distress and impairment in social and occupational functioning. Stressor activates his dysfunctional belief which shifts his attention to minor bodily perturbations and results in misinterpretation of these trivial variations. According to DSM-IV TR, he met the criteria for hypochondriasis. Cognitive Behavior Therapy successfully restructured his dysfunctional beliefs and remarkably improved his functioning.*
Conclusion: *On the basis of results, it can be ascertained that Cognitive Behavior Therapy is an effective approach to treat hypochondriasis.*

Keywords*: Hypochondriasis; cognitive behavior therapy; dysfunctional belief*

INTRODUCTION

'The only health problem I haven't got is Hypochondriasis' although it is a witty one-liner, it reflects what hypochondriasis is. Hypochondriasis is a disorder wherein a person misinterprets the trivial symptoms as a serious medical condition and their conviction in having an illness persist despite the lack of any objective medical evidence[1]. People who suffer hypochondriasis frequently visit doctors to seek reassurance but on being reassured, they assume that the medical reports and physicians are unable to diagnose their condition. Consequently, doctor shopping is the common behavior associated with hypochondriasis, where they keep consulting different doctors in the hope that somebody would be able to diagnose and treat them. Conversely, in few cases, complete avoidance has also been reported. Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)[2] classified hypochondriasis as a somatoform disorder and the duration criterion required for the diagnosis is six months. However, the recent version of DSM has redefined hypochondriasis as 'Illness Anxiety Disorder'[3].

Numerous postulations have been put forward to explain the development of hypochondriasis. Applying social learning model, it can be hypothesized that hypochondriasis can develop if a person has had aversive health related experiences in childhood, for instance having or knowing someone with a serious illness[4]. Behavioral approach stresses that having parents who are health conscious can also be a risk factor for hypochondriasis and the positive

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[1] Garyfallos, G., et al. (2008). Hypochondriasis: Demographic characteristics and comorbidity with other psychiatric diagnoses in Greece. *Hellenic Psychiatry*, 5(2), 75–82. Retrieved from http://www.psychiatryjournal.gr/ftpdir/200805/080709 20275 2.pdf

[2] American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

[3] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

[4] Sadock, B. J., & Sadock, V. A. (2008). *Kaplan and Sadock's Concise Textbook of Clinical Psychiatry*. (3rd ed.). Philadelphia: Lippincott Williams & Wilkins.

reinforcement of sick role serves to maintain health anxiety[5]. Cognitive paradigm explains that hypochondriasis is the result of dysfunctional beliefs related to health and low tolerance level for discomfort which compels the person to misinterpret minor bodily sensations[6]. Noyes et al.[7] presented the interpersonal model of hypochondriasis which emphasizes that hypochondriasis can be attributed to the insecure attachment with caregiver in childhood which results in maladaptive pattern of seeking care. According to psychodynamic hypothesis, traumatic or frustrating childhood experiences leads to unresolved conflicts which gets revived during stressful situations and the lack of direct expression of emotions brings about physical manifestations of the conflict, in the form of hypochondriasis[8]. From the perspective of genetics, Taylor & Asmundson[5] have asserted that apart from environmental factors, heredity also plays a substantial role in the etiology of hypochondriasis.

Hypochondriasis is known as a treatment-resistant disorder. However, it cannot be left untreated because of the significant distress and the functional impairment associated with hypochondriasis. Distress is quite apparent in view of the fact that depressive and anxiety disorders often accompany hypochondriasis[1]. Moreover, people with hypochondriasis have disturbed interpersonal relationships[7]. Therefore, it is crucial to focus on the treatment of hypochondriasis. Among all the available treatments, Cognitive Behavior Therapy (CBT) has proved its efficacy in several empirical studies. In a controlled trial, people with hypochondriasis who were given CBT sessions

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[5] Taylor, S., & Asmundson, G. J. G. (2012). Etiology of hypochondriasis: A preliminary behavioral-genetic investigation. *International Journal of Genetics and Gene Therapy*, *2*, 1–5. doi:10.5348/ijggt-2012-2-OA-1

[6] Sadock, B. J., & Sadock, V. A. (2008). *Kaplan and Sadock's Concise Textbook of Clinical Psychiatry*. (3rd ed.). Philadelphia: Lippincott Williams & Wilkins.

[7] Noyes, R., Stuart, S., Langbehn, D., Happel, R., Longley, S., Muller, B., et al. (2003). Test of an interpersonal model of hypochondriasis. *Psychosomatic Medicine*, *65*, 292–300. doi: 10.1097/01.PSY.0000058377.50240.64

[8] Abramowitz, J. S., & Braddock, A. E. (2006). Hypochondriasis: Conceptualization, treatment, and relationship to obsessive-compulsive disorder. *Psychiatric Clinics of North America*, *29*, 503-519. doi:10.1016/j.psc.2006.02.008

showed significant improvement than their counterparts in the control group[9]. Barsky and Ahren[10] have also found that CBT significantly reduces the hypochondriacal symptoms, beliefs and attitudes and considerably improves the functioning of people with hypochondriasis.

Case History

Zain (pseudonym) is a 40-years old married man who approached therapy with multiple physical complaints, fear of death, sensitivity towards criticism, conflict between real self and ideal self and marital conflicts. He reported that when he was twelve years old, his father died of a sudden cardiac arrest. After the death of his father, his family had to undergo a lot of crisis and he feels that he was neglected at that time. It was then that he became sensitive to criticism but the problem aggravated when he entered professional life. This is so because he believes that, in a competitive environment, people criticize and discourage each other every now and then and he is unable to handle that criticism. Gradually, he started remaining preoccupied with physical complaints which led to a fear of developing severe illness. He consulted several physicians for his physical complaints and despite repeated reassurance from different physicians, he feels certain that he has multiple illnesses (asthma, ulcer, hypertension and irritable bowel syndrome) which could turn into a life-threatening condition. He was referred to a psychiatrist by a gastroentologist in 1999 and since then, he has been taking different anxiolytics and mood stabilizers sporadically. In 2011, he consulted a psychiatrist at Aga Khan who informed him that his complaints are psychosomatic and asserted that he needs psychological intervention.

According to Zain, throughout his childhood, his family had a dispiriting attitude towards him. He had never been appreciated for his achievements. His

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[9] Warwick, H. M., Clark, D. M., Cobb, A. M., & Salkovskis, P. M. (1996). A controlled trial of cognitive-behavioural treatment of hypochondriasis. *British Journal of Psychiatry, 169*, 189-195. Retrieved from http://www.ncbi.nlm.nih.gov/ pubmed/887 1795

[10] Barsky, A. J. & Ahern, D. K. (2004). Cognitive behavior therapy for hypochondriasis: A randomized controlled trial. *Journal of the American Medical Association, 291*, 1464-1470. Retrieved from www.jamapeds.com/data/Journals/JAMA/4921 /JOC320 97.pdf

sisters used to get most of the attention. Although he has three brothers who also faced the same situation, he feels that they are not as sensitive as he is, so they did not get affected by that discrimination and neglect. After father's death, his maternal uncle used to impose decisions on him. He verbalized that he constantly had a feeling that he doesn't get attention from his family. Regarding marital relationship, he dejectedly mentioned that his wife fails to provide the love and approval that she owes him. He further reported that they often have conflicts over trivial issues because she is argumentative and at times, she tries to dominate him which is unacceptable for him.

He mentioned that initially he was an average student back in school but later at the university level, his academic progress declined and he holds his family responsible for that. He graduated from an engineering University recently; he is serving as a field operational specialist in a multinational company. He reported that although he often gets appreciated for his work, his boss pointed out that he lacks interpersonal skills. He has no intimate friends because he does not feel like talking to anyone. He verbalized that he thinks of himself as a superman and needs excessive admiration but at the same time he feels intense disappointment when he realizes that the reality is far from what he desires.

Client's Behavior

He appeared to be well kempt and no oddities were observed in his speech. His voice, in the initial sessions, was so low that it was barely audible but it got better as the sessions proceeded. He was well oriented to time, place and person however his mood was low and he reported to have a lethargic feeling. Low self-worth was evident from his repeated verbalization of self-depreciating statements.

TREATMENT

Analysis of the Problem

For the ABC analysis of cognitive behavior therapy (CBT), Zain was asked to report precise events when his symptoms get heighted. One of the incidents that he mentioned was the downsizing of his department in the organization that he works in which brought a huge amount of stress for him. During that period, he became preoccupied with his heartbeat and chest pain and

became over-anxious that his heart rate is much higher than normal. He reported that within thirty minutes, he started sweating along with the breathing difficulty. At this point, he was convinced that he was going through a heart attack. He rushed to a hospital in emergency but he didn't drive himself and took the driver instead because once he read that one should not drive in such condition. At the hospital, the duty doctor got his tests done which were all clear and indicated no heart irregularity. However, he was not satisfied and the next day he visited his physician who gave the similar remarks about his health and further referred him to cardiologist. There, he asked the doctor that if it was not heartache, then why he felt such symptoms. He was informed by the cardiologist that his symptoms were the consequence of anxiety and not indicative of a heart problem. He further advised him to visit a psychiatrist or a psychologist; therefore, he brought this concern in therapy.

Stressor (downsizing of his department) activated his checking behavior (he noticed a minor chest pain) which triggered his belief that he is vulnerable and as an emotional consequence, he became anxious and fearful. Taking safety measure (rushing to the hospital) and reassurance-seeking (consulting physician, cardiologist and psychologist) reflects the behavioral consequence of that belief.

Case Conceptualization

Fear of developing severe illness was dormant until he got married and stepped into professional life wherein he had to face a lot of stressors. Almost every stressor, either domestic or professional, is followed by the increase in the symptoms. Sudden death of his father and the emotional deprivation that he felt after his father's death induced a belief that he is vulnerable, i.e. he is susceptible to physical and emotional injury. To cope up with perceived vulnerability, he believes that he needs to be perfect to eradicate any chances of harm, be it physical or emotional. Multiple physical complaints and fear of death stems from the distorted belief that he is physically vulnerable and bodily variations are indicative of serious medical illness which could possibly turn into a grave-illness. In order to avoid that deadly condition, he should be in good health which means he should not experience any perturbation at all. Emotional vulnerability is reflected from his sensitivity towards criticism and the conflict between, what he says, real self and ideal self arises from the paradox of perfectionism. His idealized self is characterized by several unrelenting standards and not being able to meet those standards leads to self criticism which increases the disparity

between real and ideal self. Likewise, marital distress springs when he perceives the arguments and disapproval of his wife as an emotional injury.

The problem impinges on almost every aspect of his life. Financially, the cost of consulting different doctors and going on unpaid leaves are the major consequences in terms of expenses. Due to his symptoms, he verbalized that he is not working as efficiently as he can which indicates that his occupational functioning is also affected. Moreover, current relationships are not in harmony because he feels that people don't love and appreciate him. In terms of health, physical complaints give him the message that he is not a healthy person and he generally feels dissatisfied with his life which contributes to poor emotional well-being.

Therapeutic Process

Client's symptoms meet the DSM-IV TR criteria for hypochondriasis and Cognitive-Behavior Therapy (CBT) was selected as a major treatment approach. Since CBT is a re-educative therapy, client was first psycho educated regarding the basic approach of CBT. Then, hypothesized mechanism was presented to the client and it was discussed that how a stressor triggers a belief (I'm vulnerable and I must be perfect/healthy) which shifts his attention to the trivial bodily variations (minor chest pain) and the constant focus on those variations exacerbates his hypochondriacal concerns. During sessions, the term 'health anxiety' was used instead of 'hypochondriasis'. This was done because clients with hypochondriasis are more likely to study their symptoms and internet provides the easiest access, producing cyberchondria (amplification of medical concerns through surfing the internet about illnesses). However, technique called bibliotherapy was used to psychoeducate the client about health anxiety. Articles that were given to the client were carefully selected to provide just the relevant information in as simple terms as possible. Next, client was facilitated to identify the cognitive distortions inherent in his distorted beliefs. Main distortions that were identified were; mental filter (focusing only on information that supports his health anxiety), catastrophization (minor chest pain magnified as being an indication of heartache), unrelenting standards (I should not experience any symptoms at all; I must be loved and appreciated by everyone at all times), all-or-nothing (good health means being 100% free of symptoms and not being absolutely free of symptoms mean that there underlies a debilitating illness) and jumping to conclusion (fortune-telling that he would be diagnosed with a life-threatening illness). Beliefs saturated with distortions were disputed through

Socratic questioning and cognitive restructuring was done by inculcating healthy core beliefs. Technique known as 'Decatastrophizing Continuum' was applied to make him realize how he magnifies the discomfort that he experiences. Initially, he was reluctant to do the exercise when he was asked to reassess the situations (bodily changes, criticisms) that he has previously considered to be extremely miserable. He argued that the reference point changes when he compares those situations with the ones that are more severe. At this point, he was explained that he needs to acknowledge the fact that it is just the transient discomfort that he faces being in his comfort zone instead of magnifying the discomfort which further aggravates his distress. On a behavioral level, client was encouraged to reduce the excessive monitoring of bodily symptoms and seeking reassurance from different physicians and he was motivated to generate a new behavioral goal of giving up these unhelpful behaviors and tolerating the short-term anxiety. Behavioral experiment was designed to test out the prediction that he would collapse if he tolerates the anxiety instead of rushing to the hospital for reassurance-seeking. 'Postponement Exercise' was applied to help him reduce the amount of time he spends worrying about and focusing on his health. Coping skills were also imparted so that he can directly deal with the stressors instead of being overwhelmed which triggers his health anxiety. Furthermore, communication skills training and conflict resolution training was done to improve his social functioning.

Outcome

Gradually, his hypochondriacal concerns got alleviated as he restructured his belief regarding vulnerability. He has learnt to identify cognitive distortions and dispute them to adopt healthy beliefs. Moreover, he is able to retrain his attention and tolerate the mild level of anxiety in case he experiences it. He has become active at his workplace and takes interest in the tasks that have been assigned to him. His interpersonal relationship has also improved substantially since he is now able to deal with the conflicts. He handles criticisms and other problems with a positive outlook. He has been on follow-up from past six months and so far the progress has been maintained.

Conclusion

The present case study highlights the factors that contribute to the development and maintenance of hypochondriais. A 40-years old man with a

diagnosis of hypochondriasis was treated using cognitive-behavioral approach. Various cognitive and behavioral interventions were used which not only gave client the relief from distress but also modified his hypochondriacal and other dysfunctional beliefs, thereby significantly improving his overall functioning. Therefore, it can be established that although hypochondriasis is a treatment-resistant disorder, it can be treated successfully with Cognitive-Behavior Therapy.