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Multiple choice questions

1. In primary hypochondriasis:
   a sufferers often have high levels of anxiety
   b abnormal illness behaviour includes bodily checking
   c sufferers may have secondary depressive symptoms
   d repeated physical examinations should be conducted
   e dysfunctional assumptions about health are not prominent.

2. People with primary hypochondriasis:
   a fear immediate death
   b only ever have concerns about one illness
   c are malingerers
   d amplify physical sensations
   e may have had previous experience of ill-health.

3. Therapists working with hypochondriasis should:
   a not involve relatives in treatment
   b discuss appropriate treatment with involved professionals
   c use Socratic questioning
   d not imply that the patient is experiencing real symptoms
   e always answer their patients' questions about illness.

4. Cognitive–behavioural treatment for hypochondriasis involves:
   a homework exercises for the patient
   b no 'pure' behavioural strategies
   c no attention to assumptions
   d re-attribution
   e self-monitoring.

MCQ answers

1	2	3	4
a T	a F	a F	a T
b T	b F	b T	b F
c T	c F	c T	c F
d F	d T	d F	d T
e F	e T	e F	e T

Commentary

Richard Stern

"Hypochondriasis is a condition in which there are no established effective treatments" (Fallon *et al*, 1991).

Warwick's paper shows how recent advances have completely altered the previous therapeutic nihilism expressed in the above quotation. Physicians and surgeons have long been aware that medical and surgical problems turn out to have no organic cause. Joyce *et al* (1986) from New Zealand examined 105 people with abdominal pain who had been admitted to a surgical ward. They found that the most common surgical diagnosis was non-specific abdominal pain, closely followed by appendicitis. Those with non-specific abdominal pain contained a very interesting group of patients: they were predominantly female, did not have any physical findings, and were more anxious and conformed to the pattern of patients showing fear of illness. This

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https://doi.org/10.1192/apt.4.5.291 Published online by Cambridge University Press

group presented, in the words of the New Zealand team:

> "a caricature of the female 'non-organic' abdominal pain patient ... whose health is the greatest difficulty of her life, who fears she may suddenly fall ill, who denies having silly thoughts about health yet thinks there is something seriously wrong with her body, who admits to no problems or personal worries other than her illness, and for whom illness may be construed as a punishment. These patients also deny feeling irritable towards other people and yet lose patience with them, while being unable to express angry feelings."

This damning caricature would be strongly objected to by most sufferers with fear of illness. However, the overall message of this study is clear: psychological factors are very important in people with abdominal pain where no organic pathology is found.

Development of cognitive therapy

Salkovskis & Warwick (1986) described the case of a 32-year-old engineer with an intense, itchy rash of weals surrounded by red areas. Medical examination revealed nothing wrong, but the rash persisted. His doctor had told him the rash was caused by his white cells attacking foreign matter in his blood. The man latched on to the words 'white cells', made the link between white cells and leukaemia, and became convinced ever after that the real problem was leukaemia. He constantly looked at the rash, and could talk of little else to his wife, family and friends. He eventually became depressed and suicidal and was admitted for psychiatric treatment. Treatment consisted of getting the man to understand how repeated medical investigation, checking of the rash and requests for reassurance were making him worse. He agreed not to do this, and allowed Salkovskis to cover up the mirror in his room. He also agreed to pat the rash rather than scratch it. Reading medical textbooks was forbidden. The habit of asking nurses and doctors to reassure him about the rash was tackled by a team approach – each and every health professional he might come into contact with was briefed to say something along the lines of:

> "You are in a treatment programme with Dr Salkovskis that means we cannot answer that sort of question; you know it will only make you worse if we do; why don't you try and distract yourself by some activity (such as going for a walk, watching TV, or going to the occupational therapy room?)".

The results of this type of approach were dramatic, and such individual experiments suggested that it was the reassurance-seeking that maintained the fear of illness, and when the professionals around the patient carefully and consistently stopped giving reassurance the patients recovered.

At around the same time as these studies were being done in Oxford, the Harvard psychiatrist Barsky had similar ideas about treating his patients with fear of illness (Barsky *et al*, 1988). He gave questionnaires to out-patients attending the Massachusetts General Hospital in which they were asked about attitudes to health and medical care, beliefs about illness and health practices. Barsky wanted to test the idea that people with hypochondriasis amplify the normal bodily sensations we all have and then misinterpret these as symptoms of serious illness. His questionnaire had items such as: "are you quick to sense the hunger contractions of your stomach?" and "are you very aware of changes in body temperature?".

The results of Barsky's study gave us a strong clue about what could be going on the minds of people with fear of illness. There was a definite relationship between amplification and hypochondriacal attitudes. According to Barsky, if a person has fear of illness, then they are likely to be overly aware of the sensations reaching the brain that most people manage to ignore, such as peristaltic action and changes in heart rate.

These results led Barsky to impliment a treatment he named cognitive–educational therapy. The 'cognitive–perceptual model' was explained by asking people with hypochondriasis to think of their nervous system as a radio receiver whose gain is set so high that the background 'noise' is so loud that it interferes with signal the radio is set to receive. They were told:

> "imagine you are very anxious and under stress. You are alone at night in your house and you hear a soft tapping at the window pane. Because your nervous system has gone into overdrive you assume the worst and imagine a burglar is breaking in to attack you. When you investigate the noise it turns out to be a moth tapping against the window. As soon as you know this you calm down. This is a good example of how cognitions affect our perceptions."

Another component, the situational context , gives emphasis to where we happen to be and recognises that what we are doing affects the way we experience pain. I get backache when sitting for long periods of time, but I notice this more when sitting through long and tedious meetings than when sitting at my word processor (which is an activity I happen to like) for the same amount of time.

A patient of mine had chronic backache that was bad at the office, but better when he went fishing:

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his life-style was terrible, he had high blood pressure (for which he was on medication) and he complained of severe palpitations for which no remedy could be discovered. The physician who referred him mentioned that the patient lived "under considerable stress and had an impossible life-style". The patient admitted his work meant everything to him, and that although his business was already successful and there was no real need to expand, he claimed he was never happy unless he was working.

The role of depression in hypochondriasis can be shown in a case involving a 55-year-old married woman who complained of depression which had troubled her for eight years. She had a large number of bodily complaints which included: mucous discharging from her eyes, intermittent abdominal pain, joint pain in hands and feet and chronic constipation. She could not sleep, despite taking sleeping tablets, her appetite was poor and she had lost weight. The somatic symptoms were worse when she was depressed.

She had been referred after intensive investigation by her physician, who had not been able to uncover any cause for her symptoms apart from suspecting "an underlying depressive illness". On assessment, there did not appear to be any precipitating stress for her depression, except that she was finding it hard to come to terms with the fact that she was getting older, and because of arthritis could no longer be as active as she would wish.

In the past she had been treated with three different kinds of antidepressant medication, but each had been stopped because of side-effects. She was not convinced that medication of any kind could help her, was reluctant to change her current medication which consisted of analgesic tablets for arthritis, benzodiazepine sleeping tablets at double the recommended dose, a benzodiazepine tranquilliser taken three times daily and a laxative each morning. After the assessment the next step was to convince the woman that the depression she was suffering from was related to the bulk of her complaints, and that this might be amenable to the combined approach of cognitive therapy and antidepressant medication. It was pointed out that she had not really tested the hypothesis about whether antidepressant tablets could help because she had not taken them for long enough in the past, and those she was taking currently were tranquillisers not antidepressants. Instead of having the view 'no doctors can help me', she was gradually persuaded that it might be useful to try to test the hypothesis that a different treatment might work. After three months on adequate antidepressant treatment combined with this cognitive approach her depression score reduced, she gained weight and was no longer so preoccupied with her physical symptoms.

Research into fear of illness gained an impetus from the World Congress of Cognitive Therapy which took place in Oxford in 1989. Salkovskis and Barsky met there for the first time and it was clear their work had much in common. Barsky reported success from treating his patients in groups and this was replicated in London (Stern & Fernandez, 1991).

Warwick *et al* (1996) carried out the first controlled trial of cognitive–behavioural treatment for hypochondriasis, which is described in her review. Warwick told me she was surprised by the fact that only 6% of the patients dropped-out of treatment, and that the results were so clear-cut: the active treatment group improved most and this was maintained at three-month follow-up. Warwick measured a variety of things including conviction of having a disease, need for reassurance, time spent worrying about health, frequency of checking for illness, depression and anxiety. There was a great variation in the patients' tendencies to search out medical information: some were addicted to reading medical textbooks and watching all the medical 'soaps' on television, while others positively avoided such activities. As Warwick put it, the conclusions were clear:

> "The general emphasis was to help the patient identify clear cut evidence that their problem was health anxiety, rather than to reassure them that the medical tests had proved negative. This approach was appealing to patients and helped get round the problem of their suspiciousness about the validity of negative medical test results and their feeling that they were not understood by their clinicians."

This landmark trial was the first controlled evidence that psychological treatment for hypochondriasis really worked.

The issue of reassurance

The problem of whether to give reassurance to people with hypochondriasis has been discussed by Kellner (1992). He suggested a useful subdivision of those people with a 'disease phobia' and those with 'disease conviction'. The former have an irrational fear of having an illness, and avoid reading about illness, talking to other people with illnesses or going to the doctor. In my view the more subtle avoidance these people show is not facing the consequences of going without reassurance. This is similar to any other phobia and the treatment involves exposure to these consequences and not giving reassurance. According to Kellner, people with disease conviction are entirely different, in that they are convinced that they suffer from an undiagnosed serious illness. In

https://doi.org/10.1192/apt.4.5.291 Published online by Cambridge University Press

treatment the psychiatrist must use some ploy, for example, telling the person that they suffer from anxiety or depression. Kellner points out this is not deception, as these people are also usually anxious and depressed. Advocated treatments include education, explanation and persuasion. Reassurance alone is bound to fail, as emphasised by Warwick & Salkovskis (1985).

The issue of reassurance is taken up by Slavney (1987) from Johns Hopkins University School of Medicine. The need for reassurance is considered central to the problem, and the subject is told about 'Murphy's law' which states that there is no such thing as a normal patient – just one that has not been sufficiently investigated. This 'law' is introduced with the first proposition that the normal value for a measurement is anything that lies within 95% distribution of such values in the population. It can be shown by simple mathematics that the more times a test is repeated the probability of being 'normal' decreases in direct proportion to the number of tests done. Therefore, a normal person is anyone who has not been sufficiently investigated! Slavney describes a case where this technique was employed to good effect in a person with hypochondriasis, and proposes that for many people the main problem is one of fear of illness.

The importance of medical reassurance was directly investigated in an original way by a team at the University of Leeds (Lucock *et al*, 1997). They monitored reassurance in people who were having a gastroscopy carried out. Sixty people, all of whom had been told that 'there is nothing seriously wrong', were asked to fill in questionnaires immediately after this reassurance, 24 hours later, one week later, one month later and after one year. Patients all had their anxiety about health measured at the outset. The results clearly showed that about one-third of the patients remained concerned about their health after medical reassurance, and these were the group with the highest anxiety before the gastroscopy. In this group anxiety levels increased to their former level 24 hours after the reassurance and remained so at all the follow-ups to one year. There are several important implications. First, the notion that reassurance may make anxiety about health worse is strongly and directly supported by this study. Second, it is significant that even patients who remain anxious in the long term do have an immediate reduction in anxiety. This suggests that doctors will think that reassurance is a successful intervention. In other words, reducing anxiety in a patient makes the doctor feel better, thereby making it more likely that he will give reassurance next time. We all have experience of seeing a different doctor each time we visit the hospital: this makes it even more likely that doctors will not be able to notice the poor long-term effects of reassurance (because they do not follow-up the patient themselves). Third, there are great individual differences in the way people respond to health anxiety. Important characteristics of those responding badly include: negative interpretation of symptoms and information such as reassurance, preoccupation with symptoms, and reassurance-seeking behaviour. The Leeds team advise that ambiguous messages (which are more open to negative interpretations) should be avoided, and feedback should always be given after investigations. Their study showed that people prone to persistent anxiety about health will, without satisfactory information and explanation, continue to attribute symptoms to a serious illness and remain preoccupied with health.

Conclusion

Warwick shows we have moved a long way in the treatment of hypochondriasis. The earliest efforts were hampered by lack of a therapeutic model. In the 1980s a breakthrough was made simultaneously in Oxford and in Harvard. I suggest, instead of giving either team prominence, that this development should be called the 'Barsky–Salkovskis hypothesis'. The hypothesis suggests, among other things, that the relationship between amplification of normal physical sensations and illness behaviour is crucial. Therapeutic studies flowed from this hypothesis and effective cognitive–behavioural therapy was developed in individual cases, in groups of patients treated together and finally in convincing controlled clinical trials.

The behavioural consequences of reassurance also had to be examined before progress could be made. The traditional medical notion of reassuring patients does not work in hypochondriasis and indeed may be one mechanism that makes patients worse. It is essential to understand the reinforcing potential of reassurance. Altering the way doctors behave may be key to preventing hypochondriasis.

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https://doi.org/10.1192/apt.4.5.291 Published online by Cambridge University Press