

Editorial

Hypochondriasis and health anxiety:
conceptual challenges†

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**Summary**

The relationship between hypochondriasis and health anxiety is examined by considering a DSM-5 proposal to replace the current heterogeneous concept of hypochondriasis with two disorders. The key issues are to ascertain whether these conditions are relatively distinct and whether they

adequately represent the full range of clinical manifestations encompassed by hypochondriasis.

Declaration of interest

None.

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Hypochondriasis has always been surrounded by controversy. The concept has been plagued by ambiguous definitions and vague and unreliable diagnostic criteria. It sits uncomfortably on the crossroads of somatoform, anxiety, depressive and personality disorders and often overlaps and co-occurs with many of these. Manifestations of hypochondriasis are frequently found in other mental disorders, for example panic disorder and major depression. Given the heterogeneity of hypochondriasis and doubt about the validity and practical utility of the diagnosis, it comes as no surprise that hypochondriasis has also presented treatment dilemmas.

The latest hypochondriasis-related quandary is about its relationship with health anxiety. The article by Sunderland *et al*¹ illustrates some aspects of this dilemma. The authors reported a lifetime prevalence of health anxiety of 5.7% in the general Australian population, with health anxiety being defined as illness worries lasting for at least 6 months and persisting despite appropriate medical reassurance. Such a high prevalence is difficult to contextualise because there are no other epidemiological studies of health anxiety. In contrast, prevalence rates of full-blown hypochondriasis in the general population have been reported to be much lower, generally under 1%.^{2,3} Considering that in the Sunderland *et al* article health anxiety was defined in a way similar to hypochondriasis, but apparently without some elements of DSM-IV hypochondriasis (for example preoccupation with the idea that one has a serious disease and misinterpretation of somatic symptoms), this striking difference in the prevalence rates might have been due to an ease with which criteria for health anxiety were met, further implying that hypochondriasis may be a more severe variant of the same disorder. Alternatively, could different prevalence rates suggest that health anxiety and hypochondriasis are distinct conditions?

Components of hypochondriasis and health anxiety

Disease phobia and disease conviction had been identified as the two main components or dimensions of hypochondriasis.^{4,5} Recent research has confirmed that despite a high correlation between these dimensions, they can be distinguished and represent

separate constructs.⁶ Hypochondriasis and health anxiety share a component of disease phobia (and more broadly, health- and disease-related concerns) but that does not seem to be the case with disease conviction, as definitions of health anxiety usually do not include an idea or belief that a serious illness is present.

Moreover, health-related beliefs that have been identified in patients with hypochondriasis are usually not considered characteristic of individuals with health anxiety. This pertains to rigid belief systems about disease, health, body and/or physical symptoms and beliefs that bodily symptoms are always dangerous because health is supposed to be a state without any symptoms.⁷ More broadly, beliefs about having a serious illness in hypochondriasis often take the form of an ego-syntonic overvalued idea,⁸ which dominates a person's thinking and behaviour and is held with relatively strong conviction. People with hypochondriasis have typically not come to a closure regarding their belief that they are ill and remain in a painful flux because they are not sure. In some instances, however, this belief can become delusional.

Whereas overvalued ideas about the presence of a serious illness (disease conviction) are not a hallmark of health anxiety, they are one of the key features of hypochondriasis. With regards to disease conviction and any other differences between health anxiety and hypochondriasis, it is worthwhile examining how the proposals for DSM-5 have addressed this issue.

Illness anxiety disorder and somatic symptom disorder: the way forward?

The architects of DSM-5 have apparently been keen to remove both the heterogeneous concept of hypochondriasis and the term hypochondriasis from the nomenclature. They have suggested somewhat arbitrarily that about 75% of individuals with hypochondriasis are excessively concerned about and preoccupied with their somatic symptoms and that this condition could be named somatic symptom disorder.⁹ In contrast, 25% of individuals with hypochondriasis may have only a few or no somatic symptoms, with their main feature being anxiety about, and preoccupation with, having or acquiring a serious illness – a condition named illness anxiety disorder.⁹ Neither condition is explicitly characterised by an idea or belief that one already has a serious illness (disease conviction); a related, but vague criterion for somatic symptom disorder is 'persistent thoughts about the seriousness of one's symptoms'.⁹

Illness anxiety disorder is relatively well defined and may correspond to the concept of health anxiety. Depending on

†See pp. 56–61, this issue.

whether it is characterised by excessive reassurance-seeking and related behaviours or by avoidance of seeking healthcare, two subtypes have been proposed: 'care-seeking' and 'care-avoidant'. The former may be more likely to be associated with anxiety about already having a serious illness, whereas the latter would be more likely to be associated with anxiety about becoming seriously ill in the future. Perhaps health anxiety in illness anxiety disorder may appear in various forms, for example as illness worry, phobia of illness, fear of certain medical procedures and so on. The boundary between illness anxiety disorder and normal health worries needs to be established more firmly to minimise the likelihood of 'pathologising' and possibly stigmatising health-related concerns.

In contrast, somatic symptom disorder appears vague and more heterogeneous, as many of its features have not been clearly specified. In that sense, it resembles the current and broad diagnostic concept of hypochondriasis and may have the same fate as hypochondriasis, even if it looks less stigmatising and more acceptable to patients. Apart from the presence of physical symptoms, perhaps somatic symptom disorder differs from illness anxiety disorder, especially its 'care-avoidant' subtype, in terms of being characterised by the following: (a) anxiety about already having a serious illness rather than anxiety about becoming seriously ill in the future; (b) excessive reassurance-seeking and proneness to excessive healthcare-seeking rather than avoidance of health- and disease-related cues and avoidance of seeking healthcare; (c) belief about already being seriously ill (disease conviction). These possible distinctions between somatic symptom disorder and illness anxiety disorder remain to be investigated.

Moreover, it should be clarified whether somatic symptom disorder is characterised by higher levels of health anxiety than illness anxiety disorder; that is, whether there is also a dimensional relationship between them. Such a relationship may additionally pertain to other shared characteristics of these disorders. Further studies would help ascertain not only whether somatic symptom disorder is a distinct disorder, but also whether it is a more severe condition than illness anxiety disorder, with worse prognosis and poorer response to treatment.

Implications

If illness anxiety disorder and somatic symptom disorder do not prove to be two relatively distinct conditions along the lines suggested here, it will seem that the partition of hypochondriasis

in DSM-5 has failed to adequately address the heterogeneity of the concept of hypochondriasis and represent the range of its manifestations. If, on the other hand, further research confirms that illness anxiety disorder and somatic symptom disorder are relatively distinct, this may help to explain the discrepancy in the prevalence rates for health anxiety and a broadly conceptualised hypochondriasis. It may also have important treatment implications. For example, patients with illness anxiety disorder with prominent avoidance may need treatment that would primarily target avoidance behaviours, whereas an important treatment target in patients with somatic symptom disorder would be beliefs about being ill and other maladaptive health-related beliefs. Greater diagnostic precision and a carefully tailored therapeutic approach may therefore improve the outcome of psychological treatments (such as cognitive-behavioural therapy) that have been used with somewhat mixed results for the heterogeneous group of patients with hypochondriasis.

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