

Case Report

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Psychological Interventions for a Male with Hypochondriacal Disorder

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ABSTRACT

Hypochondriasis, characterized by persistent fears of having a serious illness despite medical reassurance, significantly impacts patients' lives. This case report describes a 42-year-old male accountant with severe health anxiety, highlighting the therapeutic approach and management outcomes.

Keywords: *hypochondriasis, health anxiety, psychotherapy*

INTRODUCTION

Severe health anxiety, named hypochondriasis in ICD-10 and DSM-IV (1,2), involves an unfounded dread of having a major illness (3). Patients often misinterpret normal bodily processes as symptoms of serious illness. The prevalence of hypochondriasis is between 0.02-8.5%, with a population prevalence of 10.7% (4). This condition is associated with disability, high healthcare costs, comorbid anxiety and depression (4,5). Childhood trauma, illnesses, stress, anxiety disorders, and abuse are major contributors to hypochondriasis, which is often comorbid with personality traits of paranoia, avoidance, and obsessive-compulsive disorder(6).

CASE REPORT

A 42-year-old accountant was referred to the psychiatry clinic of the National Hospital of Sri Lanka by a consultant gastroenterologist with persistent health concerns. He had swallowing difficulties for nine years, followed by avoiding solid

foods, and fears of contracting AIDS for four years. He was worried of having a spinal disc bulge and a parotid tumour. He struggled to maintain his job and lived separately from his wife due to health anxieties in the background of anxious avoidant and dependent personality traits. He was not depressed. His physical examination was normal, except for a benign cheek lump of 1cm with soft rounded margins.

Management

The patient was prescribed sertraline, gradually increased to 100 mg, and clonazepam 0.5mg at night as needed for sleep. He opted to take the medications in ground form due to difficulty swallowing tablets. Medical records showed no underlying organic issues. He was offered 12 psychotherapy sessions by a postgraduate trainee in final stage of MD Psychiatry, during which a functional assessment identified his health anxiety triggers and safety behaviours. Negative automatic



thoughts (NATs) and dysfunctional beliefs were explored through Socratic questioning and CBT formulation was prepared (Figure 1).

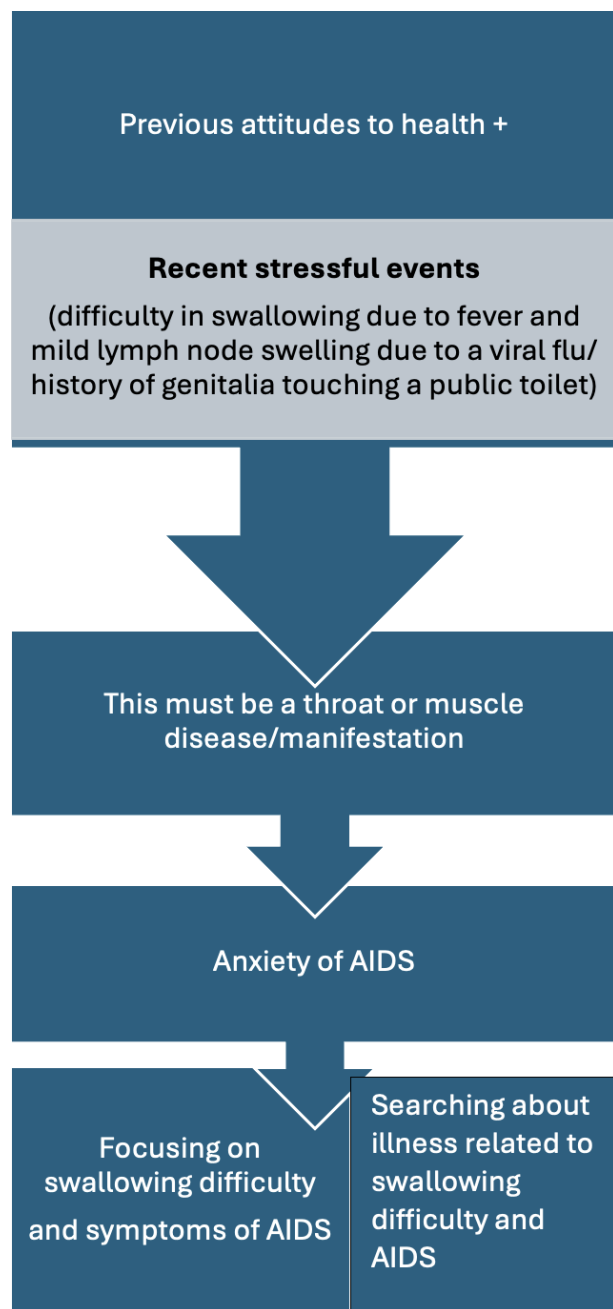


Figure 1: Cognitive behaviour formulation for this patient

The patient engaged in therapy through an empathetic interview addressing his physical concerns and distress. He often requested HIV blood tests during sessions which was managed with reassurance and referral to the formulation. A therapeutic agreement was established for three months, outlining that the patient would consult therapist before seeking further medical advice,

refrain from internet searches about illnesses, and attend sessions punctually with completed homework. Regular summaries were prepared to ensure understanding, and each session began with a review of the previous.

The patient was asked to monitor episodes of health concern, triggering symptoms, anxiety levels, negative thoughts, and actions taken (Figure 2).

Situation Date and time	Trigger for health anxiety	Emotion (Rate intensity 0-100%)	Negative thought (Rate belief 0-100%)	How I responded	Rational response to negative thought	Outcome (Rate belief in negative thought)
01-09-2018	Feverish	Fear (70%)	Is this prodrome of AIDS?	Meeting a Venereologist		
05-09-2018	Neck pain	Worry (90%)	Am I having a disc bulge?	Avoid exertion and restricting to bed.		
09-09-2018	Testicular discomfort	Fear (60%)	Am I having a testicular tumour?	Consulting an Oncologist		

Figure 2: Seven column diary to monitor triggers, emotion, thoughts and actions

Cognitive restructuring and experiments involved the patient providing evidence for being physically ill and against having major physical illnesses. Idiosyncratic and false evidence was re-evaluated. He was 90% convinced his neck pain was due to a disc bulge. After listing several illnesses and benign causes, he suggested odd postures as the most common cause. A brief behavioural experiment demonstrated the accuracy of his beliefs. Dysfunctional core and intermediate beliefs were identified to prevent future relapses. He prepared features of a person with incurable illness and curable minor illnesses, placing himself closer to the curable illness end, convincing him of his true state. Graded exposure and response prevention for swallowing difficulty involved preparing a hierarchy of foods from the least to most difficult to swallow (e.g., soft cake to tablets). Anxiety levels were measured using subjective units of distress scales (SUDS) before and after ingestion. He was

trained to consume specific meals within a short duration after chewing.

The patient underwent relaxation training for anxiety but was advised against using it during meal intake for phagophobia. Activity scheduling, behavioural activation, and challenging NATs improved mood and functional level.

The core belief was challenged by drawing an inverted pyramid of patients with similar symptoms (Figure 3). The main challenges were the patient's spending a long time chewing to liquefy foods inside the mouth at graded exposure and the patient's reluctance to termination the therapy. The former challenge was overcome by guiding the patient to swallow a maximum within 2 minutes.

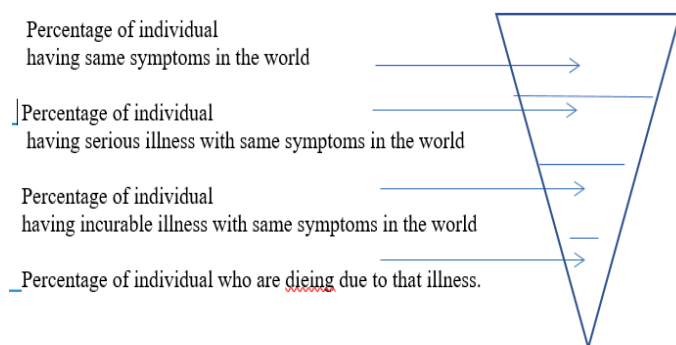


Figure 3: Inverted pyramid of percentages of patients who are having illnesses with his current symptoms

Therapy continued for 6 months for 12 fortnightly sessions. Patient started to show improvement after the 6th session. His depressive symptoms, health-seeking behaviour, and functional capacity improved. He reunited with his wife and resumed subfertility treatment. However, he defaulted follow up 6 months after ending therapy and presented again with relapsing symptoms and inappropriate and frequent health seeking behaviour. He has breached the therapeutic contract and consulted a surgical specialist for his benign lump on left cheek. It was surgically removed but resulted in left sided lower motor neurone facial nerve palsy.

DISCUSSION

In this case report, we describe a patient who

presented with multiple hypochondriacal complaints impacting life.

The reported economic burden of hypochondriasis is underestimated (7). This patient presented to psychiatric services nine years after onset, indicating the long duration taken by such patients to present (8). For patients with severe hypochondriasis, illness lasted 5 years or more for 42% and 10 years or more for 24.7% by the time of their diagnosis (9). The contribution of multidisciplinary specialists for analysis of presentations, investigations, and assessment by an experienced psychiatrist would be vital for a final diagnosis (8).

In studies on medically unexplained symptoms and hypochondriasis, recovery rates were between 30% and 50% (10). The number of somatic symptoms at baseline and the seriousness of these conditions influenced the course as well as the prognosis (10). A favourable prognosis is associated with high socioeconomic status, sudden onset, and the absence of medical conditions (11). Long-term follow-up studies have shown that predictors of long-term illness include a history of childhood punishment and lower use of SSRIs during the treatment period (12). This patient had poor prognostic factors of personality disorder, childhood adversities, and poor medication compliance. Positive factors included a satisfactory socioeconomic background and no major medical illnesses. Main challenges with therapy is termination of therapy in a patient with anxious avoidant personality as well as achieving a sustainable remission. Therapy was terminated at 6 months with the plan of continuing monthly follow up with therapeutic contract and supervision of his compliance by his maternal aunt. Relapse of illness behaviour after 6 months highlights the chronic nature of this illness. Easy access to specialist services bypassing primary care doctors further maintains the symptoms. High risk of iatrogenic harm in hypochondriasis is highlighted in this case.

Abbreviations:

AIDS: Acquired Immune Deficiency Syndrome

HIV: Human Immunodeficiency Virus

ICD: International Classification of Diseases

DSM: Diagnostic and Statistical Manual

CBT: Cognitive Behavioural Therapy

SUDS: Subjective Units of Distress Scale

MD: Doctor of Medicine

NAT: Negative Automatic Thoughts

SSRI: Selective Serotonin Reuptake Inhibitors

Author declaration

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Statement on data availability:

Data including the consent form are available on request.

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