Psychological Treatment of Health Anxiety & Hypochondriasis

A Biopsychosocial Approach
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To Stacy, Emily, and Miriam with all my love.
— J.S.A.

To Eric, the love of my life.
— A.E.B.
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A Biopsychosocial Approach

Jonathan S. Abramowitz, PhD
University of North Carolina

Autumn E. Braddock, PhD
VA Greater Los Angeles Healthcare System
About the Authors

Jonathan S. Abramowitz, PhD, ABPP is Associate Professor and Associate Chair of Psychology as well as Research Associate Professor of Psychiatry, at the University of North Carolina (UNC) at Chapel Hill. He also serves as Director of the Anxiety and Stress Disorders Clinic at UNC. From 2000 to 2006 he was Director of the OCD/Anxiety Disorders Treatment and Research Program at the Mayo Clinic in Rochester, Minnesota. Dr. Abramowitz conducts research on the psychopathology and treatment of anxiety disorders and has authored or edited 5 books and over 100 peer-reviewed research articles and book chapters on these topics. He currently serves as Associate Editor of two professional journals, *Behavior Research and Therapy* and *Journal of Cognitive Psychotherapy*, as well as serving on the editorial boards of a number of other professional journals. Dr. Abramowitz is a member of the Obsessive Compulsive Foundation’s Scientific Advisory Board and a member of the Anxiety Disorders Association of America’s Clinical Advisory Board. In 2005 he was elected to the Board of Directors of the Association for Behavioral and Cognitive Therapies (formerly AABT). He also served on the DSM-IV-TR Anxiety Disorders Work Group. In 2003, Dr. Abramowitz received the Outstanding Contributions to Research Award from the Mayo Clinic Department of Psychiatry and Psychology, and in 2004 he received the David Shakow Early Career Award for Outstanding Contributions to Clinical Psychology from Division 12 (Clinical Psychology) of the American Psychological Association. He currently lives in Chapel Hill, North Carolina with his wife, Stacy, and their daughters Emily and Miriam.

Autumn E. Braddock, PhD, is a primary care psychologist within the Veterans Affairs Greater Los Angeles Healthcare System, specializing in behavioral medicine and cognitive-behavioral therapy for anxiety. She is the former Codirector of the Anxiety Disorders Clinic at Mayo Clinic (2006–2008), where she served as a staff clinical health psychologist in the Department of Psychiatry and Psychology and an Instructor in the Mayo Medical School. Dr. Braddock received her B.A. in Psychology from Yale University and her Ph.D. in Clinical Psychology with a minor in Sport Psychology from UCLA. She completed an APA-Accredited internship at the VA Greater Los Angeles Healthcare System (West Los Angeles) and a 2-year APA-Accredited postdoctoral fellowship in Clinical Health Psychology at Mayo Clinic. She has received numerous awards and grants including the Howard R. Rome Fellow Grand Rounds Award at Mayo Clinic, Distinguished Teaching Award at UCLA, and the Mead Prize for Lead-
ership and Character at Yale University. Dr. Braddock has presented her research, primarily addressing anxiety within medical populations, at national and international conferences. She enjoys visiting with her loving parents and brothers in Colorado. Currently, she lives in Santa Maria, California with her partner and best friend, Eric.
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Preface

Despite a rich 2000-year history, hypochondriasis remains a controversial topic in the fields of mental health and medicine. Some experts consider it a primary mental disorder; others view it as secondary to more prominent psychological conditions such as depression; still others view it as a personality trait or disorder – a Freudian defence mechanism, an abnormal perceptual style, a means of nonverbal communication, or a response to stress, trauma, or abuse. Not surprisingly, throughout the millennia, hypochondriasis has been a much misunderstood, criticized, and scorned condition. Even today, at the beginning of the 21st century, hypochondriasis evokes mostly a bewildered sigh from many clinicians, who often view those with this and related conditions as little more than a nuisance. But what sufferers of this and related problems truly need is for their treatment providers to listen more carefully to their complaints – and to listen in a different way. The focus of this book thus reflects recent advances in the understanding of hypochondriasis and related problems as health anxiety.

Our collaboration began at the Mayo Clinic in Rochester, Minnesota. Mayo Clinic is one of the best places in the world to study health anxiety because it attracts medical patients from around the United States (and indeed from around the world) who have been referred from primary care and specialty physicians in their local areas who were unable to successfully diagnose or treat the individual. Once at Mayo, most of these patients receive consultation and, often, helpful treatment for their medical problems. A significant minority, however, are examined thoroughly yet found to have no organic basis for their physical complaints. A proportion of such individuals are relieved to receive the news that they are in fact medically healthy. Yet, there remains one last group of patients who appear unsatisfied when test after test, exam after exam, yields nothing but negative results. It is as if such individuals simply cannot accept their being told they are healthy.

That’s where we, the clinical psychologists, come in! Our colleagues in internal medicine, cardiology and cardiovascular diseases, neurology, and gastroenterology (among other specialties) rely on our expertise in anxiety and behavioral medicine to provide proper evaluation and consultation for patients with persistent but medically unexplained (or undiagnosed) physical symptoms who do not respond to what would otherwise be a convincing reassurance of good health. There is but one further difficulty: Many individuals in this position do not appreciate being told by their physicians that they need to see a mental-
health professional. They often perceive this as akin to being told that “it’s all in your head.” Thus, the initial hurdle in working with such individuals is engaging them in consultation or treatment.

As the reader can gather, the task of helping individuals with medically unexplained symptoms to view their problem as one involving psychological factors such as anxiety and fear (as opposed to a serious or rare medical condition that requires even further evaluation) is a difficult one indeed. After much training and practice (and much trial and error), we have, often on the basis of existing theoretical and empirical work, developed a conceptual framework that helps us understand these patients as suffering from health anxiety – characterized by excessive fear and worry that they might have a terrible disease. We have also adapted techniques for assessing, consulting for, and treating individuals with health anxiety using empirically supported techniques. We share this information in the present volume.

Part 1 of the book presents the scientifically based theoretical framework for understanding health anxiety and related phenomena. The opening chapters help clinicians form a conceptualization of the problem to guide them through the use of treatment procedures described in Part 2 of the book. Chapter 1 presents a case example illustrating the symptoms of health anxiety from the perspective of the patient and his treatment providers. In Chapter 2, we explore the nature of health anxiety; in Chapter 3, we examine various explanations of the causes of health anxiety; and in Chapter 4, we outline a biopsychosocial model to explain how the problem persists despite medical evidence to the contrary. Part 1 concludes with Chapter 5, which presents a review of the health-anxiety treatment literature.

Part 2 illustrates how to conduct assessment, consultation, and psychological treatment for health-related anxiety. The treatment procedures described have a solid scientific foundation, yet applying them is still very much an art that requires a blend of sensitivity and ingenuity. Effective treatment relies on thorough assessment, motivating the patient for change, and includes a strong educational component. The emphasis is on helping patients (1) to correct mistaken beliefs and interpretations about relatively benign body sensations and other health-relevant stimuli, and (2) to stop performing behaviors that interfere with the correction of these mistaken beliefs. Thus, an implied goal of therapy is to increase tolerance for acceptable levels of uncertainty when it comes to one’s health.

Within Part 2, Chapter 6 describes the initial assessment of health anxiety using interview and self-report questionnaire techniques. The aim of Chapter 7 is to give the clinician techniques for engaging the patient in psychological treatment, which is often a very challenging task. Chapters 8 and 9 describe how to build on the diagnostic assessment and gather information about the patient’s difficulties in a way that guides the construction of an individualized case
formulation and treatment plan. Chapter 10 (psychoeducation), Chapter 11 (cognitive therapy), and Chapter 12 (exposure and response prevention) constitute a flexible manual for implementing empirically supported cognitive and behavioral treatment as informed by the conceptual model presented in the first part of the book. Finally, Chapter 13 provides solutions to a number of common obstacles in treatment as well as describes a maintenance program to be implemented following termination of treatment. Case examples illustrating phenomenology, assessment, and treatment are abundant throughout the book (the names of patients have been changed to protect confidentiality), and worksheets to be used in therapy are provided in many of the chapters.

Let us offer some words about treatment manuals in general, especially manuals for the treatment of health anxiety. Psychological treatment manuals are intended to standardize therapy procedures across clinicians and patients. Optimally, such documents should specify the essential principles of assessment and treatment, and provide respective guidelines for implementation. The challenge in writing such a manual is to describe the principles of treatment in sufficient detail that they can be applied to a variety of patients, but not in so much detail that the manual becomes overly cumbersome. Striking this balance is difficult in the case of health anxiety, since this constellation of problems is heterogeneous: Each patient presents with his or her particular health concerns. Indeed, no manual could adequately address the implementation of treatment across the countless personal variations of health anxiety. Our solution, therefore, is to present numerous case examples and emphasize the need for thorough assessment, flexibility, and creativity in dealing with the symptom variations one is likely to be come across in clinical practice. In general, any manifestations of health anxiety we do not address in this volume can be managed by relying on the cognitive-behavioral conceptualization that forms the basis of successful treatment.
Acknowledgments

This volume reflects how we conceptualize, provide consultation for, and treat the constellation of problems known as health anxiety. The theoretical model and intervention strategies elucidated herein are based on a firm foundation of scientific literature of which we are both consumers and contributors; we would like to thank all those who have helped us learn from and add to this knowledge. This includes the countless patients we have evaluated and treated, and whose treatment we have supervised; as well as our teachers who have taught us so much about the clinical and research methods described in this book.

We have been very fortunate to have formed many collaborative relationships with fine researchers, clinicians, and teachers in the field of anxiety. We would especially like to thank those with whom we have worked most closely, including Michelle Craske, Brett Deacon, Kristi Dahlman, Sarah Kalsy, Dean McKay, Katherine Moore, Bunmi Olatunji, Mary Sheeran, Jill Snuggerud, and Steven Taylor: They have helped us refine our thinking about the concepts and treatment techniques discussed herein. Thanks also to Rob Dimbleby from Hogrefe & Huber Publishers for his enthusiastic support and assistance throughout the writing process.
PART 1

What Do We Know About Health Anxiety?
Part 1: What Do We Know About Health Anxiety?

1. The Clinical Picture: Health Anxiety in Their Own Words


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The Clinical Picture: Health Anxiety in Their Own Words

This opening chapter gives the reader an example of the experience of health anxiety from the perspective of the patient and his or her treatment providers. Health anxiety involves physiologic, cognitive, and behavioral processes that exert influence on one another. Although the three factors might not have an equal impact on dysfunction in any given individual (e.g., a person’s health anxiety might be determined primarily by physiological factors rather than by behavioral factors at any particular time), most often it is important to attend to all three domains in assessment and therapy. The following case example illustrates the complex interplay of the factors in one man’s struggle with intense health anxiety.

Background

Gabriel is a 42-year-old married man with two school-aged children. He is employed as a computer security analyst at a regional airport and describes this job as “often pretty stressful.” An avid soccer player in high school and college, Gabriel had always taken good care of his body and had always been particularly conscientious about his health – habits that he continued even after the birth of his children. For instance, he consumes alcohol only rarely and maintains a healthy diet. He also has a full gym in the basement of his home where he and his wife work out several times each week. Sleep is very important to Gabriel, and he is careful to get at least 7 hours of rest each night. He says he notices a difference in how his body feels after only 6 hours of sleep as compared to when he has a “full 7-hour” night of sleep.

Gabriel takes his personal health seriously, perhaps in part because of the fact that he has always been athletic. Yet another possible explanation is that several members of his family had suffered medical problems and died somewhat early in life, making Gabriel feel somewhat vulnerable to illnesses. When Gabriel was 17, his grandfather developed heart problems and passed away suddenly. Later, when Gabriel was 27, his father developed a serious case of liver cancer and died.
within several months. The death of his father was particularly distressing to
Gabriel since the two had been very close. Gabriel had spent lots of time tending
to his ill father’s needs and providing care. When his father was given just 6
months to live, it made Gabriel put his own life into perspective. Although he
began to show greater concern with his own health after witnessing his father’s
illness and eventual death, significant problems involving health anxiety – un-
der which Gabriel now suffers – did not begin until a decade later. Below, in his
own words, is Gabriel’s story . . .

Gabriel’s Perspective

Since my father died I had always felt like it was only a matter of time before I

got ill; and finally, 6 months ago, it struck. I remember the exact moment. I was
walking up the stairs to my office at work and I felt my heart beating more
rapidly than normal. I had trouble breathing. I felt lightheaded for a few min-
utes. My fingers and toes started to feel cold and numb like I was dying. It was
awful – I’d never felt that way before in my life. I wondered what could be wrong
with me since I climb those three flights of stairs every day without any prob-
lem. I remember breaking out into a cold sweat and my head spinning as if my
brain had become detached from the rest of my body and was just swimming
around in my head. I’d heard about people – even those who never smoked –
developing lung cancer at my age, and for a few days I couldn’t get the idea out
of my head that that’s what I had. After that incident, my health start going
down hill. One sign was when I got on the treadmill, my heart would start to
race and I would feel short of breath. “I must be putting too much strain on my
lungs,” I said to myself. So, I figured it was a good idea for me not to exercise
until I saw a doctor. I also stopped sexual relations with my wife because that
increased the strain on my heart and lungs, too.

I had to know just what was going on and couldn’t wait until my doctor’s
appointment later that week. I spent lots of time researching my symptoms on
the internet; and sure enough, I read that shortness of breath, lightheadedness,
and tachycardia could be signs of lung cancer. So, when I went to see my pri-
mary care physician, Dr. Watson, I explained to him what had been happening
to me. When I mentioned my concerns about lung cancer, to my surprise he
didn’t seem very alarmed. He only asked me how work was going and if every-
thing was all right at home. When I said that everything had been going fine, he
physically examined me by listening to my heart and lungs, feeling my neck and
throat, taking my blood pressure, and doing a few other tests and asking a few
more questions. During that appointment, I remember feeling worried that he
was about to tell me I was in big trouble; but again, he didn’t seem concerned.
At the end of the exam I asked Dr. Watson, “So, how do I look?” He confirmed that my heart was beating rapidly and that my breathing seemed a little strained, but said that nothing serious had come up during my physical exam. Still, he said he would get to the bottom of it and he asked me to have some other blood tests which would help reveal what was wrong. When I went back to Dr. Watson a week later to get the test results, he said they didn’t show anything serious. At that point, I objected and suggested a second opinion. That’s when Dr. Watson sent me to a heart and lung specialist, Dr. Singleton.

A week later I met Dr. Singleton, who looked over my medical records and examined me. During my consultation he ran some tests on my heart and lungs, but when these came up negative he rather quickly concluded that my heart and lungs were healthy, and that my problems were due to “stress.” I disagreed with him, but he reiterated that he thought everything was OK, and that I should “go home and rest,” and feel reassured that I was in fine health. I didn’t like this kind of treatment; my problems were not caused by stress – there was something seriously wrong with my heart and lungs. I had hoped Dr. Singleton would help me figure out what was happening to me and start me on the road to recovery. Instead, I left his office feeling worse. All I could think about was what could be wrong.

More trouble came my way a few days later when I woke up one morning (it was a Tuesday). As I was getting out of bed, I started feeling dizzy and lightheaded again. I think I almost fainted on my way into the bathroom. This was especially disconcerting because I had just had 8 full hours of sleep, so my body should have been in top condition and ready for the day. That’s how I knew there must be something seriously wrong. I stayed home from work that day and it seemed the only thing I could do to keep from getting dizzy and passing out was to just lay in bed. After some persistence with Dr. Singleton’s office, I was given a referral to see a specialist in hematology. I made an appointment for the following week and proceeded to read all the information I could about blood diseases so that I would be prepared for my visit.

Meanwhile I ended up missing work the rest of the week because of my illness. Every time I tried getting up from the bed I felt lightheaded. Going to the bathroom became an adventure. Even while I was in bed I would notice my heart rate speeding up and my breath becoming shallow from time to time (I prayed to God not to take me before I could at least figure out what was wrong with me). My fingers, toes, and lips sometimes felt numb and tingly, my mouth and eyes felt dry, and I occasionally felt chest pains. I was also weak and unable to deal with anything. My wife even had to bring me my food. On one of my internet searches, I read that all of these physical symptoms could be signs of diseases I hadn’t even considered: multiple sclerosis, diabetes, and even amyotrophic lateral sclerosis (ALS or Lou Gehrig’s disease). I remember reading the book Tuesday’s with Morrie, which is about a man who died of ALS. It was an awful demise. I worried that this was in store for me as well. I thought about

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Dad a lot that week. Like him, I had quickly gone from feeling very healthy to feeling very sick. I suppose it’s in our genes.

My much-anticipated visit with Dr. Brody, the hematology specialist, was not exactly what I’d expected. I had been very hopeful, but she didn’t have any answers for me. She read over my medical records, interviewed me about my symptoms, physically examined me, ran a few tests on my blood and urine. But in the end, she told me she thought I was in good health. When I ask about Lou Gehrig’s disease and M.S., she chuckled at me and tried to reassure me that I didn’t have these diseases. It took several times restating my symptoms before I could get her to recommend some extra lab tests just to be sure she wasn’t missing anything. This scared the hell out of me. Why would she refer me for more tests if she didn’t think anything was wrong?

So, I had some lab work done on my blood to check for lupus, anemia, lymphoma, Hodgkin’s disease, and other diseases. But these all came up negative. Perhaps, I thought, I was suffering from an extremely rare condition that no tests could detect. Dr. Brody tried to reassure me one day on the phone, “You have no serious medical history, you’ve taken good care of yourself, and you’re young. When I consider all of this along with the results from all of these tests, my experience and judgment tells me that you are a healthy man.” But I disagreed – she had to be missing something. After two visits with more specialists to get additional opinions, I met again with Dr. Watson (the primary-care doctor) who reviewed all of my records and said he was referring me to the Mayo Clinic for a complete work-up. “Now we’re getting somewhere,” I thought. Surely the doctors at the Mayo would be able to figure out what was wrong with me.

One month later I was in Rochester, Minnesota, at the Mayo Clinic. I started out with a general internal medicine specialist, Dr. Newman, who read my medical history and arranged for me to see five different doctors in four days. Each of these specialists conducted various tests which were fed back to Dr. Newman to review with me at the end of my visit. I was curious as to why one of the doctors on my list was a clinical psychologist. After all, I was here for a medical work-up, not a psychiatric problem. When I met with her, the psychologist, Dr. Davis, said most Mayo patients see a psychologist since Mayo’s philosophy is that mind and body are interrelated. Dr. Davis asked me about my experiences feeling frustrated with not having a good explanation for my medical symptoms. She never said I was making up my symptoms, but she did give me the name of another psychologist in my hometown. She recommended I call this person if I don’t get a satisfactory explanation for my medical problems and continue to feel frustrated.

Unfortunately, my frustration continued since even the “world-famous” Mayo Clinic couldn’t give me a straight answer. At the end of my stay in Rochester, Dr. Newman reviewed each test result with me. But all of the tests were negative, and all of the doctors had indicated that they considered me generally
healthy. Although this uniform conclusion put me at ease temporarily, I wondered why the doctors had also suggested I keep an eye on my symptoms. Some had even recommended one or two further tests that could be done to rule out possible problems, which they said were “unlikely.” Puzzled and uncertain, I asked Dr. Newman why I was having all of these physical symptoms if I was medically healthy. He again suggested that it could be due to “stress.” But, I didn’t like that answer: I was not going crazy, and I was not making up these symptoms! Then something made me start to wonder whether the Mayo doctors had all discounted me as a hypochondriac. Maybe I would never get a straight answer. Part of me wanted to believe there was nothing wrong, but deep inside I couldn’t stand not knowing for sure.

When I returned home things started getting worse. I was missing more work and wasn’t socializing very much since all I could think of was my health. I avoided certain places where I might encounter second-hand smoke and other dangerous airborne chemicals; and I restricted my diet based on advice I had read on various medical websites. I didn’t do anything I thought might put unnecessary strain on my body. I bought a stethoscope, blood pressure cuff, and lung capacity meter so that I could keep track of my symptoms and report this to my doctors, who I called and visited every few weeks. I was referred to five or six different specialists to get more opinions, but no two physicians had the same impressions. After a number of MRIs, EKGs, and stress tests came up negative I was beginning to feel suicidal. I had invested so much time and money in trying to find out what was wrong with me, but I had literally nothing to show for it.

My wife was becoming more and more upset with me. She wanted our life back. She was sick and tired of how much time and energy I was spending on trying to get a grip on my illness. She was also infuriated by the financial costs I had incurred. Finally, she pleaded with me to see the psychologist I was referred to while at the Mayo Clinic. She was right. Things were getting out of control. Perhaps the psychologist could at least help me cope with my illness. So, I decided to give it a try. I went and saw Dr. Moore for a consultation. She seemed to understand how frustrated I was feeling, although I wonder whether she really believed I was sick (a few times she interrupted me rather than listening to all of my symptoms). Anyway, I am going back for a second visit to see what therapy is all about. I have my doubts, but I’ve caused so much upheaval in my family that I owe this to my wife.
The Physician’s Perspective

Dr. Watson (Gabriel’s Primary-Care Physician)

When Gabriel first came to see me I thought there might be some sort of serious medical illness present. After all, he was very persistent, and his complaints sounded serious. When a thorough physical exam didn’t show anything, I even ordered some comprehensive lab tests. I remember sending him home from that first visit by reassuring him that we would get to the bottom of things. I thought the tests would reveal something definitive, but when they came back unremarkable, I decided he needed to be referred to see a specialist. Perhaps I was missing something important.

When I saw Gabriel a few months later he had been evaluated by a number of specialty doctors – experts in their field – who had run numerous tests, all of which had come back negative. The specialists had unanimously concluded that Gabriel was not ill. Instead, they suggested he was suffering from stress and hypochondriasis. I agreed that Gabriel’s somatic complaints were probably caused by a psychological problem such as stress, anxiety, or depression, but not a medical illness. I found this interesting since I’d had a hunch Gabriel was a hypochondriac the first time I saw him. I noticed the way he described vague symptoms and was preoccupied with having terrible and very rare illnesses. It raised a red flag for me. Things just didn’t seem to add up when he told his story. Still, I wasn’t absolutely sure; and because you have to practice defensive medicine these days, I didn’t want to take any chances. After all, how could I tell someone they are a hypochondriac?

But now we had lots of evidence of good health. Still, when I confronted Gabriel with this reality, he was quite displeased. He wanted more tests and was not ready to accept that his problems were all in his head. I tried very hard to reassure him that everything was fine, but each time he kept calling my office asking about more and more possible problems that he might have. It’s almost as if he was trying to stump me. What would it take to make him happy? Once when I suggested he see a psychiatrist he became very angry and hung up the phone on me. What was I to do? I think he wanted me to show concern for him, but that was hard to do when he was being so intrusive and disrespectful. He would call my secretary every few days trying to speak to me. So, I finally gave in and told him he could be right – something could be wrong that was not caught despite all of the testing. That’s when I made the referral to the Mayo Clinic. They would either find something wrong or reassure Gabriel once and for all that he was healthy. Gabriel liked the idea of going to Mayo.
Dr. Newman (Department of Internal Medicine, Mayo Clinic Rochester)

The Mayo Clinic Department of Internal Medicine serves a regional and national patient base. Most of our clientele is referred from primary-care and specialty physicians who either desire a second (or third or fourth) opinion or who feel unable or unequipped to handle cases of very serious illnesses. Our department is the first stop when most people come to Mayo. From here, they are commonly referred for consultation (and perhaps treatment) in other specialty areas at the clinic. Before going home, most patients meet again with us to put closure to their visit.

We see our share of patients with unexplained physical complaints. These patients are not satisfied with their medical care at home – not that their care is actually deficient in any way, but the patient is not satisfied with the feedback (the results) they receive from their doctors. When all referral options are exhausted in the patient’s region, they might then be referred to Mayo for our expertise. In the words of many of our patients, we are their “last hope” of finding a diagnosis.

In the case of Gabriel it was not surprising that medical tests were not helpful in determining a definitive diagnosis, since there did not appear to be anything seriously medically wrong with him. It is our job, however, to provide a comprehensive workup and rule out all possible medical explanations: We don’t want to leave any stone unturned. That said, I ordered a consultation with a psychologist for Gabriel since there were notes in his medical record indicating that he seemed to be preoccupied with his health. The behavioral medicine psychologists at Mayo are adept at recognizing the role that stress can play in influencing medical symptoms, even if these symptoms are not part of a serious disease. Patients like Gabriel often feel cast off when told they will be seeing a psychologist, yet I try to explain the importance of a thorough workup that includes mental as well as physical health. It is important for them to see the links between the two. In the end, what Gabriel really needs is a psychologist who can give him reassurance that he is well and teach him strategies for relaxing when he is feeling stressed.

The Psychologist’s Perspective

Dr. Davis, Behavioral Medicine Section, Mayo Clinic

Our section is part of the Psychiatry and Psychology Department at Mayo, and we generally serve the other medical practices. For example, we conduct consultations and short-term therapy for patients with serious diseases (e.g., cancer, diabetes, and those in need of organ transplants) who are also having prob-
lems with depression, anxiety, or with issues related to the self-management of their medical conditions. Another population we serve includes patients with somatic complaints but no organic pathology. Often, these individuals present as overly preoccupied with concerns about having serious illnesses and have seen many physicians and undergone many tests, the results of which are generally negative. Nevertheless, they seem determined to find a medical diagnosis for their suspected problem and often do not (and are unwilling to) consider the possibility that psychological factors are playing a role in their difficulties. My job is to determine what role such factors might be playing and to recommend getting help from this perspective along with (if not in lieu of) continuing the search for a proper medical diagnosis (which usually does not bear fruit).

Like many patients the physicians from Internal Medicine refer to us for consultation, Gabriel appeared perturbed that he was in a psychologist’s office. He must have told me that he wasn’t “stressed or crazy” at least 10 times during the 90 minutes I spent meeting with him. It wasn’t exactly clear where Gabriel got the message that he is stressed or mentally ill, but it is unfortunate he feels he has to deny this so vehemently. After all, I wouldn’t refer to his problems as “mental illness.” I don’t think he is making up his symptoms; nor do I think he has a personality disorder and is trying to gain attention. Instead, I fully accept that Gabriel is experiencing the physical sensations he reports. The question is, however, whether these sensations are really as serious as Gabriel thinks they are. I had reviewed Gabriel’s medical records before his visit, but took the time to ask him about them during our session. Although his physicians aren’t finding anything wrong, Gabriel is having a very hard time accepting that perhaps he is not as sick as he thinks. That is, he appears to be misinterpreting his bodily sensations as more serious than they really are. The following interaction took place during the consultation:

Dr. Davis: So, what have your doctors told you about your physical complaints?
Gabriel: They don’t seem to find anything wrong with me. None of the tests are positive.
Dr. Davis: I see; that’s what I read in your medical records, too. I wonder what that’s like for you. You know, to be told that you aren’t ill even though you have all of these symptoms.
Gabriel: It makes me very upset … and worried. First, they say that they can’t find anything wrong, but then the doctor usually wants to rule something out, so he tells me to get another test. What am I supposed to think?
Dr. Davis: I can understand your frustration. It would be nice to have a straight answer, wouldn’t it?
Gabriel: Well, I’m going to keep searching until I get one. I have one more test in hematology later today. That’s my last hope.
Dr. Davis: Hmm. Let me ask you a question. How many tests have you had since you started feeling sick?
Gabriel: Oh God, probably between 15 and 20 for different sorts of problems.
Dr. Davis: Can I ask you, then, given what the previous test results have shown, would you bet that this afternoon’s test is going to give you a definitive answer or not?
Gabriel: Probably not, but I need to know anyway. I just know there is something wrong with me. We just have to get to the bottom of this.

Sometimes in trying to helpful, physicians inadvertently reinforce somatization, illness behavior, and problems involving health anxiety. For example, by suggesting that there are more and more problems to “rule out,” doctors perpetuate concerns that something could be seriously wrong. This also reinforces the patient’s mistaken belief that any and all bodily symptoms must be accounted for with a medical explanation. In other words, it would be impossible to feel something in your body without being sick. Suggesting “one more test” also keeps patients in the sick role and puts them on an emotional roller coaster of mixed messages (“she said I was healthy, but suggested one more diagnostic test”). Even suggesting that Gabriel “keep an eye on” his symptoms reinforces paying attention to bodily sensations that don’t seem to be serious, but that evoke excessive illness concerns.

How would I help Gabriel? Not by trying to reassure him that he is fine! This approach clearly hasn’t worked when his other doctors have tried, and he already spends lots of time trying to gain assurances about his health from textbooks and the internet. What good would it do for one more person (a nonphysician) to try to convince him that he’s healthy? Instead, I would help him develop alternate, less threatening, explanations for his bodily sensations by closely exploring with him and helping him challenge his own logic about what these symptoms mean. For example, there are a lot of relevant facts that Gabriel ignores when he gets concerned about his health. I would also explore with him how he responds when he notices certain bodily symptoms, and how such responses might actually be making his problems worse. For example, monitoring his vital signs only makes him more aware of body symptoms. He should learn new techniques for dealing with such symptoms so that they do not lead to preoccupation and illness worry. Of course, the first step would be helping Gabriel to buy into the possibility that examining behavioral and psychological factors could be helpful. Engaging him in therapy will not be an easy task, but there are nonconfrontational strategies that can help motivate people like him to more carefully consider the advantages and disadvantages of trying out this new approach. We wrapped up the consultation by having the following exchange:

Dr. Davis: So, if you had to decide on the percentage of your symptoms that is due to a medical illness versus the percentage that might be due to psychological factors, what would your estimates be? Is it 50–50? 60–40?
Gabriel: No, I’d say it’s more like 90–10. No offense, but my problems are 90% medical. Maybe 10% is psychological.

Dr. Davis: Hmm. So, what kind of a role do you think psychological factors might be playing, even if they are only 10% of the problem?

Gabriel: Well, I guess I do get pretty stressed out by not having an answer. But, I don’t understand how that makes my symptoms worse.

Dr. Davis: So, if I recommended that you get some help for managing stress – even if this is only 10% of the problem – would you consider it? I mean, you’ve got nothing to lose, and perhaps it could be helpful, don’t you think?

Gabriel: Maybe . . . sure. I’ll think about it.

As the chapters to follow will reveal in greater detail, health anxiety is a complex problem involving the perception that somatic complaints are always evidence of a serious medical condition. In order to prevent a catastrophic health outcome, patients typically seek excessive medical evaluations from multiple providers despite the absence of any findings suggestive of a medical problem. Patients commonly present first to their primary-care doctor complaining of vague, diffuse symptoms. Only after all medical avenues have been exhausted – if ever – do these patients present to mental health providers. Such patients can present to psychologists extremely frustrated with their medical providers, emphatically stating that their doctors have “missed something,” and that they are truly suffering from a serious medical illness, often believed to be chronic and terminal in nature. As Gabriel’s case illustrates, these patients are typically reticent to embrace a psychological conceptualization of their symptoms. In addition, the medical providers can be equally frustrated with individuals constantly complaining of symptoms despite their consistently negative test results. Unknowingly, the physicians may be maintaining the individual’s health anxiety through ordering unnecessary tests and offering reassurance. Thus, health anxiety involves not only distressed and frustrated patients, but also perplexed and annoyed medical providers. We have opened this volume with a case example illustrating in anecdotal fashion the experience of health anxiety from personal, medical, and psychological perspectives. Next, we consider the perspective of a growing body of clinical observations and research literature.