Group cognitive and behavioural treatment for hypochondriasis

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Abstract

Objective—To assess the feasibility of carrying out group cognitive and behavioural treatment for hypochondriasis in a general hospital setting.

Design—Assessment of patients referred for therapy.

Setting—District general hospital.

Patients—Six patients aged 35 to 55 (mean 43) years with a mean duration of symptoms of 12 years who fulfilled the *Diagnostic and Statistical Manual for Mental Disorders* (DSM III-R) criteria for hypochondriasis.

Main outcome measures—Number of visits to their doctors, time spent thinking about illness, and scores on the hospital anxiety and depression scales.

Results—The mean number of visits to a doctor fell significantly after treatment (3 before treatment *v* 0.8 after treatment; $p=0.03$) as did the time spent thinking about illness (57.3 *v* 40.6; $p=0.14$). The depression and anxiety scores also fell, although the differences were not significant (depression: 9.5 before *v* 8.5 after; anxiety: 13 before *v* 12 after).

Conclusion—It is feasible to carry out group cognitive and behavioural treatment in patients with hypochondriasis, and controlled studies are now indicated.

Introduction

Cognitive educational treatment for hypochondriasis, was first proposed by Barsky and colleagues^{1,2} but patients with hypochondriasis are usually reluctant to accept referral to a psychiatrist because they consider their condition to be due to some undiscovered disease. The concept of stress has become widely known among the general public, and for this reason patients are likely to accept a course of therapy labelled stress management, although they would probably refuse a psychiatric referral. As hypochondriac patients take up a lot of primary carers' and other doctors' time³ we decided to test the feasibility of a group cognitive and behavioural therapy programme, described to patients as stress management, in a district general hospital. The programme was conducted in a hospital to emphasise the medical rather than psychiatric milieu.

Hypochondriasis is a learnt behaviour in which the patient focuses unduly on a particular symptom, or set of symptoms, and continued medical investigation serves to reinforce this. Group treatment was carried out to show patients that they were not unique in having this problem and also because it was hoped that patients would help each other become less self centred.

The cognitive and behavioural hypothesis proposes that three mechanisms act in preoccupation with illness. Firstly, increased autonomic arousal occurs, and this is interpreted by the patients that they are unwell. Secondly, the patients focus their attention on some normal variation of physiological function. Thirdly, an obsessive checking behaviour develops. For example, one of our patients was preoccupied with minor variations in her temperature and became convinced that this represented something serious and checked her temperature several times each day with

various thermometers. Reassurance from doctors about this type of behaviour can make the problem worse.⁴

Subjects and methods

We recruited patients to the study by informing all the hospital's consultants of the availability of a new treatment for hypochondriasis. All patients entered into treatment had to be referred by a consultant, aged 18-65 years, and had to fulfil the criteria for hypochondriasis in the third revision of the *Diagnostic and Statistical Manual for Mental Disorders* (DSM III-R).⁵

These criteria were (a) preoccupation with the fear of having, or the belief that one has, a serious disease, based on interpretation of physical signs or sensations as evidence of physical illness; (b) appropriate physical evaluation does not support the diagnosis of any physical disorder that can account for the physical signs or sensations or the person's unwarranted interpretation of them, and the symptoms are not just those of panic attacks; (c) the fear of having, or the belief that one has, a disease persists despite medical reassurance; (d) duration of the disturbance is at least six months; (e) belief in the symptoms is not of delusional intensity, as in somatic type delusional disorder—that is, the person can acknowledge the possibility that his or her fear of having, or the belief that he or she has, a serious disease is unfounded.

All the patients were told they would be offered a course in stress management.

Patients were assessed with the hospital anxiety and depression scale.⁶ To determine the amount of medical attention patients received they were asked to state how often they had visited any doctor in the previous month. We also devised a scale to measure the amount of time patients spent thinking about illness. It consisted of a line 10 cm long, at one end of which was written "no time at all" and at the other end "24 hours a day." Patients were asked to place a mark on this line to represent the time spent thinking about illness at the time of the rating. All these ratings were administered three to six months before treatment (baseline measures), just before the first group treatment, after the last treatment, and at six months' follow up.

TREATMENT

We treated patients weekly for nine sessions, each lasting one and a half hours. The structure of the sessions was as follows.

Session 1—We told patients that their treatment would go beyond stress management so that they could understand how the symptoms arose as well as how to cope with stress. Education started with an acknowledgment that the symptoms really existed—and that the treatment aimed to explain them satisfactorily. Patients were helped to distinguish between helpful, relevant information and reassurance with repetitive information. The patients were told that further investigations were not part of this new treatment, and we proposed that they commit themselves to working in the group along these new lines for the nine weeks. We had less difficulty in negotiating this agreement than expected. Patients expressed considerable anger with their doctors for suggesting their symptoms were

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“all in the mind,” but they recognised the compulsion to visit doctors, which some of them likened to an addiction.

Session 2—The attention focus aspect of hypochondriasis was emphasised. One of us illustrated this by asking the group to focus on their throats, which induced swallowing in most patients and a mild attack of coughing in the group. One patient stated that he had backache in the office but not when he went fishing. The well known hypochondriasis among medical students was illustrated to emphasise how widespread the phenomenon can be. We asked patients to keep a symptom diary, to test further the attention focus theory.

Session 3—We taught patients relaxation exercises in the group, and the instructions were tape recorded to enable further practice at home. The symptom diaries were discussed in the group, and patients were additionally asked to record any dysfunctional thought experienced at the time of a symptom.

Session 4—The diaries were reviewed. One patient could see the illogical assumptions another was making but not her own, and in this way group members helped each other. They received reassurance not only from doctors but from home medical encyclopaedias and television programmes. The group were found to be fans of the television soap *Casualty*, set in an accident and emergency department, and the group were asked to watch and discuss the next episode and to try to identify the reassurance seeking behaviour in each other.

Session 5—The role of relatives in providing reassurance was discussed. One patient constantly asked her husband about her symptoms, and another asked his wife to sit on his knees to relieve joint pain. We pointed out that this behaviour provided only short term relief and led to an increased need for reassurance in the future. We asked patients what procedures would fully convince them that they were not suffering from the feared illness. Illustrations were given to emphasise that it is never possible to be certain that illness is not present in the same way that it is never possible to prove that they will not be run over by a bus on the way home. The way doubt can be instilled was shown by a group member asking another what he did the day before, and his response was then questioned by others: “Are you really sure?”

Session 6—The role of depression in some patients’ symptoms was discussed. Most patients felt under considerable pressure of some kind, and their physical symptoms made this worse. The depression was considered along cognitive lines⁷ and patients were encouraged to examine negative thoughts and to list them at home.

Session 7—The work of previous groups continued, and homework exercises were reviewed. Some patients found relaxation more beneficial than others. One patient was notably more angry than the others and objected to the group pressure that he should stop seeking reassurance from his relatives.

Session 8—All patients had succeeded in obtaining

less reassurance from doctors—one patient reported that her general practitioner had telephoned her to inquire why she had not attended. The possibility of positive change despite most patients’ negative past experiences was brought out in the group. This irrationality has been expressed by Ellis: “The idea that one’s past history is an all-important determiner of one’s present behaviour and that because something once strongly affected one’s life, it should indefinitely have a similar effect.”⁸

Session 9—Material from previous sessions was dealt with. Some patients developed supportive bonds and these were encouraged, but care was taken to ensure that mutual reassurance about symptoms was prevented. We asked patients to summarise what had been said, to check that they understood the main points in the treatment. The patient with a compulsion to check her temperature reported that she had thrown away her thermometers, but that on one occasion could not resist the urge and had had to go next door and borrow a neighbour’s thermometer.

Results

We recruited six patients (three men and three women) to the study aged 35 to 55 (mean 43) years. The duration of symptoms ranged from 28 to seven (mean 12) years. We thought six a suitable number for group treatment, and it took a year to recruit this number. The patients each had a huge folder of case notes, reflecting the burden they had placed on medical services.

The values obtained in the assessments of patients did not change significantly between the baseline and pretreatment measurements. This period ranged from three to six months (table).

The difference between mean number of visits to the doctor before and after treatment was 2.2 (95% confidence interval 0.36 to 4.0), and the difference between mean time spent thinking about illness was 16.7 (p=0.14).

For the measurements on the hospital anxiety and depression scale the difference in the median score for anxiety before and after treatment was 1.0, as was the difference in the median depression score (table). Although these results show a clinically noticeable reduction in psychological symptoms the difference was not significant for the whole group (Wilcoxon’s paired test). This is not surprising given the small number of patients.

Follow up data showed that the gains made in treatment were maintained at follow up at six months (table). None of the patients dropped out from treatment, which in view of the demanding nature of the therapy, is worth emphasising.

Discussion

We used the hospital anxiety and depression scale to give scores for depression and anxiety. This was constructed from data supplied by outpatients between the ages of 16 and 65 attending general medical clinics, a population comparable with our own. The scale has been shown to be a valid measure of anxiety and depression, and we hoped that it would give useful information concerning the patients’ progress, although the scale has not been validated in hypochondriasis.

About 30-80% of patients present with symptoms for which there is no physical basis.⁹ Treatment of hypochondriasis has been poor, possibly because until the advent of cognitive and behavioural approaches there was no viable treatment. Patients were simply reassured, which made them worse, or doctors tried to reassure themselves by ordering more, or more

Results of assessment in six patients undergoing cognitive and behavioural treatment for hypochondriasis

Measure	Baseline	Immediately before treatment	Immediately after treatment	Six month follow up
Mean No of visits to doctor/month	3	3	0.8*	1
Mean proportion of time spent thinking about illness/day (%)	56	57.3	40.6†	43
Median depression score‡	10	9.5	8.5§	8.7
Median anxiety score‡	13	13	12¶	11

*p=0.03 compared with before treatment by Student’s *t* test.

†p=0.14 compared with before treatment by Student’s *t* test.

‡Hospital anxiety and depression scale.

§Values of *T* are 13 and 2, p>0.05; Wilcoxon’s signed rank test.

¶Values of *T* are 11.5 and 3.5, p>0.05; Wilcoxon’s signed rank test.

intensive, investigations. Alternatively these patients refused to accept a psychiatric explanation and turned to alternative medicine, as did one of our patients. Our patient consulted a homoeopath, who again gave reassurance.

NEED TO CHANGE ATTITUDES

The cognitive and behavioural approach gives us a new model, and we have shown that it can be applied in a general hospital. Nevertheless, it took one year to recruit the six patients from consultants. The medical profession is conservative in its approach to new treatments, and perhaps a sense of failure at their own approach militated against referral. Going further one could propose the condition has a large iatrogenic component, being caused by doctors' belief in physical causes of illness and compliance with patients' demands for further tests despite previous fruitless investigations.¹⁰

Bass and Murphy point out that in the white paper *Working for Patients* ill health was reduced to a consumer need for ever expanding diagnostic procedures, and talking with patients to help them see their symptoms another way would be unprofitable.¹⁰ Most psychiatrists have little experience of working in a general hospital, just as most physicians have no training in the psychological approaches described in this study. The role of the psychiatrist in the general

hospital has been discussed by Crisp, who proposed: "Ultimately his position will be dictated, apart from his own inclination and interest, by whether he is seen to be and found to be of value by his medical colleagues."¹¹

This is a small study of only six patients. The results of a cognitive and behavioural approach in hypochondriasis are encouraging, but further studies in more patients are needed before this approach is generally advocated.

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Detention of British citizens as hostages in the Gulf—health, psychological, and family consequences

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Abstract

Objective—To describe the physical, psychological, and family consequences of the detention of British subjects as hostages in Kuwait or Iraq, or both, after the invasion of Kuwait on 2 August 1990 and to investigate the relation between types of trauma experienced and these reactions.

Design—Postal questionnaire.

Subjects—381 respondents.

Results—Many health, social, and psychological sequelae were identified. Problems with present finance, accommodation, and work are important causes of distress. Many hostages coped well and gained self esteem.

Conclusions—A minority of respondents require further support and treatment. Expatriates in risk areas should retain assets in their home country.

Introduction

Over 1200 British citizens, the largest Western national group, were held against their will in Kuwait and Iraq following the invasion of Kuwait on 2 August 1990. Not all were people who lived or were staying in the area; a British Airways jet in transit through Kuwait was detained with all passengers. Most went into hiding or were taken by Iraqi guards to strategic sites, where they were described as a "human shield." Many of the women and children were released in September; other hostages escaped or obtained freedom following humanitarian initiatives but most were held until their unexpected release in mid-December 1990.

One of us (JAE) had visited Baghdad as medical adviser on one of the missions in October 1990. This experience and the sudden release of all the remaining

detainees led to the present investigation of former hostages and their families.

Ideally, an unbiased sample of all the hostages would have been selected for study.¹ In this case the suddenness of the release of more than 1000 people, many of whom had lost their homes; their immediate dispersal throughout the United Kingdom and beyond; and the non-existence of an accurate database rendered such sampling impossible. Nevertheless many possible contact addresses were obtained from sources such as the Gulf support groups and personal recommendations.

The retention of hostages in this conflict was unusual for several reasons: large numbers of people, most of whom had perceived no prior risk, were detained without warning; as well as losing their freedom, many were taken to strategic sites apparently as human deterrents against military attack; there was usually no opportunity for a personal relationship between hostage and responsible captor, which is probably essential for the development of the Stockholm syndrome² (in which some hostages develop a positive or even protective feeling towards their captors); it is very unusual for so many Western citizens to be subjected to the state repression widely reported to occur in Iraq.³

Previous studies have examined the psychological conditions of individuals held hostage,² civilians subjected to normal war trauma,⁴ and refugees subjected to state organised violence within their own countries.⁵ There is now widespread interest in post-traumatic stress disorder^{6,7} and there is no doubt that a syndrome of this type follows a wide range of traumatic events.⁸ Post-traumatic stress disorder is known to be associated with increased rates of depression^{9,10} and alcohol misuse,¹¹ yet these alone do not account for the severe functional impairment that may accompany it. After the initial event persistent distress may be related to the

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