1 Wulff HR, Anderson B, Brandenhoff P, Guttler F. What do doctors know about statistics? *Stat Med* 1987;6:3-10.
2 Berwick DM, Fineberg HV, Weinstein MC. When doctors meet numbers. *Am J Med* 1981;71:991-8.
3 Cassells W, Schoenberger A, Grayboys TB. Interpretation by physicians of clinical laboratory skills. *N Engl J Med* 1978;299:999-1001.
4 Krall JM, Hall DS, Garland BK, Pearson RJ. Physicians' view of the teaching and utility of courses in epidemiology and biostatistics. *J Med Educ* 1983;58:815-7.
5 *Holy Bible*. Gospel according to St Matthew vii, 1-5.
6 Colditz GA, Emerson JD. The statistical content of published medical research: some implications for biomedical education. *Med Educ* 1985;19:248-55.
7 General Medical Council. *Recommendations as to basic medical education*. London: General Medical Council, 1967.
8 Clayden AD, ed. The teaching of medical statistics at undergraduate and post-graduate levels. Leeds: University of Leeds. (Available from Department of Community Medicine.)
9 Langman MJS. Towards estimation and confidence intervals. *Br Med J* 1986;292:716.
10 Gardner MJ, Altman DG. Confidence intervals rather than p values: estimation rather than hypothesis testing. *Br Med J* 1986;292:746-50.

Hypochondriasis: an acceptable diagnosis?

Can a persistent belief in a non-existent illness be an illness itself? Hypochondriacal fears and feelings are well recognised features of depression,[1] but doctors disagree over the existence of a neurotic syndrome of fear of and preoccupation with disease unaccompanied by a more fundamental psychiatric disorder. Early writers were sceptical,[2] and (despite an absence of statistical analysis and in apparent defiance of its own data) one influential study concluded that an underlying depression would surface sooner or later.[3]

Supporters of the proposal that hypochondriasis is a distinct entity have claimed that the primary condition occurs with only mild disturbance of affect[4] and is characterised by a prominence of those symptoms—pains, especially in the musculoskeletal system—that are typically hypochondriacal.[3] From closer examination has emerged a precise descriptive triad of the patient being convinced that he has a disease, fearing the disease, and being preoccupied with his body; this triad arises without underlying affective illness and responds at most temporarily to reassurance.[5,6]

The debate has, however, been muddied by its emphasis on psychiatric patients, an inevitably biased sample—most of those labelled as hypochondriacs are seen by non-psychiatrists. But a recent study of medical outpatients has confirmed that the components of the triad correlate not only with each other but also with the number of somatic symptoms, though not the number of established medical diagnoses.[7] Depression, though often present, is not invariable. Any comment that hypochondriacal beliefs probably lie on a continuum with depression at one end does not diminish the usefulness of the diagnostic category, as, for example, with obsessions. So to view hypochondriacal symptoms as masks of depression is both to undermine the meaning of depression itself and to ignore the mounting evidence.

Despite the lack of supporting information psychiatrists often assume that reassurance is ineffective and that even to consider hypochondriacal complaints encourages further complaining. Thus a belief that such patients should be directed "out of the office as quickly as possible because the time they take up is spent to no good purpose" enjoys unjustifiable popularity.[8] This negative view probably originates in the absence of physical illness to explain physical symptoms and in the frustration evoked by equally frustrated, possibly antagonistic, patients. It may also reflect a departure from the sick role, which expects the patient to cooperate with his doctor—that is, to accept his word.[9]

But to be effective reassurance must be credible, educative and specific, and directed at both expressed and concealed fears.[10] Hypochondriacal patients may misinterpret normal sensations[11] or feel them more sharply.[12] Childhood experiences[13] and social reward[14] may encourage somatic complaints under stress. The scarce research into treatment suggests that such explanation of psychosomatic symptoms coupled with careful examination and reassurance leads to lasting improvements.[15] Moreover, detailed reassurance becomes increasingly effective over time and can reduce the worries aroused by fresh symptoms. When followed by family counselling on reinforcement[16] it may be the treatment such patients desperately seek. The sufferer from hypochondriacal neurosis sees perfunctory or ill directed reassurance as dismissal, as failure to take him seriously. He does not want to be told there is nothing wrong; he needs to understand his symptoms as a first step to overcoming them.

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1 Kreitman N, Sainsbury P, Pearce K, Costain WR. Hypochondriasis and depression in outpatients at a general hospital. *Br J Psychiatry* 1965;111:607-15.
2 Bleuler EP. *Textbook of psychiatry*. Brill AA, trans. New York: Dover Publications, 1924.
3 Kenyon FE. Hypochondriasis: a clinical study. *Br J Psychiatry* 1964;110:478-88.
4 Pilowsky I. Primary and secondary hypochondriasis. *Acta Psychiatr Scand* 1970;46:273-85.
5 Pilowsky I. Dimensions of hypochondriasis. *Br J Psychiatry* 1967;113:89-93.
6 American Psychiatric Association Committee on Nomenclature and Statistics. *Diagnostic and statistical manual of mental disorders*. 3rd ed. Washington, DC: American Psychiatric Association, 1980.
7 Barsky AJ, Wyshak G, Klerman GL. Hypochondriasis: an evaluation of the DSM III criteria in medical outpatients. *Arch Gen Psychiatry* 1986;43:493-500.
8 Alvarez WC. A gastro-intestinal hypochondriac and some lessons he taught. *Gastroenterology* 1944;2:265-9.
9 Parsons T. Illness and the role of the physician: a sociological perspective. *American Journal of Orthopsychiatry* 1951;21:452-60.
10 Kessel N. Reassurance. *Lancet* 1979;i:1128-33.
11 Mechanic D. Social psychologic factors affecting the presentation of bodily complaints. *N Engl J Med* 1972;286:1132-9.
12 Pennebaker JW, Skelton JA. Psychological parameters of physical symptoms. *Personality and Social Psychology Bulletin* 1978;4:524-30.
13 Parker G, Lipscombe P. The relevance of early parental experiences to adult dependency, hypochondriasis and utilization of primary physicians. *Br J Med Psych* 1980;53:355-63.
14 Wooley S, Epps B, Blackwell B. Pain tolerance in chronic illness behaviour. *Psychosom Med* 1975;37:98.
15 Kellner R. Psychotherapeutic strategies in hypochondriasis: a clinical study. *Am J Psychother* 1982;36:146-57.
16 Barsky AJ, Klerman GL. Overview: hypochondriasis, bodily complaints and somatic styles. *Am J Psychiatry* 1983;140:273-83.

Inequalities and the new Health Education Authority

When our reporter arrived at the Health Education Council last week to attend a press conference on a new report,[1] she found the press conference coming out to meet her. The report was an update of the Black report on inequalities in health,[2] and Sir Brian Bailey, chairman of the now defunct Health Education Council and new chairman of its successor, the Health Education Authority, had ordered the press conference to be cancelled. He was apparently annoyed that the council had not had a chance to approve a report that he said was "political dynamite in an election year." Sir Douglas Black, Margaret Whitehead (author of the report), and other distinguished guests were not upset at being thrown out: they knew that any attempt at suppression would guarantee front page coverage—and so it turned out. But this episode raises important issues—in particular what is the future of the new authority and its chairman?

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