Managing health anxiety in primary care

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Once a medical condition has been ruled out, patients with health anxiety should be treated with cognitive behavioural therapy.

Patients with health anxiety worry excessively about having a serious illness despite adequate medical assurance that they do not. They often experience medically unexplained symptoms and misinterpret bodily sensations as signs of serious illness. Patients with health anxiety can be frustrating and costly to treat. The current article provides guidelines for the management of these patients in primary care.

Common and costly

Health anxiety is a dimensional construct, ranging from a disregard for ones' health to entrenched hypochondriasis. The prevalence of hypochondriasis in primary care is estimated at 3.4 to 6.3%.[1] Although most patients with health anxiety will not meet the restrictive diagnostic criteria for hypochondriasis, syndromes with subthreshold criteria are highly prevalent.

One Australian study found that 18.5% of patients presenting to GPs report clinically significant symptoms of somatisation and hypochondriasis.[2] In the general population, 29% of adults report that they worry a lot about their health.

Health anxiety is very costly. In the USA, patients with health anxiety use twice the amount of outpatient and inpatient services compared with non-somatising patients.[3]

Presentation

Patients with health anxiety frequently present with fears of cancer, heart disease, aneurysm, multiple sclerosis or AIDS. They also report common symptoms as evidence of disease (e.g. pain, headache, bowel and bladder symptoms, nausea, numbness, fatigue, gynaecological pain, skin discolouration and lumps).

Patients with health anxiety have a level of fear and preoccupation that is excessive given their medical status. Although patients may have a significant illness history, the presence and/or severity of their current symptoms are medically unexplained. Comorbid depression and anxiety disorders occur frequently, and patients may report substantial distress and disability from their symptoms.

Medical investigations that do not assign a cause to the symptoms may not assuage patients' concerns – they frequently report fears that 'something' has been missed. They may have difficulty tolerating uncertainty and will consult multiple physicians ('doctor shop'). Alternatively, patients may avoid the GP's surgery because it triggers health worries and doubts.

Although insight is variable and may be influenced by an anxious state, patients with health anxiety often resist psychosocial explanations for their symptoms and persist in seeking a medical cause.

Differential diagnoses

The presence of a medical condition must be ruled out before health anxiety becomes the primary focus of care. Health worries are frequently reported in patients with generalised anxiety disorder, panic disorder, obsessive compulsive disorder or depression. However, the patient's anxiety is not restricted to illness fears in these conditions, and additional difficulties are the primary clinical concern. For example, patients with generalised anxiety disorder experience excessive worry about a number of everyday events and patients with depression report low mood and/or anhedonia. Patients with panic disorder experience recurrent unexpected panic attacks, and patients with obsessive compulsive disorder engage in

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Example of a case conceptualisation: a 37-year-old women with health anxiety about bowel cancer

A cycle develops in patients with health anxiety. A trigger leads to excessive worrying, apprehension and a preoccupation with possible symptoms.

Trigger

- A friend's mother is diagnosed with breast cancer

Thoughts and worries

- 'What if I get cancer?'
- 'I might have bowel cancer'
- 'I could not cope'
- 'I cannot bear not knowing for certain'

Leads to anxiety and apprehension

- Increased awareness and monitoring of symptoms
  - awareness of nausea, bloating, pain in lower back and urges to urinate and defaecate
- Checking, seeking reassurance, avoidance behaviours
  - monitoring bowel movements and checking for blood in stools
  - searching internet for symptoms and consulting with GP and spouse
  - avoiding all fatty foods, just in case, and avoiding asking about the friend's mother

Experiences more symptoms and becomes more preoccupied with them

Interprets symptoms as signs of bowel cancer

Leads to more thoughts and worries and the cycle continues

repetitive behaviours (e.g. washing, checking, ordering) in order to neutralise distressing thoughts.

As comorbidity is common, patients with health anxiety often meet criteria for additional disorders. Consider a diagnosis of somatisation disorder when patients present with a history of multiple medically unexplained physical symptoms beginning before the age of 30 years.

Conceptualisation and formulation

Cognitive behavioural therapy (CBT) provides the most robust conceptualisation of health anxiety. Illness fears (e.g. 'I have multiple sclerosis') are triggered by internal and/or external stimuli (e.g. feeling weakness in the legs or reading a magazine article about multiple sclerosis) and may be influenced by past experiences (e.g. death in the family, childhood illness, anxious parenting).

Illness worries lead patients to become vigilant to bodily symptoms. They notice and focus on the normal physiological changes that the body experiences all the time, and subsequently misinterpret them as catastrophic. Apprehension and hypervigilance produce more bodily symptoms and patients then engage in 'safety behaviours' (subtle avoidance behaviours designed to prevent the feared outcome from happening) to reduce their distress (e.g. seeking reassurance from doctors and the internet).

Although safety behaviours temporarily reduce patients' anxieties, they increase somatic preoccupation, increase patients' beliefs that bodily symptoms are signs of serious illness and prevent patients finding out that the feared outcomes do not occur. Over time, patients avoid triggers for their worry (e.g. hospitals and medical TV shows) and their illness beliefs and attentional bias towards illness-related stimuli become entrenched. The box on this page provides an example of a case conceptualisation for a 37-year-old woman with health anxiety about bowel cancer.

Evidence-based treatment

CBT is the treatment of choice for patients with health anxiety. It involves:

- exposure to internal and external triggers (e.g. bodily symptoms and hospitals) and ceasing the use of safety behaviours (e.g. excessive reassurance seeking)
- reappraisal of unhelpful beliefs about symptoms and about coping with distress and uncertainty (e.g. 'I cannot get on with my life until all my symptoms are gone')
- acceptance and management of symptoms using the behaviour of people who do not experience health anxiety as a guide (e.g. 'How do most people manage a headache?')
- increasing pleasurable and meaningful activities, and engaging in positive health behaviours (e.g. improved diet and exercise).

CBT is ideally conducted by a specialist clinical psychologist or psychiatrist over eight to 16 sessions following a standardised treatment protocol.

Currently, there is only preliminary support for the use of selective serotonin reuptake inhibitors (SSRIs) in the treatment of patients with hypochondriasis. Empirical support for the use of antidepressants in patients with somatoform disorders is also limited and inconclusive. If there is prominent depression and/or comorbid anxiety disorders (e.g. panic disorder), consider treating these patients with an SSRI as per standard protocol; this may reduce somatic preoccupation and facilitate CBT.

Management in primary care

Patients with health anxiety may be reluctant to accept referrals to mental health specialists because they perceive their difficulties to be physical in origin. The following provides guidelines for using CBT to manage patients with health anxiety in the primary care setting.

Rule out physical illness

On initial presentation, conduct a thorough physical examination and investigation of symptoms as per standard care.

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Explain results in an empathic fashion

It may be helpful to book a long consultation to allow time for the patient to ask questions and understand the results of medical investigations. Emphasise that you understand the patient's symptoms are real and distressing. Validate the patient's anxiety and assure him or her that you do not believe the symptoms are 'all in their head'. However, explain that the symptoms are not associated with organic pathology. Some patients may find it helpful to know that medically unexplained symptoms are common in the general population.

Cope rather than cure

Describe that the recommended approach is based on coping with and tolerating symptoms rather than seeking to eradicate or cure them. Collaborate with the patient about how they can manage the symptoms using the behaviour of people who do not experience health anxiety as a guide.

Where appropriate, clearly identify when symptoms require further investigation (e.g. if a lump grows or changes colour). Schedule regular review appointments that are independent of symptom severity to avoid crisis-only consultations and to foster the coping-based approach.

Educate patients about psychological factors

Explore triggers for symptoms, as well as the factors that tend to relieve or aggravate difficulties (e.g. psychosocial stressors, anxiety, excessive checking behaviours or dwelling on negative feelings and thoughts).

Where possible, mutually develop a conceptualisation with the patient (see the box on page 66). Describe how psychological factors (e.g. thoughts, feelings, attention and behaviours) can influence physical sensations. Explain that when a patient is worried about his or her health, he or she will often pay a lot of attention to bodily sensations and engage in checking and monitoring behaviours. This increases the patient's sensitivity to bodily symptoms and increases anxiety. Invite the patient to experiment with reducing safety behaviours and coping with doubt and uncertainty. Where needed, provide public health guidelines for recommended check-ups (e.g. Pap smears every two years).

Reduce avoidance and checking behaviours

Seeking medical reassurance is a common safety behaviour that perpetuates anxiety. Provide limited reassurance once you have explained the results of medical investigations. If patients persist in seeking reassurance, discuss the CBT conceptualisation with them and explore if your reassurance actually helps them feel less anxious in the long term. Often patients acknowledge that the relief is short lived. Alternatively, set up an 'experiment' with the patient whereby you provide reassurance and then see if the anxiety has significantly reduced a week later.

Avoid over-investigating and over-treating symptoms, and discourage patients from consulting multiple physicians. When patients are reluctant to reduce checking behaviours and persist in seeking medical explanations, consider setting a date with them, say in a month, to review if their approach has significantly reduced their distress and disability. If it has not, there may be an opportunity to try the new approach of ceasing checking behaviours.

Bibliotherapy and CBT

Bibliotherapy is a readily accessible intervention. A sound CBT self-help approach to managing health anxiety is provided for patients in the book *It's Not All In Your Head*.[4] During appointments, ask patients about their reading and discuss how they can apply the skills and principles.

When a patient accepts a referral to a specialist clinician for CBT and/or pharmacotherapy, regular liaison with the clinician is ideal because it ensures that the patient receives unambiguous and consistent advice. It is particularly important that clinicians agree on guidelines regarding reassurance seeking and other safety behaviours.

Conclusion

Health anxiety is common and costly for the community. GPs are encouraged to manage patients using a cognitive behavioural model emphasise coping. This will with symptoms and uncertainty rather than providing continuous medical investigation and reassurance. Whenever possible, bibliotherapy and specialist referral are recommended. MT

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Further reading

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COMPETING INTERESTS: None.

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