Health anxiety: a hidden epidemic – and why we should take notice

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First

A bit of phenomenology and classification
DSM-IV Definition of Hypochondriasis

Hypochondriasis is characterised by preoccupation with either fears of having, or the idea that one has, a serious disease based on the person’s misinterpretation of bodily symptoms.

The definition requires that the preoccupation persists despite appropriate medical evaluation and reassurance, meaning that the failure of a psychological intervention (reassurance) by a doctor is required in order for the diagnosis to be made.

The preoccupation has additionally to cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
DSM-5 criteria for illness anxiety

- **Preoccupation** with having or acquiring a serious disease
- Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition the preoccupation is excessive or disproportionate
- There is a high level of anxiety about health, and the individual is easily alarmed about personal health status
- The individual performs excessive health-related behaviours (eg repeated checking of body) or exhibits maladaptive avoidance (eg avoid doctor or hospital appointments)
- The illness preoccupation has been present for at least 6 months
- The disease-related preoccupation is not better explained by another disorder (eg panic disorder).
Characteristics of health anxious patients

- Trigger
- Hyper-vigilance for bodily sensations and symptoms
- Misinterpretation of bodily sensations and symptoms
- Physiological reactions
- Adoption of safety seeking behaviours (including avoidance, checking and reassurance seeking)
- Affective changes (particularly anxiety and depression)
What I will be talking about:

(i) What is the likely prevalence of health anxiety

(ii) Why it is likely to be increasing

(iii) How it can be treated successfully
What needs to change in our thinking about hypochondriasis and health anxiety?

To stop thinking about it as a source of not very good jokes.

A man goes to his doctor and tells him he’s suffering from a long list of illnesses. ‘The trouble with you,’ says the doctor. ‘Is that you’re a hypochondriac.’ ‘Oh no,’ says the man. ‘Don’t tell me I’ve got that as well.’
My first psychiatric patient (SM)(1964)

‘Duirt me leat go raibh me breoite’
What needs to change in our thinking about hypochondriasis

• The experienced psychoanalyst’s view:

• ‘The hypochondriacal patient does not seek cure but palliation through a long-term relationship with the physician. If cure is the goal of physicians they will almost certainly be disappointed’ (Adler, 1981 p.1395)
LOS ANGELES (Reuters) - The family of "Top Gun" director Tony Scott told medical examiners the British-born filmmaker did not have brain cancer or any serious illness when he jumped to his death from a suspension bridge, a Los Angeles County Coroner Department official said on Tuesday. Craig Harvey, operations chief for the coroner, also said Monday's autopsy revealed Scott, 68, had no obvious signs of a heart attack. Media reports said to end a suicide note, police said.
What was wrong with Tony Scott?

• Could it be that he had pathological health anxiety?
Essential features of health anxiety

The fear that you are developing, or already have, a serious illness that has not been recognised

This fear persists even after medical reassurance

This fear is intrusive and interferes with everyday life

It is persistent and tends to continue for months or years

It can lead to suicide
Epidemiology of pathological health anxiety

• **Community prevalence:** Not fully known, but likely to be around 3-4% (Sunderland et al, 2013)

• **General practice prevalence:** Around 9%

• **Medical clinic prevalence:** 15-24%

• **General hospital prevalence:** probably 20%
Prevalence in medical clinics (data from CHAMP)

- Neurology 24.7%
- Respiratory medicine 20.9%
- Gastroenterology 19.5%
- Cardiology 19.1%
- Endocrinology 17.5%

- Overall 19% have abnormal health anxiety*

*Tyrer et al, 2011 – data from 28,991 patients in CHAMP
Why do we think the prevalence is increasing?

Cyberchondria
Health Anxiety inventory
Each question in this section consists of a group of four statements. Please read each group of statements carefully and then select the one, which best describes your feelings over the past six months.

1. I never worry about my health (0)
   • I occasionally worry about my health. (1)
   • I spend much of my time worrying about my health (2)
   • I spend most of my time worrying about my health (3)

2. I notice aches/pains less than most other people (of my age). (0)
   • I notice aches/pains as much as most other people (of my age). (1)
   • I notice aches/pains more than most other people (of my age). (2)
   • I am aware of aches/pains in my body all the time. (3)

3. As a rule I am not aware of bodily sensations or changes. (0)
   • Sometimes I am aware of bodily sensations or changes. (1)
   • I am often aware of bodily sensations or changes. (2)
   • I am constantly aware of bodily sensations or changes. (3)

4. Resisting thoughts of illness is never a problem (0)
   • Most of the time I can resist thoughts of illness (1)
   • I try to resist thoughts of illness but am often unable to do so (2)
   • Thoughts of illness are so strong that I no longer even try to resist them (3)
The typical story of health anxiety

It often starts with an event that acts like a trigger (eg childbirth)

This provokes anxiety symptoms, including bodily sensations, that are regarded as unfamiliar

These symptoms are monitored and often become more marked, after which they are judged to be evidence of serious disease

Medical consultations lead to temporary relief only (ie reassurance seems to work but only for a short time)

The focus on illness becomes more intense the longer the symptoms persist

Symptoms are accentuated by advice in emergency settings and internet browsing
Main CHAMP hypotheses

• (1) Primary outcome is reduction in health anxiety symptoms after one year (in CBT group)

• (2) Costs of care after two years are equivalent
Other hypotheses

• Generalised anxiety and depression, social functioning, and quality of life compared at all times of testing

• Patients with personality disorder, especially hypochondriacal personality disorder, would improve less than others

• Nurses would perform at least as well as psychologists as therapists
CHAMP trial assessments

- Baseline: HAI, HADS Scale (anxiety and depression, SFQ, EQ-5D, PAS-Q, ICD-11 provisional
- 3m: HAI only
- 6m: HAI, HADS, SFQ, Clinic & GP attendance, EQ-5D
- 12m: As for 6m
- 24m: As for 6m
Recruitment details

**Numbers of patients:** 444 patients recruited over 20 months. This involved five research assistants and 21 CSO’s from the North London and East Midland Hubs of MHRN visiting up to 20 clinics a week (ie it could not have been done without this extra help)

**Distribution by clinic:**
Cardiology 110
Endocrinology 84
Gastroenterology 149
Respiratory Medicine 59
Neurology 42 (highest proportion of high HAI scorers)

**Hospitals:** Chelsea & Westminster : 49, Charing Cross: 57; Hillingdon Hospital: 119; St Mary’s Hospital: 75; Kings Mill Hospital: 144
Results
Significance: P<0.001 or <0.01 at all times of testing

Note: Primary outcome is change in HAI scores at 1 year (P<0.001)
Self-rated generalised anxiety using Hospital Anxiety and Depression Scale (Anxiety)
# Changes in anxiety and depression scores in CHAMP

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Summary statistics</th>
<th>Results from mixed model analysis</th>
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<tbody>
<tr>
<td></td>
<td>N, mean improvement from baseline (SD)</td>
<td>Difference (95%CI) P value</td>
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<td>Visit -HA Standard Care</td>
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<tr>
<td>Health anxiety (HAI)</td>
<td>3 Months 205, 4.41 (7.63) 212, 2.62 (6.17) 1.79 (3.10, 0.48) 0.0076</td>
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<td></td>
<td>6 Months 197, 7.11 (7.83) 204, 2.33 (5.76) 4.86 (6.18, 3.53) &lt;.0001</td>
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<td>12 Months 194, 6.44 (7.47) 193, 3.20 (6.54) 2.98 (4.33, 1.64) &lt;.0001</td>
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<td>24 Months 190, 5.90 (7.54) 183, 3.66 (6.57) 2.05 (3.41, 0.70) 0.0030</td>
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<td>Generalized anxiety (HADS-A)</td>
<td>6 Months 197, 2.74 (4.41) 204, 1.46 (3.89) 1.29 (2.06, 0.52) 0.0011</td>
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<td>12 Months 194, 2.80 (4.40) 192, 1.67 (4.04) 1.04 (1.82, 0.25) 0.0095</td>
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<td>24 Months 189, 3.33 (4.57) 181, 2.07 (4.35) 1.00 (1.79, 0.21) 0.0137</td>
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<td>Depression</td>
<td>6 Months 197, 1.38 (4.32) 204, 0.51 (4.14) 0.78 (1.57, -0.01) 0.0529</td>
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<td>12 Months 194, 1.43 (4.44) 192, 0.43 (3.69) 0.79 (1.59, -0.01) 0.0527</td>
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<td></td>
<td>24 Months 189, 1.37 (4.95) 181, 0.51 (4.38) 0.63 (1.44, -0.18) 0.1263</td>
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<td>Measure</td>
<td>6 Months</td>
<td>12 Months</td>
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<td>----------------------------------------------</td>
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<tr>
<td><strong>Social function</strong></td>
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<td>197, 0.42 (4.46)</td>
<td>204, 0.39 (3.68)</td>
<td>0.14 (0.92,-0.63)</td>
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<tr>
<td>194, 0.57 (4.46)</td>
<td>192, 0.39 (3.65)</td>
<td>0.19 (0.98,-0.60)</td>
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<tr>
<td>190, 1.06 (4.76)</td>
<td>182, 0.83 (3.81)</td>
<td>0.21 (1.01,-0.58)</td>
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<td><strong>Health-related quality of life (EQ-5D scores)</strong></td>
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<tr>
<td>196, 0.04 (0.33)</td>
<td>203, 0.04 (0.35)</td>
<td>-0.00 (-0.06,0.06)</td>
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<td>194, 0.08 (0.34)</td>
<td>191, 0.08 (0.35)</td>
<td>-0.00 (-0.06,0.06)</td>
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<tr>
<td>189, 0.08 (0.32)</td>
<td>181, 0.07 (0.34)</td>
<td>0.02 (-0.04,0.08)</td>
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<td><strong>Health-related quality of life (EQ-5D visual analogue scale)</strong></td>
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<tr>
<td>189, 6.04 (29.94)</td>
<td>194, 2.33 (23.65)</td>
<td>4.32 (-0.27,8.90)</td>
</tr>
<tr>
<td>185, 7.06 (29.12)</td>
<td>184, 5.72 (25.20)</td>
<td>1.56 (-3.10,6.21)</td>
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<tr>
<td>183, 9.29 (30.43)</td>
<td>172, 5.81 (23.42)</td>
<td>4.06 (-0.87,8.79)</td>
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Figure 2.1.2: Mean HAI Score by Treatment and Clinic

- Clinic = Cardiology
- Clinic = Endocrinology
- Clinic = Gastroenterology
- Clinic = Neurology
- Clinic = Respiratory Medicine

Visit (Month):
- Screening
- 3
- 12

Main HAI Score:
- 25.0
- 22.5
- 20.0
- 17.5
- 15.0

Treatment:
- CBT-HA
- TAU
Adverse events

• CBT  Death = 3
  Deliberate self-harm = 0
• Is this ‘diagnostic over-shadowing?’
• Control  Death = 6
  Deliberate self-harm = 1
Comparison with CBT in anxiety disorders

- *Durham RC et al* Long-term outcome of eight clinical trials of CBT for anxiety disorders: symptom profile of sustained recovery and treatment-resistant groups.
- Few clinical trials of cognitive behaviour therapy (CBT) for anxiety disorders have conducted follow-up beyond one year post-treatment. Follow-up at 2-14 years with 396 patients.
- **Results:** Only 38% recovered with little or no treatment over the follow-up period while 30% had a very poor outcome despite extensive treatment for anxiety over many years. The symptom profile of this 'treatment-resistant' group was comparable to 76 patients with chronic depression and significantly worse than normative data for psychiatric outpatients.

**Conclusions:**
- The long-term outcome of anxiety disorders, irrespective of diagnosis or active treatment, is diverse but with a tendency towards chronicity. Distinctions between acute and chronic presentations of common mental disorders are more important than distinctions between chronic anxiety and chronic depression.
Nurses versus other therapists

• Did nurses do as well as psychologists in the study?

• Our trial adviser, Tim Beck, thought they wouldn’t
Nurses better than other groups at all times of testing (P<0.001)
Summary

Pathological health anxiety is very common in medical clinics

It causes long-term suffering and disability

It can be helped by a relatively simple psychological intervention

Nurses are very good cbt therapists and should be trained and deployed in every medical discipline
References


Tyrer P & Tyrer H (2014) Two CPD On-line modules on health anxiety

