



Scientia Psychiatrica

Journal Homepage: www.scientiapsychiatrica.com

eISSN (Online): 2715-9736

Hypochondriasis: A Literature Review

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ARTICLE INFO

Keywords:

Hypochondriasis
Somatoform disease
Delusional disorders

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The author has reviewed and approved the final version of the manuscript.

<https://doi.org/10.37275/scipsy.v3i1.85>

ABSTRACT

Hypochondriasis is one of six somatoform disorders categorized in the DSM-IV. Hypochondriasis is distinguished from other somatic delusional disorders because this disorder is associated with the experience of physical symptoms experienced by the sufferer, whereas other somatoform disorders do not show physical symptoms in themselves. Symptoms that arise may be an exaggerated statement of physical symptoms, which will actually exacerbate physical symptoms caused by the belief that the patient is sick and in a worse condition than the actual situation. Treatment of hypochondriasis includes recording symptoms, psychosocial review, and psychotherapy. Good prognosis is associated with high socioeconomic status, sudden onset, absence of personality disorders and absence of concomitant non-psychiatric medical conditions.

1. Introduction

Hypochondriasis is one of six somatoform disorders categorized in the DSM-IV. Hypochondriasis is distinguished from other somatic delusional disorders because this disorder is associated with the experience of physical symptoms experienced by the sufferer, whereas other somatoform disorders do not show physical symptoms in themselves. Symptoms that arise may be an exaggerated statement of physical symptoms, which will actually exacerbate physical symptoms caused by the belief that the patient is sick and his condition is worse than the actual situation. Somatoform disorders were introduced in the DSM-III as a diagnostic category for somatic symptoms that cannot be explained by a general medical condition.¹

Recent studies have reported a prevalence in the last six months of 4-6 percent in the general medical clinic population. However, this percentage figure can

reach 15%. Men and women are equally affected by hypochondriasis. Although the onset of symptoms can occur in any person, onset is most common between the ages of 20 and 30 years.²

Somatoform disorders are a group of disorders that have physical symptoms for which there is no adequate medical explanation, with the main character being a persistent preoccupation with the possibility of suffering from one or more serious and progressive physical disorders. Attention is usually focused on one or two organs or body systems. Often accompanied by depression and severe anxiety. Patients with hypochondriasis disorder usually present with fear and concern for their disease rather than the symptoms they feel, patients believe that they are suffering from a serious disease that has not been

detected and cannot accept an explanation for their disorder.^{1,3}

In hypochondriasis, patients usually complain of severe disease and the investigation does not find any underlying disorder. The patient feels certain that there is something wrong with him and always wants to be checked for any disturbances in his body. Another thing that is different from somatization disorder where patients usually ask for treatment for their disease which often causes drug abuse, then in hypochondriac disorders the patient is even afraid to take medicine because it is thought that it can increase the severity of the pain.

Somatoform disorders require creative and bio-social treatment planning by clinicians who include general practitioners, sub-specialists, and professional psychiatrists. Management strategies for hypochondriasis include symptom recording, psychosocial review, and psychotherapy.^{1,3}

Hypochondriasis is a diagnostic category remains controversial despite good evidence of the occurrence of a series of illness beliefs, related to distress and seeking medical help, these symptoms are said to be better understood as a form of anxiety that occurs to focus on a health problem, and is closely related to the form of hypochondriasis. other than anxiety disorders.

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Overview of hypochondriasis

Hypochondriasis is defined as a person who is preoccupied with the fear or belief that he has a serious illness. Patients with hypochondriasis have unrealistic or accurate interpretations of physical symptoms or sensations, even if no medical cause is found. The patient's preoccupation causes suffering for himself and interferes with his ability to function properly in the social, interpersonal, and work fields.⁵ (Psychiatric Fk ui) In contrast to somatization disorder where patients usually ask for treatment for their illness which often leads to drug abuse, hypochondriac disorders. The patient is even afraid to take medicine because it is thought that it can increase the severity of the pain.

The main feature of hypochondriasis is a focus or fear that a person's physical symptoms are the result of a serious underlying disease, such as cancer or heart problems. This disorder most often appears between the ages of 20 and 30, although it can occur at any age. The prevalence of hypochondriasis is 4-6% of the general medical patient population, and the highest probability is 15%. The onset of symptoms can occur at any age but is most common at the age of 20-30 years. The incidence rate is not influenced by social strata, education, or marriage. Complaints of hypochondriasis occur in 3% of medical students, which generally occurs in the first 2 years of education but is only temporary.⁵

People with hypochondriasis do not consciously fake their physical symptoms. They generally experience physical discomfort, often involving the digestive system or a mixture of aches and pains. In contrast to conversion disorder, which is usually characterized by an indifference to symptoms, people with hypochondriasis are very concerned, even really care too much about their symptoms and the things that may represent what they fear.

In this disorder, the person becomes very sensitive to minor changes in physical sensation, such as slight changes in heart rate and slight aches and pains. Whereas anxiety about physical symptoms can cause physical sensations themselves, such as excessive sweating and dizziness, and even fainting. They have more health concerns, and more psychiatric symptoms, and perceive poorer health than others. Most also have other psychological disorders, especially major depression and anxiety disorders.

Epidemiology

One recent study stated that the prevalence of hypochondriasis in the last six months was 4-6 percent in the general medical clinic population. However, this percentage figure can reach 15 percent. Men and women have the same ratio to suffer from hypochondriasis. Although the onset of symptoms can occur in any person, the onset is most common between the ages of 20 and 30 years.¹

Primary hypochondriacal disorders are more common in people of lower social classes, young people, and the elderly. Hypochondriasis is also found in 3 percent of medical students, especially in the first 2 years of education but is temporary. Some evidence suggests that the diagnosis is more frequent among blacks than whites. Marital status does not appear to have a diagnosis. ¹

Etiology

In the diagnostic criteria for hypochondriasis, the DSM-IV states that symptoms reflect bodily symptoms. Sufficient body data suggest that hypochondriacal people increase and magnify their somatic sensations; they have a lower threshold and tolerance for physical disturbances. For example, what a normal person perceives as abdominal pressure, a hypochondriacal person may focus on bodily sensations, misinterpret them and become signaled by them because of faulty cognitive schemas.

Another theory suggests that hypochondriasis can be a learned trait that begins in childhood when family members are often exposed to a disease. Another proposed etiology is that hypochondriasis is part of a depressive or obsessive-compulsive disorder with a focus on symptoms of physical complaints. ⁶

The second theory is that hypochondriasis can be understood based on social learning models. The symptom of hypochondriasis is seen as a desire to get sick by someone who is facing a problem that seems severe and unsolvable. The sick role provides a way out, as the sick patient is allowed to avoid anxiety-provoking obligations and delay the unwelcome and forgivable challenge of normally expected obligations.

A third theory is that this disorder is a variant form of another mental disorder. The disorders most often hypothesized to be associated with hypochondriasis are depressive disorders and anxiety disorders. It is estimated that 80 percent of patients with hypochondriasis may have a depressive disorder or an anxiety disorder that coexists. ⁶

The fourth line of thought about hypochondriasis is the field of psychodynamics which holds that

aggressive expectations and hostility toward others are transferred to physical complaints. The hypochondriacal patient's anger stems from disappointment, rejection, and loss in the past, but the patient expresses it in the present by asking for help and attention from others and subsequently rejecting it because it is ineffective. Hypochondriacal are also seen as a defense against inherent guilt, an expression of low self-esteem, and a sign of excessive self-care. Pain and somatic suffering subsequently become tools for atonement and cancellation and can be experienced as punishment for past wrongs and feelings that one is evil and shameful. ⁶

Pathophysiology

Neurobiochemical deficits associated with hypochondriasis and other somatoform disorders such as somatization disorder, contrition, and body deformity are seen in conjunction with mood and anxiety disorders. Hollander et al described the "obsessive-compulsive spectrum" to include obsessive-compulsive disorder, body dysmorphic disorder, anorexia nervosa, Tourette's syndrome, and impulse control disorders (e.g., trichotillomania, pathological gambling). Other authors have postulated that somatoform disorders such as hypochondriasis may be the result of the patient's unconscious habits to avoid internal conflicts and external stressors. ^{1,7}

This formulation of obsessive-compulsive spectrum disorder, although not part of the consensus diagnostic and classification of psychiatry, crosses the path of some of the diagnostic categories in the DSM-IV. Although the case encounters of these neurobiokinetic deficits are mild, some of the deficits demonstrate why symptoms may become exaggerated, and result in comorbidities, and why effective therapy parallels one person to another. ⁷

In a recent study of biological markers, studies based on the diagnostic criteria for DSM-IV hypochondriasis found that there were decreased levels of neurotrophin 3 (NT-3) and platelet serotonin (5-HT) in plasma compared with control subjects. NT-

3 is a marker of neuronal function while platelet 5-HT is an important marker of serotogenic activity.¹

Clinical overview

Patients with hypochondriasis typically present with fear and concern about their disease, rather than the symptoms they experience. Hypochondriacal patients believe that they have severe, undiagnosed disease and they cannot be convinced of the opposite. Hypochondriacal patients may maintain the belief that they have a particular disease or over time, they may change their beliefs about a particular disease. This belief persisted even though the lab results were negative. They continue to harbor the belief that they have a serious illness. Hypochondriasis is usually accompanied by symptoms of depression and anxiety and is usually associated with depression and anxiety disorders.⁸

The patient has an intense and persistent fear of the disease. They are wary of indications of even a very mild illness, but for them, it is a very strong signal. Their body preoccupation is severe and extends to their general health status. Patients self-examine their own bodies intensely. They have a habit of visiting general practitioners and hospital clinics and have a large history of medical treatment. In the end, they are still dissatisfied with their contact with the medical profession which they often criticize and blame for their continuing complaints. Bad doctor-patient relationships are common.⁸

Although the DSM-IV states that symptoms must be present for at least six months, a transient hypochondriacal state can occur after severe stress, most often death or serious illness in someone important to the patient, or a serious (possibly life-threatening) illness that has been cured but leaves the patient hypochondriacal. temporarily with the consequences. Such a hypochondriacal condition lasting less than six months should be diagnosed as a somatoform disorder not classified as a somatoform disorder. Transient hypochondriacal response to external stress usually resolves when the stress is relieved but can become chronic if reinforced by people

in the patient's social system or by a healthcare professional.

Diagnosis

Diagnosis of hypochondriasis (F45.2) based on PPDGJ III, both of these must be present:⁹ Persistent belief in the existence of at least one serious physical illness that underlies the complaints, even though repeated examinations do not support the existence of adequate physical reasons, or there is a persistent preoccupation with possible deformities or changes in physical appearance (not until delusion); does not want to receive advice or support explanations from several doctors that there is no disease or physical abnormality that underlies his complaints.

Meanwhile, based on the diagnostic and statistical manual of mental disorders, the Fourth Edition (DSM-IV) defines hypochondriasis (F45.2) based on the following criteria:^{3,9} The preoccupation with the patient's fear or the idea that he or she has a serious illness is based on the person's misinterpretation of bodily symptoms; the preoccupation persists despite proper medical examination and reassurance; beliefs in criterion 1 have no delusional intensity (as in delusional disorder, somatic type) and are not limited to limited concerns about appearance (as in body dysmorphic disorder); the preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; the duration of the disturbance is at least 6 months; the preoccupation is not better defined by a generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, major depressive disorder, separation anxiety, or another somatoform disorder.

Treatment

Hypochondriacal patients are usually resistant to psychiatric treatment. Some hypochondriacal patients receive psychiatric treatment if they do receive psychiatric treatment if done in a medical setting and focus on reducing stress and education about coping with chronic illness. Among these patients, group psychotherapy is the method of choice because in part

it provides social support and social interaction that appears to reduce the patient's anxiety. Insight-oriented individual psychotherapy may be useful but is usually not successful.¹⁰

An orderly and regular schedule of physical examinations is useful to reassure patients that they are not neglected by their doctor and that their complaints are taken seriously. However, invasive diagnostic and therapeutic procedures should be performed if only objective evidence requires it. Whenever possible the clinician should refrain from treating ambiguous or coincidental physical examination findings.¹⁰

Pharmacotherapy relieves hypochondriacal symptoms only if the patient has a drug-responsive underlying condition such as an anxiety disorder or major depressive disorder. If the hypochondriasis is secondary to another primary disorder, the disorder must be treated for the disorder itself. If hypochondriasis is a temporary situational reaction, the clinician must help the patient to cope with stress without encouraging their sick behavior and using the sick role as a problem solver.¹⁰

Management is usually carried out by a general practitioner because the patient is often unable to receive a referral to a psychiatrist. Obviously, the organic disease is otherwise ruled out and any primary psychiatric disorder such as depression should be treated.¹¹

Specific psychiatric therapy may be useful if the individual is aware of the emotional difficulties that are causing the physical complaints. Psychiatric therapy is preferably given in a non-psychiatric clinical setting, with an emphasis on reducing psychosocial stress and educating about the role of psychological factors in the onset of symptoms and how to manage these symptoms. Physicians should be aware that symptoms clearly appear to serve as a strong and all-out psychological defense. Cognitive-behavioral therapy is the specific therapy of choice.¹¹

Antidepressant drugs, especially the SSRI type, are recommended by some experts for all these patients, especially if most of the hypochondriacal symptoms in

the general population are due to depression. Antidepressant therapy is of course a second-line treatment option if cognitive-behavioral therapy fails or if there is significant comorbidity or severe symptoms. Group psychotherapy is the psychotherapeutic approach of choice although the primary goal of therapy is usually supportive rather than curative.¹¹

Overall, the patient's symptoms due to psychological and social reasons and the absence of specific surgical or medical interventions that can cure the desire to get sick should be kept in mind. The goal is to be able to focus on the patient as a whole. The patient should be monitored regularly and attention should be paid to any social and personal circumstances that are thought to give rise to the patient's complaint.¹²

Specific medical interventions should be reduced, e.g., simple physical examination. The main therapy is the personal attention of a doctor. Invasive and complex diagnostic therapeutic procedures should be performed when there is a real benefit to their use, and incidental abnormalities and significant findings should not be treated.¹³

Pharmacotherapy is used as a complement to psychotherapy and educational therapy. The goals of pharmacotherapy are to reduce symptoms and associated disorders (e.g., depression), prevent complications, and to reduce hypochondriac symptoms.^{1,11}

Hypochondriasis is almost always accompanied by depression, anxiety, and obsessive-compulsive disorders. If any of the above disorders are present, appropriate management must be carried out. Usually, pharmacological therapy is given by starting at a low dose, then increasing it to the therapeutic dose. This is to prevent side effects where patients with hypochondria disorders are very sensitive to drug side effects.^{10,11}

Cognitive therapy

The goal of cognitive therapy for hypochondriasis is to lead patients to recognize that their main problem

is the fear of suffering from a disease and not suffering from it. Patients are also asked to self-monitor the concerns that arise and evaluate the facts and reasons. The therapist also persuades the patient to consider alternative explanations for the physical signs they usually interpret as a disease. Experiments on habits are also used as an attempt to change the patient's habits of mind. In summary, patients are told to focus intensely on specific physical symptoms and monitor for increased anxiety as they arise. Families also need to be included to observe the anxiety that arises.^{1,6,11}

Prognosis

The course of the disease is usually episodic; episodes last from several months to several years and are separated by periods of repose of equal length. There may be a clear relationship between exacerbations of hypochondriacal symptoms and psychosocial stressors. Although the results of large studies have not been reported, it is estimated that one-third to one-half of all patients eventually improve significantly. A good prognosis is associated with a high socioeconomic status, a sudden onset of symptoms, the absence of a personality disorder, and the absence of concomitant non-psychiatric medical conditions. Most hypochondriacal children recover in late adolescence or early adulthood

Patients with a good premorbid psychological history usually have only hypochondriasis, while those with acute illness or stress have a good prognosis and complete recovery. Meanwhile, if the symptoms are caused by a generalized anxiety disorder or depression, the prognosis will be better.^{9,13}

2. Conclusion

Hypochondriasis is a neurotic disorder characterized by a milder focus of symptoms than the belief that one has a certain disease. Hypochondriasis is one of six somatoform disorders categorized in DSM IV. It is distinguished from other somatic delusional disorders in that it is associated with the experience of physical symptoms experienced by the sufferer.

Whereas other somatoform disorders do not show physical symptoms in themselves. Management of hypochondriasis includes a recording of symptoms, a psychosocial review, and psychotherapy. Good prognosis is associated with high socioeconomic status, sudden onset, absence of personality disorders, and absence of coexisting nonpsychiatric medical conditions.

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