Hypochondriasis and disease-claiming behaviour in general practice

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Problems of definition

Hypochondriasis presents as a frequent problem in general practice. There is a need both to exclude physical illness and to protect the patient from unnecessary and expensive referrals and investigations. The hypochondriac is also prone to invoke anger in the physician as the patient continues to complain, refuses to accept reassurance or acts aggressively. Both anger and undue sympathy interfere with objective treatment.

The hypochondriac is a problem for the taxonomist. The term was coined to describe patients with abdominal symptoms accompanied by mood disturbance (Gillespie, 1929). However the term is now more commonly used to describe patients presenting a bodily complaint for which no adequate physical cause can be found (Brown, 1936). For some authors hypochondriasis can be equated with depression (Kenyon, 1964). Others stress a multiplicity of complaints (Ray and Advanti, 1962), so that their patients resemble hysteria (in the sense defined by Guze and Perley in 1963). Thus Richards (1940) talks of hypochondriasis as a simple or diffuse eruption of somatic complaints.

In order to study hypochondriasis appearing in general practice, attention was paid to what Pilowsky (1969) called "abnormal illness behaviour". In this category it was possible to include simultaneously:

(1) those with sensations mimicking physical disease (sensohypochondriacs of Leonhard, 1961),

(2) those convinced, without foundation, of specific physical illness (ideohypochondriacs),

(3) those claiming illness, without the physician being sure that the patient had either of the above experiences (malingering).

This avoids the need to conjecture as to the contents of the patient's consciousness as well as certain semantic difficulties. Somatic symptoms which the patient correctly interprets as psychogenic are not included, e.g. in phobic anxiety.

The term, 'abnormal illness behaviour', appears over-inclusive to me; the term *disease-claiming behaviour* is preferred. This behaviour was seen for this study as relating only to the doctor; family games and strategies are thus excluded. Pilowsky stressed that these patients sought a sick role, legitimising their illness, and that usually their actions could be seen as a personal interpretation of internal phenomena.

VARIETIES OF HYPOCHONDRIASIS AND DISEASE-CLAIMING BEHAVIOUR

Organic intracranial	Early senile dementia
	Arteriosclerotic dementia
	Cerebral trauma
	Epileptic personality change
Functional varieties	'Normal hypochondriasis'
	Depression and somatic anxiety
	(a) Due to physiological changes
	(b) Accompanying other physical illness
	(c) Involutional and senile depression
	(d) Masked depression
	(e) Mourning
	(f) Situational reactions

Hysteria
Chronic hypochondriasis
(a) Obsessional neurosis
(b) Paranoid state
(c) Schizophrenia
Malingering

Objective

Disease-claiming behaviour was noted in patients seen during a period of three consecutive months in locum general practice. Such practices were often in a state of flux, e.g. from changes in partners or from illness, so that patterns of doctor-patient communication were disrupted. The high incidence of hypochondriacal complaints may be related to a regression to primitive modes of communication using iconic or body language (Szaz, 1961). Immigration and unemployment had contributed to a state of anomie in the practice area.

The varieties of hypochondriasis seen were varied, and contrast with hospital practice. They have been illustrated by cases seen in general practice over a period of three months:

Organic hypochondriasis

This is seldom seen in general practice.

'Normal hypochondriasis'

A small degree of self concern and unrealistic fear of the presence of illness, not necessarily amenable to simple reassurance, may be accepted as part of the normal distribution of self-consciousness. This is more marked in certain cultures, e.g. Indian and Jewish races. Over-concern and 'loose talk' on the practitioner's part may contribute to iatrogenic forms of hypochondriasis.

Depression and anxiety

Depression is by far the most important variety of hypochondriasis; the diagnosis is easily missed as mood change may not be mentioned or even be absent. The response to correct treatment is most gratifying. Moreover, hypochondriacal depression represents a clear suicidal risk.

(1) *Undue concern over the physiological changes of depression and anxiety*

In depressive illness there are characteristic changes of physiology, sleep disturbance, anorexia, loss of libido, slowing of peristalis and constipation. Anxiety and agitation may provide a basis for further disturbance, e.g. palpitation, dyspnoes, and headache. The patient may present with these rather than with depression.

Case 1—A woman of 33 complained of a month's illness, i.e., headache, dry mouth, diarrhoea and weakness in the legs. Enquiry elicited depression of mood with early morning waking and loss of libido. No reactive factors were apparent.

Chronic insomnia is frequently of depressive origin (Parish, 1971).

Cases of simple hypochondriasis are very common. Some are missed and referred to hospital outpatients (Maclay, 1965), where they are not always recognised.

Case 2—A newly wed young woman was seen who complained of backache. A gynaecologist had arranged a ventrosuspension operation, (despite her nulliparous state). She voiced to me fears that her sexual performance at the honeymoon had been inadequate. Simple discussion and reassurance resulted in an early return to work.

(2) *The depressive delusions may be an accompaniment to existing physical illness*

Case 3—A man of 48 had a prolapsed intervertebral disc treated with plaster cast nine months before. Although physical signs of back and leg trouble had cleared, he continued to complain of bilateral girdle pains, sufficient to prevent employment. Enquiry elicited depressed mood, ruminations, early waking and diurnal variation of mood.

Milder cases are often simple phobic or somatised anxiety triggered off by illness. Often the site of hysterical symptoms shows the 'reliving' of a previous illness. Such hysterical symptoms are commonly lit up by a masked depressive illness or reactive anxieties.

Case 4—A man of 55 in fear of losing his job developed pain in the chest over the site where a fractured rib was diagnosed four years earlier.

(3) *Involutional and senile depression*

This should be the first functional diagnosis to exclude in the older age group (De Alarcon, 1964). In the involutional age group, depression may not be complained of or may even denied, yet the demeanour of the patient shows clearly that the patient is depressed and usually agitated.

The complaint is typically made with irritable peevish importuning and is usually centred on the bowels with fears of constipation, blockage and bowel growth which are unrelieved by the daily passage of a normal stool. Weight loss is often marked. These patients require admission for electroconvulsive therapy if the condition is at all advanced. A similar hypochondriacal depression may be seen in old age when nihilistic delusions are more common.

Only one mild and atypical case was seen. This contrasts with the frequency with which such cases are seen in hospital practice.

(4) *Masked depression*

This term is useful when symptoms of a neurotic type can be shown to have erupted from a mild depressive reaction which was not obvious. Depressive mood may be negligible or entirely absent (Lopez Ibor, 1972).

Case 5—An Indian of 67 complained of pain down the entire left side of the body with cough and fear of heart disease. Follow-up and careful enquiry elicited sadness, weeping, early morning waking and diurnal variation of mood.

Kenyon (1964) drew attention to the fact that referral of symptoms exclusively to the left side of the body was nearly twice as common as referral to the right side in hypochondriasis.

(5) *Mourning*

Without evidence of psychiatric depression, mourning is observed to cause hypochondriasis.

Cases 6 *and* 7—Two patients were seen in states of grief; both had suffered a stillbirth within the preceding three months. There were no symptoms or signs of depressive illness.

One patient showed pain in the back and chest, the second held her legs painfully 'fixed' in adducted extension—she was prohibited by her religion from using any form of contraception other than the prevention of intercourse.

(6) *Anxiety reactions and situational depressive reactions*

In mild form these are frequently encountered in general practice and respond well to supportive therapy and simple environmental manipulation without drugs.

Case 8—A patient of 40 constantly sought emergency treatment for pain in the chest. These pains were short-lived and always followed a row with his wife over who should look after the children. The family were referred for marriage guidance.

Sensitivity states can encourage hypochondriasis

Case 9—A boy of 16 with sensitivity feelings was overconcerned with barely-visible acne.

De-personalisation syndrome and phobic anxiety also produce somatic complaints masquerading as physical illness. Phobic ruminations of illness are discussed with obsessional illness.

Hysteria

Hysterical symptoms as a part of another functional mental illness, usually depression, or as a personality trait (a way of life) are common. One should be very cautious of making diagnosis of hysteria itself, particularly in the older age groups. Follow-up studies show how often psychosis or physical illness appear which could have accounted for the syndrome. The acute hysterical conversion reaction is uncommon in general practice, although I saw two examples recently.

Case 10 A man of 52 had difficulty at work. Following an operation for varicose veins, he developed ataxia abasia and claimed his vision was upside down. There were no neurological signs, no abnormal signs in the legs and no mood disturbance. The condition remitted in two weeks.

Case 11 A woman of 39 called the duty doctor in the night for relief of acute back pain. Two days later she again called with severe pain in both eyes with blurred vision, such that she could barely see. She feigned inability to walk. Her condition settled within 12 hours of admission to a psychiatric hospital. The illness arose out of fury that her brother should leave her home to marry.

Although hysteria *per se* is uncommon, an hysterical personality (with labile emotion,

frequent complaints and manipulative manner) is frequently present alongside hypochondriacal symptoms, especially when there is an obsessional element in addition.

Case 12 A woman of 45 gave a 22-year history of neurosis starting from operations for ovarian cyst, appendix and fistula in ano and followed by cardiac neurosis and dyspareunia. She recently attended with five days paraesthesiae of the left side from head to toe. There was much self concern, but no neurological signs.

Hospital addiction (Munchhausen syndrome) and hysterical pseudopsychosis (complaints of hallucinations) also occur in severe hysterical personality disorders. Disease-claiming behaviour may sometimes be the simulation of psychosis or nervous illness (Ritson *et al.*, 1970).

Case 13 A woman of 29 had been the rejected child of an alcoholic father and mother who claimed madness and repeatedly threatened suicide. In her teens she nearly died of pneumonia, and retained from then a fear of imminent death. She married to escape her parents. She sought to dominate her family, and had realistic fears of harming the children. Following an argument with her sister, she renegotiated admission to hospital by a small overdose. While there she often spoke of 'hearing hallucinations' and seeing visions. There was no evidence of psychosis and her reality testing was sound. She was discharged with difficulty.

Chronic hypochondriasis

There remains a group of intransigent hypochondriacs often of mixed aetiology, in whom obsessional ruminations of illness (i.e. unwanted but compulsive thoughts in the presence of insight) shade into paranoid reactions (i.e. indulged false beliefs of illness held with total conviction yet not associated with psychosis). Occasionally such conditions have been called monosymptomatic schizophrenia or malignant hypochondriasis.

Although they consume the *attendant's* time and energy, the *patient* does not deteriorate or dement so the term malignant seems inappropriate. One or two mild cases occur in most group practices, but they occupy a small place in psychiatric hospital statistics, though they may be seen in medical outpatients.

(1) *Obsessional neurosis presenting with hypochondriasis*

Obsessional thoughts (as defined above) may take the form of compulsive thoughts of, and unrealistic fears of, illness and death; often there is a co-existent compulsion to seek investigation and reassurance. When these features are combined (as in case 12) with histrionic behaviour and attention seeking, one is faced with a formidable problem.

Usually, as in this uncomplicated case, there is a history dating back to the twenties, if not the teens.

Case 14 A woman of 63 had several months pain in the loin with frequency and dysuria. Her urine was sterile and all physical investigation was unrewarding. There was stress incontinence and undue concern over urinary function together with weeping, anorexia and delayed insomnia. She was frigid. As a child, her three brothers died in infancy. Her parents made it clear that she should have been a boy. Her mother was so strict that she insisted the child ran home from school without first urinating. She would wet herself with anxiety and be daily punished for this. Since then she has had fears and fantasies concerning urinary function.

Obsessions and fears of illness are often exaggerated by a depressive component on top of the basic obsessional neurosis and occasionally require ECT.

(2) *Paranoid hypochondriasis*

Occasionally the idea of disease becomes too deeply entrenched to be queried by the patient without a violent reaction, and remains firmly held despite incontrovertible evidence to the contrary. Where this occurs, in the absence of a psychosis, it may be labelled a paranoid reaction. Often this takes place, as below, in the presence of a deep-seated personality disorder. The patient's condition seldom changes much, despite treatment, though occasionally paranoid psychosis supervenes.

Case 15 A man of 50, whose mother and brother had both been hypochondriacal, first sought help at the age of 23 for sickness and abdominal pain. This complaint continued and became a conviction of the presence of a bladder growth. He believed that dental extraction might cause cancer, but expressed few other bizarre ideas. He was self conscious and often dreamed he was being spied upon. He was unhelped by physical treatment and psychotherapy, and he abused medication.

More rarely an acute paranoid syndrome is observed to give rise to hypochondriacal anxiety.

Case 16 A man of 42 attended several weeks running with the complaint of breathlessness. There was no objective evidence of respiratory insufficiency or disease. Although a local character, he always brought a young negro child with him, (his wife and his other five children are white). Convinced that his wife had not cuckolded him, he sought a medical explanation for the child's dark skin and Asian features! He felt teased and sensitive about his neighbours' and workmates' opinions and this resulted in respiratory symptoms.

(3) *Schizophrenia*

Hypochondriasis in the young demands careful examination. The presentation of schizophrenia illness may be suggested by the pseudo-profundity with which the illness is discussed, or by the bizarre description of symptoms (e.g. ball-bearings in the knee). Such people may conceal psychotic symptoms for many years.

Case 17 At the age of 31, a married woman complained of stiffness of arms and legs. She was treated with ECT for depression, but relapsed three times. At 43 she was tearful and perplexed, with black-outs, tinnitus and vomiting. She believed that she had an abdominal tumour, and later had the idea that she had changed sex. Her affect flattened and at 44 (two years ago), the diagnosis of schizophrenia became clear.

Malingering

Finally, malingering, though uncommon, may occur. It may be simple, or a well thought-out piece of complex acting. The former is more common.

Case 18 An Indian of 32 complained of pain in the chest. He quickly admitted that his wife was in hospital with pre-eclamatic toxaemia, and that he needed a certificate to stay at home and look after their young family.

Conclusions

Hypochondriasis occurs frequently in general practice. Organic illness must be excluded without excessive investigation and specific treatment started. The commonest cause is depression. This should always be suspected, especially where neuroticism and hypochondriasis are first seen after the age of 40. Schizophrenia is a rare cause, presenting in young patients, and frequently not recognised.

The hard core of intractable hypochondriacs show obsessional, hysterical or paranoid features, though any of these may be exaggerated by mood swings.

Summary

Hypochondriasis has been defined, for the purpose of investigation of this condition within general practice, in terms of disease-claiming behaviour and the varieties of this likely to be encountered are classified.

Typical cases, selected from those seen in general practice in a three-month period, are briefly described. These show the range of patients. Among the less common cases seen were hysterical conversions, hypochondriasis following mourning, and an acute paranoid hypochondriasis.

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