

# Hypochondriasis, its Treatment, and Exposure to the Imaginative Illness and Death Experience

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## Abstract

Patients concerned about their health are often unable to describe particular consequences of their imaginary disease. Since their thoughts and ideas produce severe anxiety, they try to block them. Therefore, persons with excessive worries about their health try not to think about the feared disease and to control their thinking by distracting their attention. This is referred to as cognitive avoidance. However, their effort “not to think about the disease” means that they think about it all the time. Our method of “imagining illness and death” is based on a therapeutic dialogue using inductive and Socratic questioning to help overcome cognitive avoidance. Patients are made to think about the worst variants of their imaginary disease and the future with it. Gradually, they imagine the worst consequences for both themselves and their relatives. The interview guides them through the severe course of their disease, its physical, mental and social consequences, dying and death experience with all emotions and details they can imagine. Then patients are asked about their fantasies about life after death. For next sessions, patients always bring written concepts of what was discussed during previous visits. The texts are read at the beginning of each session, with patients imagining everything. Gradual habituation observed, in our experience, after several exposures, lead to a significant decrease in anxiety symptoms, safety and avoidance behaviours.

## INTRODUCTION

All forms of avoidance and safety behaviour help in maintaining the patient’s negative assumptions. Therefore, the patient must be encouraged to face the feared situations or to resume the activities avoided due to his or her anxiety. This is the only way to find out if the feared consequences do appear. In hypochondriasis, a typical safety strategy is cognitive avoidance of the so-called “worst scenario”.

So far, little is known about the aetiology of hypochondriasis. It is very likely a learned behaviour. However, the patients may be inherently predisposed by a lower threshold of pain and increased sensitivity to bodily sensations (Barsky & Klerman 1983). According to the *psychodynamic* explanation, cumulative aggressive and hostile wishes towards others or sexual fantasies are transferred (via repression and displacement) into physical complaints (Stoudemire 1988). The patient's anger comes from past disappointments, refusals or losses but it is currently expressed by requesting other people's attention and help that he or she may refuse as ineffective. Hypochondriac symptoms may also be viewed as a defence against feelings of guilt (for past sins, actual or imaginary, sexual fantasies etc.), expression of low self-esteem or feeling bad at heart. Hypochondriasis is also often reported to be associated with castration anxiety. The condition has been classified as an obsessive-compulsive spectrum disorder (Hollander *et al* 1992), based on the phenomenological similarity between obsessions and hypochondriac thoughts that the patient is unable to neutralize without safety behaviors and reassurance (Martin & Yutzky 1997).

According to the theory of learning, the difficulties arise by classical conditioning (symptoms that appear and lead to anxiety are triggered by stimuli causing anxiety) and are maintained by operant conditioning (avoidance behaviour and reassurance resulting in negative reinforcement) and cognitive processing (frightening thoughts, focused attention) (Salkovskis & Warwick 1986; Stern & Fernandez 1991).

Thus, the patient assumes the role of an ill person to avoid problems in his or her life that are unpleasant or difficult to deal with.

*A feeling of danger:* Inaccurate information, misinterpretation of benign bodily sensations that appeared in a period of increased stress or somatic symptoms of a real disease, produces a feeling of danger, leading to a stress reaction.

*Increased observation of physical problems:* The feeling of danger results in increased perception of sensations induced by the vegetative nervous system. For example, the patient notices gripping pains in the stomach. It occurs to him or her that it might be cancer. The gripping sensation becomes stronger. This "confirms" the initial interpretation. Focusing one's attention also means that common feelings, previously unnoticed, are now monitored as at least "strange". The person may notice an irregular breathing pattern, "flies" in the visual field, pale nail beds etc. He or she makes the observation for the first time and believes that there has not been anything like this before. This only confirms the patient's worries. Focusing one's attention may also lead to real changes in the functioning of physiological systems under both involuntary and voluntary control (e.g. breathing, swallowing, muscle activity). For instance, the patient notices difficulties in swallowing dry foods and considers them to be a symptom of throat cancer. He or she focuses on swallowing, putting more effort into it which only increases the discomfort.

*Increased physiological activation:* The feeling of danger also increases physiological activation of the vegetative nervous system. Various physical symptoms related to this activation appear. These include excessive sweating, acroparesthesia, itchy skin, heaviness in big muscle groups, headache, hyperventilation etc.

*Checking and searching for reassurance:* The patient starts to monitor his or her physiological functions systematically. This involves frequent measurements of pulse, temperature, blood pressure or anything related to the concerns. As he or she is searching for pathologies, checking the functions brings no relief but further anxiety. He or she is frightened by any small deviations from what he or she considers "normal". The person starts visiting doctors, insisting on more and more investigations. Due to the health concerns, he or she seeks further confirmation of his worries in the physicians' explanations. Unclear conclusions, resulting from the absence of apparent physical disorders, are a breeding ground for catastrophic interpretations. The patient easily devalues any positive reassurance from the doctors by thinking that "they do not tell the truth anyway because they want to spare me." He seeks advice from several doctors, just in case. Their conclusions may be similar but may differ in details. This produces more uncertainty and worries.

*Avoidance behaviour:* The stimuli increasing anxiety may be omnipresent (media articles about diseases, questions about how the patient feels, other patients discussing diseases in the waiting room etc.) and, moreover, these are paradoxically searched for to get a feeling that "nothing is neglected". Therefore, typical avoidance behaviour such as that in phobias is relatively rare in these cases (e.g. avoiding physical activity so as not to worsen the condition). Instead, patients resort to *behaviour that might ward off the catastrophe*. This typically involves checking one's body functions, measuring blood pressure, pulse, temperature etc., repeated self-examination, need for doctors' reassurance, visiting various healers, insisting on further investigations etc. In fact, all this behaviour makes the patients focus even more on their worries, so their subjective experiences are maintained or even worsened. Some types of avoidance behaviour may even directly influence the symptoms. For example, avoiding tiring physical exercise results in gradual muscle weakening. Within several weeks, performance decreases and fatigue occurs even after the slightest physical activity.

*Cognitive avoidance:* Patients with health concerns are often unable to describe particular consequences of their imaginary disease. Since their thoughts and ideas produce severe anxiety, they try to block them. Therefore, persons with excessive worries about their health try not to think about the feared disease and to control their thinking by distracting their attention. This is when we talk about cognitive avoidance. However, their effort “not to think about the disease” means that they think about it all the time. Health concerns and thoughts about disease and death become an obsession that recurs. And the patients try to get rid of them, seeking reassurance in their own self-monitoring, visits to doctors and further investigations.

## **CBT OF HYPOCHONDRIASIS**

Therapy of hypochondriacal disorder is often arduous. Moreover, patients initially refuse psychiatric therapy and insist on the presence of a physical disorder. They are more willing to accept psychiatric therapy at the onset of the disease if it is presented as an aid to the management of stress that is harmful to them. In hypochondriasis, numerous psychotherapeutic approaches have been tried but none of them has proved to be better than the others. Kellner (1987) concludes that what may help is a supportive, rational and educational approach enabling ventilation. Hospitalization, laboratory tests and potentially addictive drugs (benzodiazepines) are not suitable. More appropriate is the administration of antidepressants (in particular SSRIs, SNRIs), possibly with low-dose antipsychotics.

Several controlled studies of CBT and several case series have shown its effectiveness (Ford 1983; Barsky *et al* 1988; Fallon *et al* 1993; Warwick 1989; Warwick *et al* 1996; Salkovskis & Warwick 1986; Starcevic 1991).

In their retrospective study, Warwick and Marks (1988) found that 15 (88%) out of 17 patients with hypochondriasis showed significant improvement and after 7 sessions with exposure to illness cues and prevention of reassurance. Of those, 65% remained in remission after 5-year follow-up. Warwick *et al* (1996) randomly assigned 32 patients suffering from hypochondriasis to either a CBT programme or a waiting list. CBT sessions were scheduled once a week for four months, with another assessment after 3-month catamnesis. Following the 16 CBT sessions, the group's average condition was significantly better than that of the control group. The improvement was maintained for the 3-month catamnesis. However, the use of an active control group (e.g. with 16 relaxation training sessions) limits the generalization of these findings. Bouman and Visser (1998) studied 17 patients prior to and after twelve 1-hour sessions with either “pure” cognitive (cognitive reconstruction) or “pure” behavioural (exposure *in vivo* and response prevention) treatment. The results showed that both approaches led to a significant decrease in symptoms and their effectiveness was identical. In their study, Clark *et al* (1998), randomized 48 patients with hypochondriasis into 3 groups (behavioural therapy, cognitive therapy, waiting controls). The treatment lasted for 16 weeks, with 1-hour sessions once a week. This was followed by three check-up sessions once a month. The follow-up was 12 months. Behavioural therapy included applied relaxation training, education on alternative explanation of symptoms and behavioural techniques to reduce worries. Cognitive therapy comprised cognitive reconstruction and behavioural experiments. After 16 weeks of acute therapy, the results of cognitive and behavioural therapies were similar, with a more rapid onset of improvement in the cognitive approach (as early as after 8 weeks). Both active approaches were significantly better than the control group. The results remained unchanged for 12 months. Fava *et al* (2000) randomly assigned 20 patients with hypochondriasis to either explanatory therapy or a waiting list. The explanatory therapy consisted of 8 group sessions over a period of 16 weeks, with patients learning to make notes of their worst fears of disease and search for alternative interpretation of somatic complaints. Although the therapy was more successful than controls, the effect was not robust enough and most patients did not achieve remission of the disorder.

CBT tries to identify automatic dysfunctional attitudes about health and looks for alternative testable explanations of symptoms. Throughout the course of CBT therapy, gradual education about the origin of physical difficulties is provided.

*In vivo* exposure refers to the confrontation of feared situations such as cemeteries, hospitals etc. Another method is exposure to feared physical sensations (hyperventilation, exercise), catastrophic thoughts and imaginations of prevention of safety and avoidance behaviour. CBT also entails physical exercise and relaxation training. CBT may be individual or groups (Ford 1983; Barsky *et al* 1988).

## EXPOSURE TO THE IMAGINATIVE DEATH EXPERIENCE

The method of “imagining illness and death” is based on a therapeutic dialogue using inductive and Socratic questioning to help overcome cognitive avoidance. Death and dying, natural processes of the end of life, are not reflected in the modern society. People live as if dying and death were always someone else’s problem. They tend to displace these topics. Paradoxically, this is even more true for patients suffering of hypochondriasis. On the one hand, patients have frequent thoughts of serious diseases or fears of dying. On the other hand, they respond to them by safety behaviour, diverting their attention, reassuring or monitoring. Since they are afraid of developing the idea of the course of disease and death, they try to avoid it in their thoughts and imagination. This is referred to as cognitive avoidance. Due to cognitive avoidance, the patient does not go through the entire worst-case scenario and thus can neither create a strategy for coping with the feared situation nor habituate to catastrophic thoughts. This in turn maintains and gradually increases the fear from suffering, dying and death. Treatment of hypochondriasis becomes markedly shorter and more intensive if cognitive avoidance is prevented. The main idea of the technique of imagining one’s own illness and death is exposure to catastrophic thoughts and prevention of cognitive and emotional avoidance. It is essential to use the approach at the time of a stable therapeutic relationship, after the patient has started cognitive reconstruction and his or her compliance is apparent. The steps in exposure with prevention of cognitive avoidance are as follows:

- Education about the vicious circle of fear from illness or death
- Explanation of the sense of exposure
- Description of the course of exposure
- Inductive questions aimed at detailed mapping of catastrophic thoughts
- Instructions of how to write one’s own scenario

After explaining the sense of exposure and obtaining the patients’ consent, inductive questions are used to confront them with their own most terrifying fantasies (in most cases, these are shown to be childhood fantasies). Patients are made to think about the worst variants of their imaginary disease and the future with it. Gradually, they imagine the worst consequences for both themselves and their relatives. The interview guides them through the severe course of their disease, its physical, mental and social consequences, dying and death experience with all emotions and details they can imagine. Then patients are asked about their fantasies about life after death. The work with catastrophic thoughts comprises:

- the worst course of disease, one’s own feelings, behaviour, *behaviour of health professionals and family members*
- the worst interpersonal consequences
- dying
- the moment of death
- after death

As a rule, patients habituate to the worst-case scenario within several (3–8) exposure sessions. Here is an example of the initial dialogue:

- T: Peter, why don’t we try to talk about your ideas of what would happen if your doctor told you that you do have cancer. How would you feel?*
- P: Well, fine... but I can’t even imagine that. It would be terrible. It would be the end... I’d rather not even think about that.*
- T: I see... Anyway, I still like to know what you think your first reaction would be like.*
- P: I guess I would start crying... I would run home... I don’t know.*
- T: Hmm... What would be worst about the situation?*
- P: Probably my feeling guilty that I caused the disease by constantly thinking about it.*
- T: I see. Let’s say we accept the fact that one may cause a disease by thinking about it. What would be worst? What do you imagine?*
- P: I have seen this film about children in an oncology ward on TV. They were just lying in their beds... with no contact with others...*
- T: Yes. This idea of having to lie in the bed and having no contacts with others, is this the worst thing that comes to your mind?*
- P: No, the worst thing would be... waiting for the surgery. This would be most terrible.*
- T: What might happen while you were waiting?*

P: *I guess... I would get some drugs, painkillers... or sedatives...*

T: *Yes, you would likely get some sedatives. What would be most difficult about the surgery?*

P: *That I would die...*

T: *Hmm... How do you imagine that? What is it that you fear most?*

P: *Well, everybody fears death. I would be alone, without people... I wouldn't have my body... just my soul... I could see all of them – my father, my mom, my brother... and I could not tell them that I am there...*

T: *Why is this so bad for you?*

P: *'cause I'm alone, without anyone...*

T: *What is this feeling like?*

P: *Sadness, helplessness... and fear...*

T: *I see. Fear from what?*

P: *Don't know... Someone... someone evil...*

T: *Who do you mean? Do you think there would be someone you don't know?*

P: *Maybe... Probably not. I think the loneliness would be the most terrible thought.*

T: *So the loneliness would be the worst...*

P: *I hope there is something... after death. I might meet my grandpa there. And some other relatives who died...*

T: *What would it be like?*

P: *Maybe nice... I did not even say the last good-bye to him... (he cries long)*

T: *What would happen next? You would meet there your grandpa and other relatives and then...*

P: *Well, years later those who are alive would die as well. We all would meet there. But I don't know... I don't really understand this... I can't control this...*

T: *You think you have to control this?*

P: *No, in fact I don't... (with a relief)*

T: *From what we've just said I get an impression that you fear loneliness rather than death.*

P: *You're probably right...*

The dialogue continues with the patient talking about his dependence on his father, his desire to be independent and fear from losing his parents by achieving this.

As soon as the patient elaborates strong emotions associated with fantasy, significant relief occurs and there is room for positive emotional experience. For next sessions, the patient always brings a written concept of what was discussed during the previous visit. The text is read at the beginning of each session, with the patient imagining everything.

After going through the worst imaginations together, with the patient being able to bear the feelings related to them, we ask him or her questions about potential ways of managing the situation. We discuss what he or she as well as his or her relatives and doctors can do in various aspects of the situation. What has to be accepted and what can be actively solved. Gradual habituation and finding of coping strategies, observed after several exposures, lead to a significant decrease in anxiety symptoms, safety and avoidance behaviour.

## CONCLUSION

Hypochondriasis has traditionally been one of mental problems difficult to treat. However, modern CBT approaches seem to increase the patients' chances of a cure or at least improved condition. The text provides a description of our own imaginative method which proved effective in many patients.

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