HYPOCHONDRIASIS

Modern Perspectives on an Ancient Malady

Edited by Vladan Starcevic & Don R. Lipsitt

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To Katarina, for all her unwavering understanding and support, and to Andrej and Rastko, for the irretrievable time taken away from them

—V. S.

With love, to Merna, who was always there when I needed her, even when she needed me more; for her courage and encouragement, forbearance, tested patience, and support over these many months

—D. R. L.

Acknowledgment

Daniel Lipsitt, without whose technological wizardry and multiple rescues from computer meltdown, this book may never have made it to hard copy

—D. R. L.

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Introduction

Vladan Starcevic
Don R. Lipsitt

Can a persistent belief in a non-existent illness be an illness itself?
Appleby, 1987

L'hypocondrie: Symptome àla croisée des chemins ou chemin à la croisée des syndromes?

Is hypochondriasis a symptom standing at the crossroads or a road crossing syndromes?
Collin et al., 1989

How can an illness that has endured for more than two millennia arouse so much controversy? A full understanding of the diversity of opinion swirling about hypochondriasis entails facing, accepting, tolerating, and responding to the challenging issues that accompany hypochondriasis as a symptom, as a syndrome, as a sign, as an illness, and as social commentary. A panoply of associated dimensions is called into view, including aspects of the mind-body relationship, ambiguity and uncertainty in medicine, the imperfection of human nature, interpersonal trust and mistrust, the limitations imposed on us by our bodies, and the pervasiveness of death anxiety in our lives.

Other attributes assigned to hypochondriasis are that it is a defense mechanism; a peculiar cognitive style; a means of nonverbal communication; a pattern of reacting to stress; an abnormal illness behavior; an obsessional trait or some other enduring personality pattern; and an aspect of identity. Thus, hypochondriasis appears to be a paradigm of psychopathological complexity and interrelatedness, and, in that sense, it occupies a rather unique place. Both physicians and laypersons rise to the challenge by either passionately endorsing or totally disregarding particular attitudes toward the "condition"; where hypochondriasis is at issue, relatively few people remain neutral.

This situation is also reflected in disagreements between experts on whether hypochondriasis is a valid and independent diagnostic category and in disagreements on various definitions of hypochondriasis, including those put forward by

accepted diagnostic systems. These definitions emphasize that hypochondriasis is a persistent and excessive preoccupation with fear and/or belief that the person has become seriously ill, despite all reassurance and evidence to the contrary.

Regardless of how hypochondriasis is defined, there is apparent agreement about the diversity of its manifestations. Thus, at one pole, some people who are given the label "hypochondriac" are, in fact, well-functioning individuals who seem only to pay marked attention to matters like physical exercise or healthy diets. Others become easily distressed by minor bodily symptoms or they develop transient and mild manifestations of hypochondriasis, usually in response to traumatic experiences or in the course of concurrent physical disease. A similar situation is encountered among medical students, usually by their second year. Hypochondriasis is often a part of the clinical presentation of other mental disorders, most notably panic disorder, depression, and personality disturbance, and in these cases it is referred to as *secondary hypochondriasis*.

Hypochondriasis may be a mental disorder *per se*, when it is also referred to as *primary hypochondriasis*. As such, it tends to be chronic and often co-occurs with other psychiatric conditions. It is classified among somatoform disorders, although some consider it more akin to anxiety or personality disorders. It is patients with this type of hypochondriasis who usually fit the stereotype of this condition; they examine every minor change in their bodies and subject themselves to countless medical investigations. In turn, such behavior has an adverse impact on the quality of life of these people, impairs their functioning, and overburdens the health care system. At the other pole of hypochondriacal phenomena are hypochondriacal or somatic delusions, not always easily distinguished from intense nonpsychotic hypochondriacal preoccupations.

The more complex the nature of illness, the more complex its treatment is bound to be. All treatment begins with an adequate assessment. Individuals with hypochondriacal manifestations may present special requirements because of the stigmatizing and deprecating attitudes with which they are often approached. It is common knowledge that "hypochondriacs" are not physicians' favorite patients. The risk that many patients may be rejected as "incurable" or "malingerers" hovers over the encounter with sufferers of hypochondriasis as in perhaps no other clinical situation. Persons with hypochondriasis need not only relief from morbid preoccupation with disease and a substantial decrease in health-related concerns, but also a sense of being understood. Understanding the essential underlying needs will provide a sound backdrop for the compassionate treatment of hypochondriacal patients.

Even when it is conducted adequately, the treatment of hypochondriasis can be a complex, challenging, and long-lasting process. It requires a skillful and flexible therapist who is capable of accepting the patient "as is," of deciphering the patient's somatic "idiom of distress," and of tolerating the frustrating behav-

iors that appear to be simultaneously seeking and rejecting help. We believe that establishing and maintaining a therapeutic relationship is the *sine qua non* of treatment regardless of whether other therapy modalities are also applied.

At the beginning of the new millennium, with increasing costs of medical care worldwide and rapid changes in modern society, hypochondriasis poses new challenges. It is timely to examine current knowledge of hypochondriasis to see how well we are equipped to respond to these challenges. In offering modern perspectives on hypochondriasis, we aim to produce a text on this ancient disorder that will provide "state-of-the-art" knowledge on hypochondriasis for years to come. More specifically, the purposes of our book are as follows:

- To demonstrate how present-day concepts of hypochondriasis are linked with its rich history (Chapters 1, 5, 8, and 11)
- To re-examine controversial conceptual issues surrounding hypochondriasis and consider ways of overcoming the corresponding obstacles (Chapters 2, 4, 5, 6, 8, 9, 10, and 11)
- To critically review diagnostic and nosological problems in hypochondriasis (Chapters 1, 2, 5, 8, and 11)
- To re-examine the heterogeneity of hypochondriasis and its relationships with other mental disorders (Chapters 2, 4, 5, 6, and 9)
- To present current views on the etiology, pathogenesis and psychopathology of hypochondriasis (Chapters 8, 9, and 10)
- To present advances in the assessment of hypochondriasis (Chapters 3 and 15)
- To present results of clinical and epidemiological research on hypochondriasis (Chapters 2, 4, 5, 6, 7, 9, 10, and 11)
- To describe principles of the therapeutic relationship in hypochondriasis and present main treatment approaches to hypochondriasis (Chapters 7, 12, 13, 14, and 15).
- To provide guidelines for treating hypochondriasis (Chapters 7, 12, 13, 14, and Epilogue)

In consideration of the different and competing views on hypochondriasis, we elected to present the subject of the book from various perspectives, representing each major "school of thought." Therefore, contributions were solicited from authors who are world experts in their respective fields. While we expect that the book will not reconcile theoretical differences between various orientations, we nonetheless hope to promote a dialogue between the "camps," in the service of achieving a well-balanced integration of different "models" of hypochondriasis.

Mainly intended for practicing clinicians, including psychiatrists, psychiatric residents, clinical psychologists, other mental health workers, primary care physi-

cians, and other medical specialists, this book offers up-to-date information on epidemiology, clinical presentation, etiology and pathogenesis, diagnostic criteria and assessment, differential diagnosis, relationship with other mental disorders, course, prognosis, and treatment of hypochondriasis. We hope that such information will help clinicians to make appropriate diagnostic decisions and to tailor their treatment approaches to the specific needs and characteristics of their patients. Because the majority of patients with hypochondriasis are seen and treated by primary care physicians, one chapter is devoted to the primary care perspective on this disorder.

Considering that individuals with hypochondriasis and their families, as well as the general lay public, need accurate and current information, we believe this volume will also be of interest to them.

In the end, there may be more questions posed and issues raised than answers given and solutions offered. Nevertheless, our objectives will have been met if the pages that follow engage readers in a consideration of their views or their practice. With this, we may "cross the road" into an era of greater enlightenment and solace as we embark on our journey to resolve the "riddle" of hypochondriasis and to decrease confusion surrounding this condition.

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I

Clinical and Diagnostic Considerations

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Hypochondriasis: History of the Concept

GERMAN E. BERRIOS

> Dans l'histoire si long-temps embrouillée de l'hypocondrie, il n'est pas moins curieux d'étudier les médecins qui ont écrit sur cette maladie que les malades qui en ont été le sujet. Les uns et les autres ont également concouru à rendre obscur ce qu'ils attachaient une si grande importance à éclairer.
>
> In the long and confused history of hypochondriasis, the study of the doctors who wrote on it is not less interesting than the study of the patients themselves. Both have contributed to make obscure the very topic that they wanted to clarify.
>
> Leuret, 1834

Like any other field of empirical research, psychiatric history has to confront general and specific problems. Among the latter, two are particularly salient to the "hypochondriacal disorders." One pertains to the *validity* and explanatory power of the so-called continuity hypothesis, (the "Greeks to the present" tale); the other relates to the finding of a *definition* of hypochondriasis that may survive historical translocation.

Matters Historiographical

The Continuity Hypothesis

The main justification for writing a historical account of hypochondriasis that starts with the Greeks and ends up in the present is the fact that it is in keeping with the official view that science is a cognitive enterprise "inching toward the

truth." Whether correct or not, this type of account is handy in that it confirms the naïve belief that "latest is truest," flatters current scientists into believing that they are "closer to the truth" than anyone else before, and keeps collaborateur historians in useful employment (on the issue of the "historicity of truth," see Campbell, 1992).

The "continuity hypothesis" is beset with conceptual problems, but only one will be briefly mentioned here, namely the nature of the element from which it derives its appealing linearity (on the theme of a "history of ideas," see Lovejoy, 1936; Bevir, 1999). One can envisage such to be a word, a concept, a behavior or combinations thereof. The commonest mechanism is decontextualized words. This is the way, for example, in which dictionaries and encyclopedias manage to create the mirage of continuity and progress. Melancholia and mania are good examples of that: Nothing but the terms alone provide the glue that holds together those histories of melancholia since the Greeks to the present day.

There is much debate on whether concepts can ever provide support for continuity narratives. The issue here is whether psychiatric concepts are always theoretically (and hence historically) tethered or whether some exist *sub specie aeternitatis* ("under the aspect of eternity"). Only those who believe in the latter feel inclined to support the view that concept on occasions provides the glue for a continuity tale.

Another possibility is the most desirable to medical historians but, alas, the rarest: It takes the form of certain behaviors that are so stereotyped they resist cultural and temporal translocation. For example, tics, hallucinations, and delirium are states that the historian can find clearly described in the literature of the ages. In this case, a history of delirium from the Greeks to the present can be said to be a history of the way in which a very stable behavior has been talked about and explained for the last 25 centuries. But even here there are problems, for sponsors of the continuity tales must explain the stability of the said behavior: Medical historians feel naturally inclined to view it as the expression of some neurobiological disorder. In contrast, social constructionists might wish to explain behavioral stability in terms of social factors. This closes the conceptual loop and starts the fun. Fortunately, we do not have to resolve this problem here. Nonetheless, the usefulness of this historiographical excursus has been to throw new light on the following question: From the Greeks on, what is the history of hypochondriasis about? We can now say that it is unlikely to be about some stable behavior related to some tenebrous brain structure. It is far more likely that it is just about the avatars of a fascinating *term*.

Defining Hypochondriasis

Defining and classifying "hypochondriasis" is not an easy matter as at least three issues must be resolved. One concerns the nature of the referent: Is it a "RRUS"—

that is, a *real*, *recognizable*, *unitary* and *stable* object of inquiry? Second, is this RRUS valid in all possible cultural universes? Third, what slot should it occupy in a nosology of "mental" disorders? For example, on what empirical evidence has it been subordinated to the "somatoform" disorders?

A good example of such difficulties running riot can be found in the current *International Classification of Diseases* (ICD-10) definitions (World Health Organization, 1992), which shows the hopelessness of pretending to construct operational definitions out of ordinary language terms. For example, by using vague words such as "preoccupation," "belief," and so on, interchangeably, the authors of F45 have caused undue confusion. Then there is the whimsical nature of the taxonomy. It would seem *de facto* (if not *de jure*) that a high-level class has been constructed: Somatoform disorders (F45). This, in turn, includes five orders: Somatization disorder (F45.0), Undifferentiated somatoform disorder (F45.1), Hypochondriacal disorder (F45.2), Somatoform autonomic dysfunction (F45.3), and Persistent somatoform pain disorder (F45.4). The order Hypochondriacal disorder, in turn, contains five species: body dysmorphic disorder, dysmorphophobia (nondelusional), hypochondriacal neurosis, hypochondriasis, and nosophobia. *Vis-à-vis* this classification, there are two options: one that it reflects a fact of nature, the other, that it does not. Because no evidential database has been made available by the ICD creators, one must assume that the classification in question is more or less a matter of opinion. If so, how can these definitions and classifications be used as the starting point for a real history of hypochondriasis?

In an attempt to deal with the two problems listed above, the historical account to be presented in this chapter will focus on the period stretching from the seventeenth century to the nineteenth century (when the core conceptual structures were worked out) and will visit the Greeks only for etymological clarification. It will not deal with the twentieth century and hence with the history of psychoanalytical hypotheses (for this, see Berrios and Mumford, 1995, or Chapter 8 of this text). It goes without saying that the history of hypochondriasis has also been written about from other perspectives (e.g., Fischer-Homberger, 1983; Kenyon, 1965; Meister, 1980; Place, 1986).

History of the Word

The word *hypochondrium* was used by Hippocrates to refer to the regions of the abdomen lying under the rib cage. For example, he reported a woman in postpartum who "suffered in her right *ὑποχόνδριον* (hypocondrion)" (Case IV, Epidemics I, Hippocrates, 1972). By the time of Celsus, the anatomical locus in question was included under the wider concept of *praecordia:* "1. The lower chest in front of the heart; 2. The region over the diaphragm, and 3. The upper abdomen below the ribs (*hypochondria*)" (Celsus, 1935, p. 100).

The Greek belief that the abdominal organs were the source of disordered emotions was still prevalent at the time of Plato (Warrington, 1965). For example, in the *Timaeus* Plato wrote: "That part of the soul which desires meats and drinks and the other things of which it has need by reason of the bodily nature, they placed between the midriff and the boundary of the navel . . . and there they bound it like a wild animal which was chained up with man" (Plato, 1973, p. 1194). Diocles Carystus (circa 350 BCE) seems to have been one of the first to report complaints of the digestive organs associated with pathology of the "hypochondria" (Ladee, 1966, p. 7). Classical writers went on to establish a firm association between the hypochondria or praecordia and, at least, two clusters of "symptoms:" one pertained to digestive symptomatology, flatulence, and so on (as in Diocles) and another to melancholia (as in Paulus de Aegina, c. A.D. 625–690). It is important to remember that during this period melancholia had little or nothing to do with depressive illness (Berrios, 1988).

The Greek view held sway up to the early seventeenth century when references to hypochondriacal or flatuous melancholia can still be found: "Besides fear and sorrow, sharp belchings, fulsome crudities, heat in the bowels, wind and rumblings in the guts, vehement gripping, pain in the belly and stomack" (Burton, 1621/1883, p. 269). Interestingly enough, Burton went on to quote Crato's prescient remark that "in this hypochondriacal or flatuous melancholy, the symptoms are so ambiguous that the most well-trained physicians cannot identify the part involved" (p. 269).

The History of the Concept and Behaviors

Between the classical thinking of Robert Burton (1577–1640) and the views of Thomas Willis (1621–1675) and Thomas Sydenham (1624–1689) there is a conceptual abyss: This was mostly due to the fact that new definitions of medical observation, causality, disease, and treatment had developed in the interim. This is also the time when the distinction between delusional and attitudinal or personality-related hypochondriasis is made, and when it becomes a "nervous disorder" (in the sense of Willis, see below).

The Great Dichotomy

It is during the seventeenth century that the two great descriptive and explanatory models of hypochondriasis appeared in the form of two classical narratives. They have since controlled thinking in this field. As part of his *Novelas Ejemplares,* Cervantes (1547–1616) published "El Licenciado Vidriera" (Cervantes, 1916), the tale of a successful undergraduate at the University of Salamanca who

after being given a love potion developed the delusion that he was made of glass. The story of the lengths he went to protect himself from breakage constitutes a classical description of what during the nineteenth century was to be called "delusional hypochondriasis": sudden onset, identifiable causal factor, lack of interaction with a physician, perceived by others as an illness, and delusional control of behavior. Sampayo (1986) has identified an Erasmian influence in Cervantes's novel. Likewise, the glass delusion had been known in European literature ever since the late fifteenth century (Speak, 1990). By the end of the seventeenth century, John Locke (1632–1704) decided to use it as a prototypical form of madness: "Others who have thought themselves made of glass have used the caution necessary to preserve such brittle bodies" (Locke, 1690/1959, Book II, Chapter XI, 13).

The other great seventeenth century narrative provides a model according to which hypochondriasis can emerge gradually, in an interactional context with physicians and relatives and express deep personality needs. *Le Malade imaginaire*, the last play by Molière (1622–1673), was performed for the first time few weeks before his death. It carried a strange subtitle, *Élomire Hypocondre*, which Molière seems to have borrowed from a pamphlet published in 1660 by someone using the pseudonym of Le Boulanger de Chalussay. The theme and personages are not entirely new, and Molière seems to have borrowed some of them from earlier plays. Argan, the protagonist, finds himself at the center of a triangle constituted by his second young wife and his lawyer (who want his money), his own family, daughter by first marriage, her boyfriend, his brother, and his servant (who love him well), and his physicians and apothecary, who are self-interested and feed his hypochondriacal fears, which grow by the day. At the end of the play, and symbolizing the very essence of neurotic hypochondriasis, Argan becomes a medic himself (Hucher, 1965).

Hypochondriasis as a "Nervous Disorder"

The concept of "nervous disorder" was created during the seventeenth century (Hare, 1991; López Piñero, 1983). Thomas Willis (1621–1675) regarded both hypochondriasis in men and hysteria in women as disorders of the brain: "As we have shewn before that the passions vulgarly called hysterical do not always proceed from the womb, but often from the head's being affected: so though it has been vulgarly held that the affects called hypochondriacal are caused for the most part by Vapours arising from the spleen, and running hither and thither; yet in truth those distempers are for the greatest part convulsions and contractions of the nervous parts" (Willis, 1685, p. 307).

To flatulence, indigestion, pain, and other gastrointestinal symptoms, Willis added complaints reminiscent of panic disorder: "Moreover, the diseased are wont

to complain of a trembling and palpitation of the heart, with a mighty oppression of the same, also frequent failings of the spirits, a danger of swooning come upon them, that the diseased always think death at hand . . . fluctuation of thoughts, inconstancy of mind, a disturbed fancy, a dread and suspicion of everything." But also (and this is one of the earliest references to *valetudinarian* complaints): "an imaginary being affected with diseases of which they are free, and many other distractions of the spirit . . . wandering pains, also cramps and numbnesses with a sense of formication seize likewise almost all the outward parts: night sweats, flushing of blood . . ." (Willis, 1685, p. 308).

Thomas Sydenham (1624–1689) noted that symptoms "which cannot be accounted for on the common principle of investigating diseases" were often preceded by "disturbances of the mind," which he regarded as "the usual causes of this disease." Sydenham noted that these symptoms were often accompanied by depression, panic, anger or despair; sufferers were "enemies to joy and hope." Like Willis, he linked hysteria and hypochondriasis "since, however much antiquity may have laid the blame of hysteria upon the uterus, hypochondriasis [which we impute to some obstruction of the spleen or viscera] is as like it, as one egg is to another" (p. 85). Furthermore, "the affection which I have characterized in females as hysteria and in males as hypochondriasis, arises (in my mind) from a disorder (ataxy) of the animal spirits" (Sydenham, 1850, p. 90).

Sydenham (1850) then comments on the remarkable frequency and the numerous forms under which hysteria and hypochondriasis appear, "resembling most of the distempers wherewith mankind are afflicted." Moreover, "unless the physician be a person of judgement and penetration," it was easy to confuse these hysterical symptoms with symptoms of physical disease. Such symptoms included severe pain "attacking the external part of the Head, between the pericranium and the cranium"; vomiting; "terrible convulsions much like the epilepsy": and "such a palpitation that the patient makes sure that the sound of the heart beating against the ribs can be heard by the bystanders" (p. 86). Sydenham's descriptions of hysterical symptoms were widely quoted by his contemporaries (Williams, 1990).

The "English Malady"

What George Cheyne (1671–1743) called the "English malady" overlaps only partially with contemporary notions of hypochondriasis. Be that as it may, the eighteenth century is blessed with great books on this disorder, which set the scene for all further developments. As that great century winds down, a trend can be noticed (particularly amongst the Scottish physicians) to consider hypochondriasis as a specific disturbance of the nerves (López Piñero, 1983).

In *A Treatise of the Spleen and Vapours: or, Hypochondriacal and Hysterical Affections* (1725), Sir Richard Blackmore (1654–1729) (physician to William III and Queen Anne) regarded pains and other sensory symptoms in various parts of the body, as well as the disturbed mind and imagination, as reflecting hysteria in women and hypochondriasis in men. Unfortunately, Blackmore observed, "Patients are unwilling their Disease should go by its right Name" because the public regarded their symptoms as an "imaginary and fantastick Sickness of the Brain, filled with odd and irregular ideas," and such individuals often become "an Object of Derision and Contempt." However, their "sufferings are without doubt real and unfeigned" (Blackmore, 1725).

Blackmore ridiculed the notion that such somatic complaints were caused by fumes or vapors rising up from the lower to upper regions of the body. For one thing, "there are no Passages, or proper Conveyances, by which these Streams and Exhalations may mount from the inferior to the superior Parts." Instead, Blackmore offered a psychological explanation: "Terrible ideas, formed only in the Imagination, will affect the Brain and the Body with painful Sensations." He also believed that hypochondriasis was not a form of insanity: "The Limits and Partitions that bound and discriminate . . . Hypochondriack and Hysterick Disorders, and Melancholy, Lunacy and Phrenzy, are so nice, that it is not easy to distinguish them, and set the Boundaries where one ends, and the other begins." Hypochondriasis and hysteria "sometimes affect the intellectual Faculties" but seldom result in "a State of Lunacy" (Blackmore, 1725).

In *A Treatise of the Hypochondriak and Hysterick Passions*, Bernard de Mandeville (1670–1733) reported the imaginary exchanges between Philopirio (a physician representing de Mandeville's views) and Misomedon, a *hypochondriacus confirmatus* who consults him after 12 years of gastrointestinal symptoms and countless episodes of bleeding and purging. The second dialogue discusses the etiological theories of Diocles, Sylvius, Willis, Sydenham, Highmore, Platter, Tulp, and Baglivi. De Mandeville then advances his own view: "That the disorders of the chylifications are chiefly the cause of the distempers in question, I shall endeavour to prove" (de Mandeville, 1711, p. 121).

In *The English Malady: or, a Treatise of Nervous Diseases of all Kinds, as Spleen, Vapours, Lowness of Spirits, Hypochondriacal, and Hysterical Distempers, etc.*, George Cheyne described the classical view of a disease that tended to affect persons of greater intelligence and upper social class. The "English Malady" resulted from "the Moisture of our Air, the Variableness of our Weather, (from our Situation amidst the Ocean) . . . the Richness and Heaviness of our Food, the Wealth and Abundance of the Inhabitants (from their universal Trade) the Inactivity and sedentary Occupations of the better Sort (among whom this Evil mostly rages) and the Humour of living in great, populous and consequently unhealthy Towns. . . . These nervous Disorders being computed to make almost

one-third of the Complaints of the People of Condition in England . . ." (Cheyne, 1733).

Nicholas Robinson (1697–1775), a governor of London's Bethlem Hospital, wanted to account "mechanically" for mental as well as bodily diseases. Influenced by eighteenth-century "nerve fibre" neurophysiology, he argued that because mind without brain was inconceivable, psychological processes were simply expressions of physical events in "the Nerves and Fibres that compose the Brain." Thus, "Every Change of the Mind, therefore, indicates a Change in the bodily Organs; nor is it possible for the Wit of Man to conceive how the Mind can, from a chearful [*sic*], gay Disposition, fall into a sad and disconsolate State, without some Alterations in the Fibres, at the same Time" (Robinson, 1729).

In relation to "those Disorders we call the Spleen, Vapours, and Hypochondriack Melancholy," Robinson (1729) argued: "Neither the Fancy, nor Imagination, nor even Reason itself, the highest Faculty of the Understanding, can feign a Perception, or a Disease that has no foundation in Nature; . . . cannot feel Pain or Uneasiness in any Part, unless there be Pain or Uneasiness in that Part: The affected Nerves of that Part must strike the Imagination with the Sense of Pain, before the Mind can conceive the Idea of Pain in that Part" (p. 406).

Robert Whytt (1714–1766) is the most original writer on hypochondriasis during the eighteenth century. In his *Observations on the Nature, Causes and Cure of Those Diseases Which Are Commonly Called Nervous, Hypochondriac or Hysteric*, Whytt defended the view that "sympathy" (an old notion used to explain how bodily components came to be coordinated) was based on a network of nerves, and hence was a function of the brain. This has been aptly summarized by French (1969): "Since sympathy presupposes feeling, nerves are the mechanism of feeling, and all nerves originate in the brain and spinal marrow . . . all sympathy was to be referred to the brain" (p. 34).

Following Sydenham, Whytt (1764) believed that hysteria and hypochondriasis were identical, but the former affected females and the latter males (p. 534). Nervous disorders, in general, resulted from "a too great delicacy and sensibility of the whole nervous system" or "an uncommon weakness, or a depraved or unnatural feeling, in some of the organs of the body" (p. 537). Hysteria and "hypochondria" resulted from a combination of these two types of causes and were but the expression of pathological sympathy.

The "Nervous Disorders" Become "Neuroses"

William Cullen (1712–1790) sponsored a version of "neuralpathology" (the view that all diseases were diseases of the nervous system). Not much has been written on Cullen's psychiatric views although he is quoted *ad nauseam* for having

coined the term *neurosis* (Bowman, 1975). Cullen's taxonomic approach was synthetic in that he blended into larger groups the often over-detailed nosological conditions of his predecessors. This also applies to his views on hypochondriasis. As someone wrote in the popular *Edinburgh Practice of Physic*: "Although some of the nosological writers, particularly Sauvages, have considered this genus as consisting of different species, Dr Cullen is of the opinion that there is only one idiopathic species, the *hypochondriasis melancholica*. He considers not only the hypochondriasis hysterica, phthisica and asthmatica, but also the biliosa, sanguinea, and pituitosa, as being only symptomatic; but he views the true melancholic hypochondriasis as being a proper idiopathic disease, perfectly distinct from hysteria, with which has often been confounded" (Anonymous, 1803, p. 358; see also Cullen, 1803, pp. 291–292).

The symptoms of hypochondriasis, according to Cullen, were dyspepsia, indigestion, pain under the ribs, palpitations, sleepless nights and occasionally "depression of spirits and apprehension of danger." Among the causes the following can be listed: "plethora and preternatural thickness of the blood, suppression of customary evacuations, high and full diet, together with a sparing quantity of drink; and hereditary disposition; indolence; atony of the intestines and violent passions of the mind" (Anonymous, 1803). "The hypochondriacal affection, when left to itself, is more troublesome than dangerous" (Anonymous, 1803).

Hypochondriasis as a Form of "Insanity"

Changes in etiological theory led to a gradual broadening of the "nervous disorders," which became "neuroses" in terms of Cullen's "neuralpathology" theory (Bynum, 1985; López Piñero, 1983). During the following century, the implementation of the *anatomo-clinical model of disease* (Ackerknecht, 1967) and the new descriptive psychopathology (Berrios, 1996) caused a progressive attrition of the "neuroses." By the second half of the nineteenth century, the group was thus much smaller than it once had been. The over-generalized nature of the Cullean definition of neuroses as "preternatural affections of sense and motion, which are without pyrexia as a part of the primary disease" (Cullen, 1827, p. 1), made little sense in the new world of specificities.

In this new climate, hypochondriasis was classified as an insanity (i.e., a disease resulting from a brain lesion). For example, Fabre (1849) wrote: "Today, and like all the other monomanias (partial insanities), hypochondria is generally and with reason considered as being caused by a disorder of brain function." When reviewing the pathological anatomy of the condition, however, Fabre ruefully states: "In the case of hypochondria this section is kept only for reasons of organization. For, in the rare cases in which it has been possible to carry out post-

mortems in subjects who have actually died whilst hypochondriacal (rather than on account of a complication of the disease) no lesion has been found to explain the disorder. Among recent authors, Broussais has been the only one to report 'gastric inflammation' only to recant later" (Fabre, 1849, p. 629). Indeed, Broussais had returned to the idea that there existed a "reciprocal influence between emotions and visceral irritations: for example, in the same way that fear causes palpitations, the latter—when caused by any physical cause—might trigger the memory of fear. This may explain the frequency of sensations in hypochondriacs who have developed chronic gastritis" (Broussais, 1828, p. 462).

Likewise, Jean Baptiste Parchappe, in his exhaustive collection of postmortem reports, included the case of a 51-year old married carpenter who developed an affective disorder in reaction to the insanity of his wife. This was accompanied by abdominal pains and "hypochondriacal complaints." On postmortem he was found to have "large cortical plaques and softening of the brain" (Parchappe, 1841, pp. 36–37).

Hypochondriasis was thus reconceptualized as a form of insanity. Luyer-Villermay (quoted in Fabre, 1841) even proposed a model to explain how this took place in a given individual: "During the first stage, the disorder only involves the organs of the abdomen; in the second, it extends to the chest and the head, and in the third and last the involvement of brain functions becomes predominant." Georget (quoted in Fabre, 1841) believed that Luyer-Villermay "had no basis other than his opinion." Dubois (d'Amiens) (quoted in Fabre, 1841, p. 91), in turn, also proposed a three-stage model, although his criterion was severity of the disorder rather than progressive involvement of organs: "The third stage consisted in a chronic inflammation of most organs . . . and recovery was almost impossible."

At the very end of the nineteenth century, George Savage (1892) attempted to reconcile the two views: "The word hypochondriasis has a very wide meaning, and includes forms of insanity, as well as many disorders which cannot properly be so-called. Under this name we shall have to describe a nervous disorder varying from slight over-sensitiveness to insanity with marked delusions and actively suicidal tendencies" (Savage, 1892, p. 619).

Hypochondriasis and Melancholia

Upon returning to the United States from Edinburgh, Benjamin Rush (1745–1813) observed: First, "It would be equally proper to call every form of madness hypochondriasm . . . for they are all accompanied by abdominal symptoms"; and second, the name "has unfortunately been supposed to imply an imaginary disease" and "is always offensive to patients who are affected with it" (Rush, 1812).

Rush himself preferred "tristimania," arguing that it differed from hysteria in its symptomatology, notably in its "extremes of high and low spirits."

Along the same lines, Guislain (1852) wrote: "Sometimes, melancholia is characterized by intense valetudinarian preoccupations . . . The patient worries about having non-existent diseases. This is called melancholic hypochondria . . . Hypochondria can be bodily and mental, the latter being melancholic hypochondria proper. The former is uncommon in mental hospitals but is often found in the community. These patients only come to hospital when severely ill" (pp. 120–121).

By defining hypochondria as a "sad monomania" (*manie triste*), C.F. Michéa (1815–1882) also committed himself to the view that the condition was a form of depression in which there was "an exaggeration or exaltation of the instinct of preservation (*biophilie*)" (Michéa, 1843, p. 575). Because of this association, Michéa believed that hypochondria had a bad outcome: It could transform itself into insanity or lead to suicide.

Prone to the disease were men between 30 and 40 years of age with family history of the condition and with a nervous temperament. There were idiopathic and secondary forms, and only the former was a "true" hypochondriasis. Michéa agreed with Dubois d'Amiens' three-stage analysis: "The first stage is characterized by mental changes such as delusions and pure monomania. The second includes functional disorders and neuroses of some organs. The third includes anatomical changes (*lésions de tissu*)" (Michéa, 1843, p. 577).

For B.A. Morel (1809–1873), true hypochondriasis was a form of insanity (*folie hystérique*) that resulted from the transformation of certain neuroses (*la transformation de certaines névroses*) (Morel, 1860, p. 264). There was a *hypochondrie simple*, which affected "those who worried excessively about their health and these persons were *le désespoir des médecins*" (Morel, 1860, p. 266). It could become a veritable delusional syndrome in which case the valetudinarian symptoms always "occupied the forefront of the condition" (Morel, 1860, p. 709). This disorder was often hereditary. As Morel observed: "I have seen hereditary insanity become complicated by hypochondriacal phenomena" (Morel, 1860, p. 525).

W. Griesinger (1817–1868) also believed that "the hypochondriacal states represent the most moderate form of insanity, and have features which essentially distinguish them from the other forms of melancholia" (Griesinger, 1861, p. 215). "The hypochondriac may reason correctly—setting out from false premises, but this does not negate the fact that hypochondria is a mental disorder, any more than because hypochondria often accompanies or complicates various chronic diseases seated in different organs, it ought on that account to be confounded with these diseases" (p. 216). Griesinger's effort to integrate hypochondriasis into the continuum of insanity is a manifestation of his support for the unitary approach to insanity (Berrios and Beer, 1994).

Hypochondria, according to Griesinger, "may arise in two different ways. In the first place, as a secondary cerebro-spinal irritation, in consequence of internal, but often slight, diseases (of the intestine, the liver, the genital organs, and even kidney), which give rise more to a feeling of general discomfort. . . . In the second place, however, hypochondria may also arise via a direct psychological route (*psychischem Wege entstehen*), inasmuch as through external circumstances the ideas may be so constantly directed to the state of the general health, or of one particular organ, as to induce morbid sensations" (Griesinger, 1861, p. 221).

Hypochondriasis as a Disorder of "Sensation"

The French clinical notion of *cénesthopathie* (Dupré, 1925; Dupré and Camus, 1907) was based on the earlier German concept of "common feeling" (*Gemeingefühl*) (Starobinski, 1977, 1990), which referred to "bodily sensations" that were not touch, temperature, pressure, and location sensations (*Tastsinn*). The common-feeling group included pain and "objectless" sensations such as well-being, pleasure, fatigue, shudder, hunger, nausea, organic muscular feeling, and so on.

In the non-German speaking countries, these sensations were named "coenaesthesis" by the middle of the nineteenth century (Hamilton, 1859) and began to be used as explanation for the "sense of existence" (Gautheret, 1961). However, why such diverse feelings converged into a common sensation of bodily "unity" needed explanation (the sort of problem that Bakal [1999] has recently tackled; for the historical origins of these ideas, see Vila, 1998; Rousseau, 1990). According to associationism, coenaesthesis resulted from a *summation* of proprioceptive and interoceptive sensations (Taine, 1890). Faculty psychology, in contrast, postulated the existence of a hypothetical *brain center* or *faculty* on which sensations converged. The latter mechanism was later invoked to explain the generation of the "body schema."

As hunger, thirst, sexual pleasure, and so on began to be studied independently, the erstwhile broad territory of coenaesthesis became eroded. In the end, all that was left were indistinct sensations common to most organs such as deep pressure, pain, and unanalyzable sensations such as "tickling" or "stuffiness" (Titchener, 1901).

Baron E. von Feuchtersleben (1806–1849) was one of the first to suggest that "hypochondriasis . . . is in its essence nothing but a coenaesthesis abnormally heightened in all directions" (Feuchtersleben, 1847, p. 222). Hypochondriasis *sine materie* resulted from a psychological heightening (e.g., persistent attention to sensations) of the *Gemeingefühl*. Hypochondriasis *cum materie* resulted from

nerve hypersensitivity caused by an organic disease. Feuchtersleben (1847) commented that Dubois (1833) was not altogether right in believing that organic hypersensitivity was the *only* cause of hypochondriasis: "In nature, however, there appears a circle between psychical and physical causes." The debate on whether imagination or real sensation was the primary cause continued well into the twentieth century (Berrios, 1985).

J. L. Luys (1828–1897) advanced the similar suggestion that hypochondriasis resulted from proprioceptive hallucinations (*hallucinations viscérales*):

> "Hallucinations that originate from disorders of visceral sensibility determine the various forms of hypochondria. . . . These are delusional types which are first intermittent and then become continuous. Patients may claim that their throat is closed, that they are edentulous, that their stomach is blocked, that they have no bowels and cannot go to the toilet, etc. . . . These complaints should be considered as veritable interoceptive hallucinations mostly resulting from the gastrointestinal regions; thoracic ones are rare. When these hallucinations become associated with those from external senses, the prognosis is somber because spreading of the irritation to the cortex can be suspected. (Luys, 1881, pp. 420–421)

J. Cotard (1840–1889) proposed a variant of the coenaesthesis hypothesis, stating that hypochondriasis is "characterized by an exaggerated psychological response. Not only visceral pains are amplified but also normal sensations cause anxiety. . . . It is less a veritable hyperaesthesia than a dysaesthesia, i.e., a hyperaesthesia linked to a blunting of sensation (*léger degré d'obtusion sensorielle*). . . . But it is mainly in the cortical site where sensations are transformed into extraordinary notions that insanity can begin" (Cotard, 1888, pp. 141–142).

Richard von Krafft-Ebing (1840–1902) also sponsored a form of sensorial theory: "Hypochondria may be called a neurosis of the general feeling (*Gemeingefühlneurose*), with effects on the psychological sphere." The important psychological manifestations of hypochondriacal neuropsychosis (*hypochondrische Neuro(psycho)se*) are "a facilitated power of apperception (*Apperceptionsfähigkeit*) of the psychological organs, as a result of which the exciting processes (often causal) in the nerves of other organs become conscious. At the same time they become colored by lively feelings of displeasure. The state of consciousness of the patient may extend from ideas of severe disease to the most absurd interpretations of sensations that are actually experienced" (Krafft-Ebing, 1893).

The concept of coenaesthesis entered in French psychiatry in the now neglected concept of *cénesthopathie*, which referred to a "local alteration of the common sensibility in the sphere of general sensation, corresponding to hallucinosis in the sphere of sensorium" (Dupré, 1913). "Painful" and "paraesthesic" co-

enaesthopathies were recognized, and each, in turn, divided into cephalic, thoracic and abdominal areas. Patients in the "painful" group felt their organs "stretched, torn, twisted"; in the "paraesthesic" group, they experienced itching, hyperaesthesiae, paraesthesiae, and so on. Some coenaesthopathies were treated as separate syndromes. For example, *topalgie* (or cephalic coenaestopathy) was reclassified as a "neurovegetative dystonia" (Bernard and Trouvé, 1977) and as a psychosomatic syndrome (Ey, 1950).

The coenaesthopathies were never fully recognized in Anglo-Saxon psychiatry, and the very complaints were named *hypochondriasis*, *neurasthenia*, or *dysmorphophobia* (Reilly and Beard, 1976). In other countries, similar phenomena were classified as "disorders of sensibility" or "psychoneuroses" (Ladee, 1966).

Conclusion

Although now it seems to have been relegated to the sad position of being just an "order" of a higher class—"the somatoform disorders" (ICD-10)—hypochondriasis still offers rich pickings as an object of historical research. Stemming from the "convergence" (probably first occurring in classical Greece) among a *word* coined to refer to an anatomical locus, a *theory* of emotions (which is no more), and *utterances* by worthy Greek citizens who worried about sensations in their abdomens, *hypochondriasis* has since those halcyon days soldiered on, regardless, and remains a challenge to medicine.

Ever since the seventeenth century, two allegorical descriptions of hypochondriasis have governed thinking on the subject. According to one, hypochondriacal beliefs and preoccupations overtake the individual like a storm and are alien to his being; hence, as in the case of Cervantes's "Licenciado Vidriera," there is the hope of a cure. According to the other description, such preoccupations are part of the psychological makeup and grow inside the individual as he or she fails to negotiate a stressful environment; such worries are difficult to get rid of, and as in the case of Molière's (*Le Malade imaginaire*), the patient has to learn to live with them.

This old literary dichotomy is reflected in the differentiation between hypochondriasis as insanity and as nervous disorder. As the seventeenth-century concept of nervous disorder became "neurosis" during the eighteenth century, hypochondriasis became diluted out by the many other conditions that constituted the noble Cullean category. During the nineteenth century, all nervous disorders related to identifiable and localized lesions were gradually separated off (to contribute to the foundation of neurology) and this, once again, emphasized the fact that there were no explanations for hypochondriasis.

Some chose to explain it as reflecting the right reading of exaggerated bodily sensations; others as the wrong reading of normal sensations; yet others, like Freud, created narratives to account for the manner in which the obscure parts of the self interacted with symbols and with the environment. Structurally, however, all accounts have remained within the framework once set by the seventeenth-century writers. The reader, however, should go through the remainder of this book before deciding whether things have improved since.

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2

Clinical Features and Diagnosis of Hypochondriasis

VLADAN STARCEVIC

The term "hypochondriasis" has been in use for more than 2,000 years. However, its meaning throughout this time has been changing (see also Chapter 1). Today, it seems more difficult to agree on the defining characteristics of hypochondriasis than on its negative interpersonal and social implications. As a result, hypochondriasis is still frequently used as a derogatory label, and not as a medical diagnosis *per se*. In this respect, the situation does not seem to change: In the 1970s, "hypochondriac" was a "term of abuse" (Kenyon, 1976), and in the 1990s, hypochondriasis is associated with a "strong social stigma" (Rief and Hiller, 1998). To many, hypochondriasis continues to imply exaggeration and "imaginary sickness" at best, and feigning and fabrication at worst. Hypochondriasis is also a disqualifying label in the sense that no further questions are asked because of the assumption that everyone accepts the unfavorable implications of the label.

But what *is* hypochondriasis? As Table 2.1 shows, many definitions of hypochondriasis exist, with more than one given by the same author. Each definition of hypochondriasis attempts to capture its essential features. Hypochondriasis can be succinctly defined as excessive and persistent preoccupation with health, disease, and body, which is associated with a fear and suspicion that one is a victim of serious disease.

An important and early factor analytic study of hypochondriasis (Pilowsky, 1967) identified three dimensions of hypochondriasis: bodily preoccupation, disease phobia, and conviction of the presence of disease with nonresponse to reassurance. The elements common to various definitions of hypochondriasis, as well as empirical studies and clinical experience, all converge to suggest that sev-

Table 2.1. *Various definitions of hypochondriasis*

- "Mental preoccupation with a real or supposititious physical or mental disorder; a discrepancy between the degree of preoccupation and the grounds for it so that the former is far in excess of what is justified; and an affective condition best characterized as interest with conviction and consequent concern, and with indifference to the opinion to the environment, including irresponsiveness to persuasion" (Gillespie, 1929)
- "An obsessive kind of preoccupation with physical symptoms or body processes which is often accompanied by the development of various, and often shifting, somatic complaints" (Laughlin, 1956)
- "Unfounded fear of suffering from a disease" (Stenbäck and Rimón, 1964, p. 379)
- "Persistent preoccupation with disease despite reassurance given after thorough medical examination" (Pilowsky, 1967, p. 90)
- "Morbid preoccupation with mental or bodily functions or state of health" (Kenyon, 1976, p. 11)
- "Form of abnormal illness behaviour (dysnosognosia) in which the individual experiences and manifests a degree of concern over his state of health, which is out of proportion to the amount considered appropriate to the degree of objective evidence for the presence of disease" (Pilowsky, 1983, p. 319)
- "Concern with symptoms and with illness that the outside observer regards as excessive" (Sims, 1988, p. 171)
- "Pervasive and excessive concern about disease and a preoccupation with one's health" (Barsky, 1992, p. 791)
- "General propensity to worry about health, focus on one's body, and amplify discomfort" (Barsky *et al.*, 1992, p. 107)
- "Constellation of health-related attitudes, a perceptual style, and a set of beliefs, which are experienced as ego syntonic and an integral part of the individual's identity" (Barsky *et al.*, 1992, p. 102)

eral key components exist in the clinical presentation of patients with hypochondriasis. These components are as follows:

1. Bodily symptoms
2. Bodily preoccupation
3. Fear that a serious disease is already present
4. Suspicion that a serious disease is already present
5. Resistance to *routine* medical reassurance
6. Hypochondriacal behaviors

There is a question of whether a single diagnosis (of hypochondriasis) should "cover" such a broad range of phenomena. In addition, these components of hypochondriasis are not present to the same degree in all patients, which further contributes to its heterogeneity. Moreover, some components are not encountered

in certain patients. For example, patients whose bodily symptoms are so overshadowed by other characteristics of hypochondriasis may seem to be without symptoms. Some authors (Noyes et al., 1992) found that somatic symptoms were absent in certain patients with hypochondriasis. Likewise, some hypochondriacal patients are predominantly afraid of having a life-threatening disease, without expressing a striking suspicion that they are already ill. Others may be so preoccupied with suspicions about the presence of a disease that the extent of their fear of that disease is not readily apparent. A reaction to medical reassurance may also vary significantly, and reassurance is not necessarily rejected; however, hypochondriacal patients usually resist it.

Another important characteristic of hypochondriasis is persistence of its features, albeit with a fluctuating intensity, over a period of many months and, often, many years. The usual onset of hypochondriasis is in the third and fourth decade of life, but the illness can appear in adults of any age. The features of hypochondriasis in the elderly are usually not significantly different from those in younger patients (Barsky *et al.*, 1991a), except that at a later age, they may be more frequently associated with depression (Brown *et al.*, 1984; de Alarcon, 1964; Kramer-Ginsberg *et al.*, 1989).

Bodily Symptoms

Hypochondriacal patients usually complain of various bodily symptoms. The symptoms either have no demonstrable organic basis ("functional somatic symptoms") or, if patients do have a medical condition, the symptoms are experienced as far more intense than what could be expected on the basis of the objectively existing, organic pathology. Patients might complain of one or more symptoms at a time, with symptoms arising from various organ systems. They often talk about their symptoms in great detail, but the overall description of symptoms may be vague. The more ambiguous the symptoms are to patients, the greater is their distress and concern about health, often because such symptoms are likely to be interpreted negatively (Hitchcock and Mathews, 1992; Robbins and Kirmayer, 1996).

There are no symptoms typical of hypochondriasis. However, some symptoms (in the head, hair, neck, abdomen, and chest and in the musculoskeletal, gastrointestinal, dermatologic, and central nervous systems) were found more frequently among patients with hypochondriasis (Kenyon, 1964, 1976; Pilowsky, 1970). Various pains, headache, and cardiovascular symptoms are also encountered frequently. Patients with chronic pain may be prone to developing hypochondriasis. A positive correlation was found between the number of symptoms and the diagnosis of hypochondriasis (Barsky *et al.*, 1986), and hypochondriacal

patients tend to report more symptoms than do healthy control subjects (Haenen *et al.*, 1996).

It is not known if there is anything—other than the association between certain symptoms and specific diseases—that determines the "choice" of symptoms *reported* by patients with hypochondriasis. In other words, although patients experience many sensations and symptoms, they may report only those they attribute to a disease with which they are preoccupied. Thus, headache may be "singled out" and reported because it is attributed to a brain tumor; in the same vein, palpitations might be attributed to heart disease and reported as most distressing. The characteristics of symptom reporting style in hypochondriasis are reviewed in Chapter 10.

The intensity of symptoms usually varies over time. Patients often have a peculiar attitude toward their symptoms: They are not so distressed by symptoms *per se* as they are by their implications and meaning (Barsky and Klerman, 1983). Haenen *et al.* (1997a) speculate that there is a relationship between perception of bodily symptoms and hypochondriacal patients' reaction to them, so that "whenever these patients feel something inexplicable to them inside their bodies, it is likely to evoke fear and irritation. Not being able to differentiate between actual cancer warning signals and non-warning signals causes a situation in which all bodily sensations are potentially threatening and, therefore, deserve full attention" (p. 131). When patients feel their symptoms "deserve full attention," it is understandable that they easily become preoccupied with their bodies.

Bodily Preoccupation

Bodily preoccupation is one of the defining, enduring, and most conspicuous characteristics of hypochondriasis. Indeed, it can be regarded as a crucial component of the hypochondriacal patient's identity, a *sine qua non* of hypochondriasis. Bodily preoccupation pertains to the excessive awareness of and interest in bodily symptoms and bodily functioning in general. It is manifested through a constant and careful "listening" to and examining of one's own body, with the consequent tendency to report more symptoms. Patients are preoccupied not only with their symptoms, but also with the *meaning* of the symptoms (Avia, 1999). In a wider sense, bodily preoccupation refers to an enduring attention to, interest in, and vigilant attitude toward a variety of health- and illness-related matters.

In addition to being excessive, bodily preoccupation is also characterized by a large decrease in attention paid to and interest shown in other people, other objects, and other matters. As a result, patients may be preoccupied with the activities related to the suspected disease and health and illness in general, to the exclusion of almost all other activities. Hypochondriasis is seen as a "thematic

restriction of experience and behavior on to the body alone" (Schäfer, 1982, p. 239). Indeed, patients may be so preoccupied with their fears of and suspicions about disease that they sometimes appear withdrawn from the outside world.

Hypochondriacal patients manifest bodily preoccupation in many ways. Thus, they pay inordinate attention to bodily sensations that others usually find innocuous and insignificant (e.g., peristalsis). They are often troubled by minor or expected variations in their normal bodily functioning (e.g., changes in the heart rate in response to physical exertion) or by minor physical symptoms (e.g., sore throat). Their bodily symptoms are so disturbing and patients so concerned about health that the disease- and health-related topics are a dominant feature in almost all of their conversations and interactions with others. Likewise, patients with hypochondriasis are exquisitely sensitive to all illness- and health-relevant information, and they may literally absorb all such information. It is usually difficult for them to be distracted when they experience the symptoms and when their attention is directed to matters of health and illness. Patients also frequently examine their bodies for signs of disease. When they hear or read about a particular dreaded disease, they often become aware of bodily symptoms, suggesting to them that they may be suffering from that disease.

The bodily preoccupation in hypochondriasis is often obsessional in nature, with emphasis on details and minutiae of the patients' somatic experience, along with a desperate attempt to attain total control over the body. The latter can be seen in their persistent pattern of reassurance-seeking and health-checking. The hypochondriacal patients' locus of control with respect to illness may be basically external (Avia, 1999), which intensifies their health anxiety and strengthens the obsessional pursuit of control. Another obsessional feature of hypochondriacal patients is their intolerance of somatic uncertainty, along with relentless insistence on certainty with regard to their state of health (Slavney, 1987). The extent to which hypochondriacal patients are anxiously preoccupied with health and disease suggests that they perceive the body as threatening and locate the danger "within," that is, in the body. Indeed, they expect to be "betrayed" by the body or feel that such a "betrayal" has already occurred.

Patients are usually immersed in thoughts and fears of one disease at a time, but they may be preoccupied with different diseases in the course of hypochondriasis. Thus, a patient who suspected having multiple sclerosis may be afraid of having developed a brain tumor at another stage of the disorder. Cancer is the disease that is probably most feared by hypochondriacal patients, but the usual focus of such patients' preoccupations has been changing over the years, depending largely on social factors and scientific and treatment advances. Whereas patients with hypochondriasis had frequently been preoccupied with tuberculosis and syphilis a century ago, nowadays they are more preoccupied with a possibility of having contracted AIDS.

Fear That a Serious Disease Is Already Present

Most people are afraid of life-threatening and debilitating diseases, and so are patients with hypochondriasis. However, most people do not regard such diseases as a direct, current threat to them. They see diseases as either a threat in the distant future ("If it happens to me, it won't be now") or a danger with a low probability of affecting them ("It will not be me"). "Allocation" of the threat of a serious disease to the distant future and/or a sense that the disease will not strike helps most people dismiss fears of such diseases. Hypochondriacal patients, in contrast, are unable to do that and, as a result, are afraid of already having a disease.

In a more general sense, hypochondriacal patients are unable to protect themselves from fears involving dangers that they cannot prevent, and they do not tolerate low-risk threats to their health—threats to which everyone is exposed, but also threats that most people are able to "live with" and ultimately dismiss (Barsky, 1996; Mechanic, 1972).

The meaning of the disease of which hypochondriacal patients are afraid may be quite specific and may have symbolic significance. For example, the feared disease may be the same as that from which a significant other died. This may be experienced and interpreted by patients in very different ways, ranging from guilt over the loss of the loved one to identification with the deceased. In other cases, patients are afraid of a particular disease because it is disfiguring or because the handicap caused by the disease might have a devastating effect on their careers.

Fear of disease in patients with hypochondriasis has certain characteristics. It is like phobic fear in that it has a clear and specific focus: disease and, ultimately, death. Patients are afraid of a specific disease, such as cancer. According to some authors (Salkovskis and Clark, 1993), hypochondriacal patients are more likely to be afraid of the presence of serious disease with a chronic course and fatal outcome in the relatively distant future (e.g., multiple sclerosis). On rare occasions, patients with hypochondriasis are afraid of mental illness. This is referred to as "mental hypochondriasis," but it is doubtful that such a condition has anything substantial in common with hypochondriasis in which somatic disease is the focus of preoccupation.

Hypochondriacal fear of disease differs from phobic fear, and especially from "simple" disease phobia, in the following respects:

- Hypochondriacal patients do not consider their fear excessive and/or unreasonable.
- Hypochondriacal patients are not as afraid of becoming seriously ill in the future as they are of already having a serious disease that has not yet been detected.

- Hypochondriacal patients do not have a marked tendency to avoid physicians and hospitals.
- Hypochondriacal patients usually do not show an immediate anxiety response to encounters with physicians, because they regard such encounters as an opportunity to seek medical reassurance and thus alleviate their fears.

Patients with hypochondriasis are usually distressed by thoughts and images of death. The excessive fear of death seems to be one of the fundamental, underlying characteristics of hypochondriasis. The fear of death and hypochondriasis have been linked both empirically and on philosophical grounds. Thus, phenomenological philosophy considers hypochondriasis a consequence of an inability to "come to terms with the finiteness" of life, and the consequent "deep-rooted unresolved fear of death" (Schäfer, 1982, p. 237). In psychodynamic terms, hypochondriasis has been seen as a defense against the fear of death (Wahl, 1963).

Although studies have consistently shown an association between fear of death and hypochondriasis (Barsky and Wyshak, 1989; Hollifield *et al.*, 1999a; Kellner *et al.*, 1987a), the direction of potential causality in this relationship remains uncertain: Does excessive fear of death precede or even cause hypochondriasis or is it a consequence of hypochondriasis? Some authors (e.g., Kellner, 1986, p. 294) regard hypochondriacal features as primary, and fear of death as secondary.

Suspicion That a Serious Disease Is Already Present

The terms "disease belief" and "disease conviction" are often used to describe the hypochondriacal patients' attitudes toward the disease with which they are preoccupied. However, these terms may be misleading, because of their implication of delusion, especially when the "belief" and "conviction" are resistant to medical reassurance and to all evidence that disease is not present. Therefore, the term "disease suspicion" seems more appropriately described as a cognitive component of the hypochondriacal experience (Starcevic, 1988). Patients with hypochondriasis typically suspect that they have a serious disease that physicians have not yet detected.

There is a crucial distinction between suspicion and belief/conviction. Suspicion reflects uncertainty, whereas a belief/conviction denotes certainty. The uncertainty of hypochondriacal patients pertains to their central dilemma: "Am I ill or not?" As long as such uncertainty persists, there is no delusion. Hypochondriacal patients find it particularly difficult to tolerate uncertainty, which compels them to look for "final" evidence or "perfect" proof that the disease is either present or not; however, the lack of such evidence or proof maintains their suspicion and strengthens their disbelief in a physician's diagnosis.

If there is no uncertainty, and patients are *sure* and *know* that they are ill, de-