THEORETICAL INSERTIONS REGARDING COGNITIVE-BEHAVIORAL AND HYPNOTHERAPEUTIC INTERVENTIONS APPLIED IN HYPOCHONDRIAC AFFECTIONS

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Abstract
In DSM-IV-TR, the main characteristic of hypochondria is the individual’s concern regarding the existence of worries related to the possible existence of a serious medical condition. This fact is based on the erroneous interpretation of corporal signs and sensations. The utilized Cognitive-Behavioral model in explaining the hypochondriac disorder allowed the drawing of a complex tableau regarding the illness. Additionally this model allowed the structuring of a protocol which includes classic Cognitive-Behavioral techniques along with hypnotherapeutic approaches. This model protocol may lead to improving the amelioration of hypochondriac states and behaviors.

Keywords: Hypochondriasis; concept of medically unexplained symptoms; somatic symptoms; cognitive-behavioral therapy; hypnosis.

1. INTRODUCTION

The hypochondriac disorder was classified within the Diagnostic and Statistical Manual of Mental Disorders as a somatoform disorder. Thus, according to DSM-IV-TR the main characteristic of hypochondria is being concerned about the existence of worries regarding the possibility of suffering from a serious medical condition (DSM-IV-TRim, 2000). This phenomenon arises from the erroneous interpretation of corporal signs and sensations.

From the Cognitive-Behavioral perspective the hypochondriac disorder can be regarded as a problem tightly connected to the anxiety for a person’s specific state of health (Wells, 2002).

The defining trait of such a disorder consists in the belief and fear that a person suffers from a serious somatic affection. This belief persists even though medical investigations do not show any elements which may justify the subject’s concerns regarding his or her state of health. The ideas of hypochondriac patients are not of delirious intensity, as they may admit that their fears could be exaggerated or there is a possibility they might not suffer from any disease ((DSM-IV-TRim, 2000). The concerns of these patients generate for them a significant discomfort, and the disorder should last for at least six months in order to be diagnosed as such (DSM-IV-TRim, 2000).

The hypochondriac disorder may coexist with panic attacks, as the concern regarding the state of health may show fluctuations through several months or even days (Fava, Grandi, Saviotti, & Conti, 1990). The acute phases of the disorder are followed by more quiet periods, when the subjects’ fears may be reduced in intensity. The hypochondriac patients seem to be more calm following the medical reassurances, but their peaceful state may not last longer than several hours or eventually several days (Belling, 2006).

The essence of this disorder consists in the erroneous interpretation of bodily sensations and symptoms which are normal or minor, being considered by the patient to be signs of a severe organic pathology (Stern, & Fernandez, 1991). Patients suffering from hypochondriacs often consider that the disaster is a catastrophic one (implying terrible suffering or death) and will be produced in a further future (Speckens, 2001).
2. HYPOCHONDRIAC DISORDER: FEATURES AND COGNITIVE MODEL

The cognitive model of the hypochondriac disorder was defined by Salkovskis & Warwick (1989). These authors consider that the disorder is established when a critical incident activates the dysfunctional beliefs regarding the state of health. Such convictions of dysfunctional character are formed during childhood or later on and are modified as a result of life experiences (Warwick & Salkovskis, 1989).

The critical incident may be represented by the appearance of unexpected somatic symptoms, by observing previously ignored sensations, by the death of a relative or of a friend or the confrontation with certain information regarding a disease (Salkovskis, Warwick & Deale, 2003).

Once activated, the dysfunctional beliefs will lead to the interpretation of physiological symptoms or sensations as being the signs of serious organic disorders. These interpretations manifest as automatic negative thoughts, which may also include images of anxiogenic content referring to organs or body parts which do not function properly (patients see their heart as damaged their lungs as being inflamed or malign tumors invading their organism). As a consequence, a series of mechanisms is activated maintaining anxiety and the concern regarding the state of health, mechanism of affective, cognitive, physiological and behavioral nature (Lecci & Cohen, 2002).

Hypochondriac patients are preoccupied with news and information regarding diverse diseases, carefully following articles or mass-media shows regarding medical issues.

Patients also present mental ruminations regarding concerns or solving eventual problems regarding the disease. Thus their concerns refer whether to preventive strategies based on a hyper vigilant state in order to detect early signs of a possible disease, or they might represent a set of superstitious strategies destined to overcoming the so-called negative effects of a positive type of thinking: “if I worry, it will not happen to me” (Clark & Wells, 1997). Permanent ruminations regarding the state of health maintain the awareness to physiological sensations and produce secondary emotional disorders such as, for instance, sleep disorders, which will further contribute to reinforcing erroneous beliefs (Hardy, Warmbrodt & Chrisman, 2001).

The most common cognitive distortions in the case of the hypochondriac disorder include: ignoring alternative explanations regarding the presence of the symptoms, selective thinking and the tendency to catastrophize. Thus, the tendency of ignoring results of investigations and the medical opinions which do not confirm the existence of a serious condition is based on the erroneous belief: “It is possible that the lab test are not able to offer certainty that I'm not suffering from a serious condition” (Holdevici, 2011).

Selective thinking refers to the fact that the patient will only receive during medical check-ups only certain fragmented information regarding their own state. For instance, the information regarding the fact that the blood pressure is within normal limits and should be checked periodically can be interpreted by the hypochondriac as a sign that something is wrong and this is why periodical monitoring is needed. Catastrophizing refers to overreacting over minor symptoms, accompanied by ignoring benign explanation regarding them (Hofmann, 2011).

The most spread emotional reaction which accompanies erroneous interpretations of physiological symptoms is anxiety. Depression may also represent a secondary reaction especially if hypochondriac preoccupations last for long (Beck, Emery & Greenberg, 2005).

Avoiding behavior also come in diverse forms, thus, the subject may avoid physical efforts or exposure to diverse information regarding certain diseases. Some hypochondriac patients will deliberately utilize strategies of distraction, trying to control their thoughts in order to not think of the disease (Fisher & Wells, 2009).

Avoiding behaviors which imply a certain degree of risk (such as physical effort) stop the expose to those situations which might contribute to infirming the negative dysfunctional beliefs, and avoiding the confrontation with information regarding medical issues only makes the hypochondriac preoccupation to persist. Also trying to repress thoughts of intrusive content leads to a paradoxical increase of frequency and their intensity (Short, Kitchiner & Curran, 2004).

3. THE COGNITIVE-BEHAVIORAL INTERVENTION IN THE CASE OF HYPOCHONDRIAC ILLNESS

The objective of the cognitive psychotherapy in the case of hypochondriac patients consists in offering more plausible explanations for their problem (Salkovskis & Warwick, 1986). The therapy is focused on collecting proof in order to construct a psychological model which is not centered on the idea of disease.

The applied psychotherapeutic techniques include from the “demystifying” the symptoms to becoming aware of avoiding behaviors; also psycho education techniques are utilized in order to explain to the patients the fact that any type of reassurance, including medical check-ups and lab analysis produce relief at least for the
moment. The psychotherapist may utilize this situation in order to lead the patient to becoming aware of the real cause of the symptoms (Taylor, Asmundson & Coons, 2005).

Other cognitive-behavioral strategies include experiments of orienting the focus toward inwards. The therapist will request the patient to focus on physical sensations which normally are not observed, being underlined the similarity between corporal checking made by the hypochondriac person and this type of experiments. Following these experiments the patient may become aware of the fact that focusing on these physiological processes leads to an intensification, which is interpreted by the hypochondriac as representing a sign of the serious condition he suffers from (Bouman & Buwalda, 2008).

The cognitive restructuring in the case of hypochondriac patients has the main objective of obtaining an understanding of their problem. In some cases the modification of the conception regarding the existence of a serious disease is hard to eliminate through the counter-argumentation. For instance there are patients who are convinced by the fact that they suffer from a severe disease but they are not sure which or think that the affection has an insidious evolution and this is why the lab investigations cannot be conclusive. In this situation verbal counter-argumentation or experiments may not lead to expected results. Additionally even if the techniques through which explanations alternative to the symptoms are presented by the patient are not proven to be effective on the long term (Visser & Bouman, 1992).

The success of the cognitive-behavioral psychotherapy in the case of hypochondriacs depends on the ability of the therapist to commute the attention of the patient from symptoms to thoughts and behavior associated with them (Looper & Kirmayer, 2002).

Direct challenge of beliefs regarding disease may be utilized in the case in which concrete predictions can be formulated in this regard. For instance, in the case when it is believed that a serious heart condition is the problem, predictions may be formulated about the conditions in which the condition may manifest and a catastrophe may occur. Physical exercises may be utilized in order to infirm such a belief.

Another set of applied techniques in working with hypochondriac patients consists in paradoxical interventions. Thus the hypochondriac patient is invited to emphasize as much as possible the exploration of their own body along with the ruminations related to a possible medical condition. This way the patient is proven regarding the way the attention focus may lead to emphasizing symptoms and emotional states regarding their erroneous interpretation.

The therapist will make with the patient an analysis of advantages and disadvantages which result from medical investigations which are requested, proving that the disadvantages are more numerous than the advantages, fact which will enforce the patient’s motivation of giving up the permanent search of reassurances. Also the therapist will guide the patient to the direction of modifying the strategy of requesting medical check-up (Holdevici, 2011).

Thus, he will be advice to postpone the check-ups as long as possible and instead of immediately addressing to the doctor for tests, to note down the symptoms in a journal and present them to the doctor after a longer period of time. The request of noting down symptoms represents a modality of countering the patient’s fear that he will forget about them thus exposing to a higher risk of becoming sick.

The patient will be asked to also note down the variables which influences symptoms such as stress factors, alcohol or caffeine consumption, alimentary diet, sleep quality, resting periods, etc. These factors will influence the emphasis of symptoms and will be utilized by the therapist in order to bring counterarguments against the existence of a severe somatic disorder (Rief, Hiller & Margraf, 1998).

### 4. VISUAL IMAGERY AND HYPNOSIS IN HYPOCHONDRIAC ILLNESS

Hypnosis is considered to be an instrument of observation and understanding of the patient’s pathology. Establishing a new order, redefining will lead to a new significance, more comprehensible of the symptomatology, a new perspective which will make the change possible (Barber & Bejenke, 1996).

Mental images play a very important role in the case of erroneous interpretations made by the hypochondriac patients. From this reason, modifying the anxiogenic images represents one of the important ways of therapeutic approach in the case of this disorder (Pelletier, 1979).

The visual imagery technique is associated to much better results when applied in hypnosis. There are two ways of using this method.

The first one refers to systematic desensibilization, in which a hierarchy of anxiogenic situations is made (in the present case, of the fears regarding the state of health), the patient in a state of health being requested to confront these until the anxiety becomes very great. The next image is switched to afterwards only when the anxiety regarding the previous image has been almost totally reduced. A second modality of using the visual imagery technique consists in modifying the content of the anxiogenic image (Kellner, 1992).
Paradoxically, some hypochondriac patients who are afraid they might suffer from a serious condition act on unhealthy behaviors such as smoking or abusive alcohol use. In such situations, one of the important tasks of the therapist consists in motivating the patient to eliminate such risky behaviors and adopt a healthier lifestyle (Taylor, Asmundson & Coons, 2005).

5. CONCLUSIONS

The involvement of the hypochondriac patients in the cognitive-behavioral therapy is rather difficult because of the mistrust they manifest towards medical personnel. Also, difficulties may interfere because of the uncontrolled wish of the patients to discuss and listen to diverse information regarding physical symptoms, despite the preocupation with psychological factors. These patients have it difficult to accept the idea that their problematic is of psychological nature and make efforts to prove that this approach does not suit them because they are severely ill (Salkovskis, Warwick & Deale, 2003).

In order to accelerate the therapeutic demarche it is desired that the patient should give up on numerous medical check-ups which he has the tendency to make. This fact is rather difficult especially when the patient refuses to give them up. When this happens, the results of the medical check-ups should be utilized along with the behavioral experiments in order to prove the patient the way in which the symptoms ameliorate as a result of reinforcements, showing their psychogenic nature (Baur, 1989). Additionally, the therapist will make predictions regarding the way in which the patient will interpret negative results of medical check-ups.

A great part of the hypochondriac patients will have the tendency of requesting assurance from the psychotherapist. They will interrogate their therapist regarding the cause of older or more recent symptoms and will look to present longer lists of symptoms (Starčević, 1990). The therapist will need to fight smoothly against these tendencies which sabotage the psychotherapy.

The development of the cognitive-behavioral model of hypochondria has lead to shaping some psychotherapeutic interventions which turned out to be efficient (Dugas & Robichaud, 2007). The cognitive-behavioral approach suggested in several times that the observation of the symptoms – both on a topographical and functional levels – are remarkably overlapped to anxiety disorders. A consequence of this fact is the reinterpretation given by DSM 5 which classifies hypochondria as Illness anxiety disorder (DSM 5, 2013).

This way it is stated that the Illness anxiety disorder (IAD) does not refer to the presence or absence of a disorder but to the psychological reaction (Rodríguez-Testal, Senín-Calderón & Perona-Garcelán, 2014). Cognitive-behavioral therapy can help patients learn to cope with IAD and lead more productive lives. For some, medications for anxiety, depression, or other mental disorders may help.

6. REFERENCES


