Chapter 15

Health anxiety and medically unexplained symptoms

Introduction

Medically unexplained symptoms

Medically unexplained symptoms (MUS) are physical symptoms that have no currently known pathological cause. These symptoms can be extremely debilitating and cause significant distress. Clinical presentations vary widely from people who regularly present with minor symptoms to people with severe disability, using wheelchairs or even becoming bed-bound.

Around 30% of patients with MUS have associated depression and anxiety. Patients with MUS may also have co-existing long-term physical health conditions. MUS can be categorised into three types, although there is much overlap.

- Health anxiety or hypochondriasis: a persistent fear of developing serious illness. Patients are highly anxious and remain convinced that they have a serious illness despite negative physical examinations, investigations and medical reassurance.
- Functional somatic disorders such as chronic back or pelvic pain, atypical chest pain, irritable bowel syndrome, chronic fatigue syndrome and fibromyalgia (see *Chapter 17*).
- Somatic symptoms presenting in patients with underlying anxiety or depression.

It is generally helpful to avoid using the term "MUS" with patients, as it may be seen as implying that the symptoms are not "real". Other potential terms include persistent physical symptoms and specific functional somatic syndromes, such as irritable bowel or chronic fatigue syndrome. If uncertain or lacking a diagnostic label, you can use descriptive terms such as "chronic facial pain" or "distressing sensation of dizziness".

Health anxiety and MUS in primary care

Physical symptoms with no known organic cause are common. In fact, most people have some daily physical sensations or symptoms, and 14–20% of primary care consultations involve a physical symptom without likely organic

disease (Mumford *et al.*, 1991; Peveler *et al.*, 1997). However, the majority of these patients will not develop ongoing anxiety or persistent symptoms if managed appropriately by health professionals in the early stages of their presentation.

Smaller numbers of patients develop more persistent or severe problems. The prevalence of health anxiety is around 1–2% in the general population and 5–9% amongst GP attendees. This group may be responsible for disproportionately high usage of health services and can become a source of frustration, stress and 'heartsink' for health professionals (see *Chapter 19*).

Typical features of patients presenting with health anxiety and MUS in primary care are shown in *Box 15.1*:

Box 15.1

Typical features of patients with health anxiety and MUS in primary care

- Frequent attendances at GP surgeries, often associated with requests for repeated investigations and referrals.
- Multiple physical symptoms affecting functioning with no obvious cause.
- Vague, changing, unusual or atypical symptoms.
- Poor or variable response to multiple previous treatments.
- Past history is complex and difficult to clarify.

CBT for health anxiety and MUS

CBT is an effective treatment for health anxiety and MUS (Barsky & Ahern, 2004; Kroenke, 2007), which improves medical symptoms and associated symptoms of depression and anxiety. Nevertheless, there can be difficulties in offering talking treatments to patients who may not perceive their condition as being psychological in nature and are often fixed on seeking a medical cure for their problems.

A CBT approach to understanding health anxiety

Background/environmental factors

Individuals who lack social support, or were exposed to family conflict, illness or death during childhood are particularly vulnerable to developing health anxiety. Other associated factors include:

- maternal overprotection
- past experiences of unsatisfactory medical treatment
- lack of parental care or affection except when unwell
- severe cases can overlap with personality disorder (Bass & Murphy, 1995)

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Figure 15.1: Developm

Illness behaviour may also be maintained by an element of 'secondary gain', including financial benefits, equipment, accommodation, and support or attention from friends, family and the medical profession.

Development of unhelpful core beliefs and rules about health

Health anxiety develops in vulnerable individuals when a *critical incident* activates underlying negative beliefs about health developed from past experiences. These beliefs include:

- viewing themselves as particularly vulnerable to illness (*"my body is weak and I am liable to develop something serious"*)
- fears about the experience of illness or death (*"I would not be able to cope with the agonising pain that always occurs in cancer"*)
- loss of self-esteem associated with a reduced ability to function normally through ill health (*"if I can't work through illness then I am a failure"*).

The development of health anxiety is shown in *Figure 15.1*.

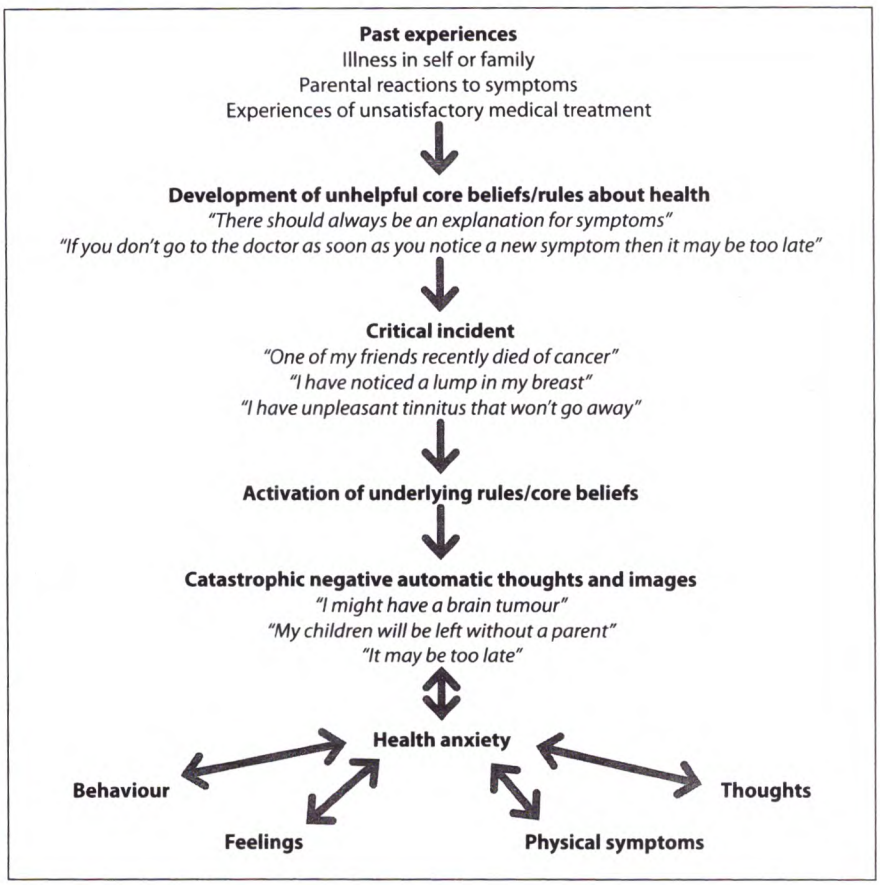

Figure 15.1: Development of health anxiety (Warwick & Salkovkis, 1989; Wells, 1997)

Case Example 15.1: The development of health anxiety

Denise is a social worker, who is married with three children. In February, she develops a flu-like illness lasting over a fortnight, where she feels feverish, weak and tired with aching muscles.

Background and predisposing factors

Denise was a premature baby who had several chest infections and was admitted to hospital at the age of 3 months. When she grew older, despite being in good health, her mother would keep her off school for minor illnesses, saying "*Your immune system is weak. We need to take special care of you.*" Denise's mother would take her to the GP with any minor signs of illness. When Denise was 10 years old, her grandmother died unexpectedly. Her family was shocked and angry about her care in hospital.

In later life, Denise continued to worry about any minor symptom. Then her son developed a severe chest infection which required an overnight stay in hospital. Denise found this terrifying and it re-awakened many of her childhood fears about illness. Although her son recovered completely, Denise found it difficult to manage her own anxiety afterwards. Denise's own flu-like illness then acted as a trigger for the development of health anxiety.

Development of health anxiety

Denise only expected to be ill for a few days, so she was surprised that the illness lasted so long. A few weeks later she felt better, but not all the symptoms had gone. She felt weaker and became tired more quickly. She sometimes felt dizzy and noticed tingling in her hands and feet.

Denise visited her GP again, who tried to reassure her that there was nothing wrong, but her symptoms seemed to be getting worse. She found a magazine article about a woman with strange symptoms which turned out to be due to a brain tumour and she worried that the same might happen to her.

Denise imagined herself developing a severe illness such as multiple sclerosis. She had a frightening image of herself in a wheelchair, dependent on others and unable to care for her children. Whenever she had a quiet moment, Denise found herself thinking about becoming ill.

Denise returned to her GP several times and was referred to a neurologist. All the investigations were normal. Each time that Denise was reassured by a doctor or had a negative test, she felt hugely relieved. But she also felt compelled to keep checking and became anxious again if she noticed any symptoms ("*Tests and doctors can be wrong!*").

Denise spent a lot of time looking on the internet for medical information, and discovered a list of terrifying diseases that might be the cause of her symptoms. She visited many doctors who gave conflicting advice and often seemed uninterested in her problems.

Because Denise felt so tired, she needed to rest a lot more. She kept checking her legs by tensing and relaxing the muscles, which made them achy and sore. *"My muscles are growing weaker"*, she thought, *"I'm getting worse"*. She stopped walking to work and avoided socialising with colleagues. At home she tended to sit down and spent less time playing with her children. She kept thinking *"If I feel this tired now, I will end up in a wheelchair in the future. My life will be ruined"*. This made her feel even more anxious and depressed.

Thoughts in health anxiety

Health anxious patients typically show a number of cognitive misperceptions, including:

- beliefs that particular illnesses are more likely or more serious than they are in reality (*"it might be cancer..."*)
- misinterpretation of harmless bodily symptoms as evidence of serious disease (*"the tiredness must be due to multiple sclerosis"*)
- viewing themselves as unable to prevent or cope with the illness if it did develop (*"I would be in excruciating, unbearable pain"*)
- constant thinking, worrying or talking about health maintains the focus on bodily symptoms, increasing anxiety and low mood
- focusing on information that confirms their fears whilst ignoring evidence of good health; this is a common cause of misunderstandings in medical communications (*"the doctor said it could be something serious"*).

Feelings and emotions

Patients with health anxiety experience high levels of anxiety about potential illness and its impact on their lives. They may also feel low or depressed. Feelings of anger and frustration are also common, and may be directed towards health professionals, who are perceived as ignoring a genuine, severe medical problem.

Physical symptoms and reactions

Any physical symptom can be associated with anxiety, depending on what meaning a patient assigns to it. Patients misinterpret normal variations in bodily sensations, or symptoms related to a benign condition such as tinnitus, as a sign of serious ill health. They also experience anxiety-related

physical symptoms, which are also misinterpreted as evidence of physical illness. Fatigue and muscle aches can arise due to reduced activity and loss of fitness. Side-effects of medication can also lead to unpleasant physical sensations.

The role of behaviour

Behaviour in health anxiety is generally designed to check for or protect from physical illness. However, these reactions just maintain or worsen the patient's anxiety. Common behaviour in health anxiety includes the following.

- *Reassurance-seeking*: seeking constant reassurance from health professionals, family and friends can temporarily reduce anxiety, but leads to a longer-term increase in fear and the need for further reassurance as a vicious cycle.
- *Body-checking and scanning*: patients constantly monitor and check their body for 'danger' symptoms and signs of disease. This often causes new symptoms such as pain, redness or swelling. Patients also notice normal variations in bodily functions, and interpret all these sensations as evidence of serious ill-health.
- *Frequent attendance at health services*: patients make frequent visits to multiple health professionals, requesting repeated investigations and referrals. These may temporarily reassure the patient, but ultimately *increase* anxiety (*"the doctor must think it's serious or they wouldn't do a test"*) and reinforce beliefs about the need for medical tests to investigate symptoms. It can also cause frustration on both sides and prevent the patient from building a trusting relationship with one health professional.
- *Behaving 'as if' they are ill*: illness behaviours such as reducing activity, using inappropriate medication, using a wheelchair or taking an illness role in family life, reinforce the patient's belief that they really are unwell. The associated reduction in enjoyable and meaningful activities also worsens any tiredness and low mood.
- *Thinking, talking and reading about health*: patients may spend a great deal of time reading medical information in books, magazines and on the internet. This worsens anxiety as they become aware of other potentially serious medical problems. Talking excessively about health problems also maintains their preoccupation with illness.
- *Avoidance*: some anxious individuals try to avoid reminders of physical illness to suppress their fears. However, attempts at thought suppression or avoidance are usually unsuccessful and often result in a paradoxical increase in unwanted thoughts, which seem more frightening than ever.

From *theory* to *practice*...

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From *theory* to *practice...*

- Think about a patient that you regularly see who is often anxious about their health. Then try to build a simple 'case formulation' by mapping out their difficulties using the five areas of the CBM.
- What typical thoughts, feelings and behaviours are associated with the person's physical symptoms?
- Which environmental factors, both past and present, might be relevant to the development of the disorder in this individual?
- Is the patient trapped in any vicious cycles?
- Finish by identifying one simple next step that you might take for trying to understand this patient and build a rapport with them.

Managing MUS and health anxiety

Steps for a CBT approach to MUS

1. Build a trusting relationship with the patient.
2. Review and summarise the patient's medical notes.
3. Conduct a longer status consultation in which you:
   - begin by reviewing physical symptoms
   - explore thoughts, feelings, physical symptoms, behaviour, environmental factors and triggers
   - include summarising, link-making and handover questions.
4. Give empowering explanations for all symptoms.
5. Broaden the agenda.
6. Negotiate treatment (medical and non-medical).
7. Ask for feedback / check patient understanding at the end of the consultation.
8. Use appropriate CBT-based strategies (e.g. goal setting).

Build a trusting relationship with patients

One of the most important goals for health professionals is to build rapport and a trusting relationship with patients with MUS. Focus on being empathic, warm, concerned and respectful, using non-judgemental language and trying to work in partnership with the patient to overcome their difficulties. Take time to learn about the person's life, family, pets and interests. *Box 15.2* highlights some common pitfalls to avoid for health professionals working with MUS patients.

Set realistic goals

It is important to set realistic goals for working with patients with MUS and health anxiety. Focus on making small steps forwards. For many patients, a

Box 15.2

What not to do – medical behaviour that worsens health anxiety

- Not giving a credible explanation for the patient's symptoms or using only negative statements (*"there is nothing wrong with you"*).
- Behaviour suggesting that you do not believe the patient or take their symptoms seriously.
- Blaming the patient for their problems.
- Giving excessive reassurance which does not address the fears underlying the individual patient's anxiety.
- Carrying out repeated unnecessary investigations or referrals to specialists.
- Giving unnecessary strong or addictive medication.

highly appropriate goal is to stabilise their condition and prevent further deterioration or iatrogenic harm.

Ensure the primary care team works together as a whole

Encourage patients to see one lead health professional on a regular basis who can get to know them well. These clinicians may require team support through practice meetings and discussions. Try to proactively arrange appointments in advance rather than allowing the patient to book on an *ad hoc* basis.

It is also essential to communicate clearly with all members of the team and specialists. Write clear notes about agreed management plans and give the patient clear, written instructions on who to contact and how to manage flare-ups or likely changes in symptoms.

Case Example 15.2: Introducing a 10 Minute CBT approach to health anxiety

Victoria is a 26 year old teacher whose father died from lung cancer when she was a child. She has become increasingly anxious about her own health since a family friend was recently diagnosed with breast cancer. Victoria is worried about her recurrent headaches, despite having been diagnosed with tension-type headaches by a neurologist. She attends the GP surgery regularly, asking for further tests to check that her symptoms are not serious.

Victoria *Hello Doctor. I need you to do something about my headaches!*
GP *How were you hoping that I might help you today?*
Victoria *These headaches must be something serious. I'd like to have some more tests to check them out.*

GP I've noticed that you have come in several times recently about your headaches, even though you got the 'all clear' from the specialist.

Victoria He might have made a mistake. It's not normal to get headaches so often.

GP You seem really worried.

Victoria I am worried. You read about this all the time – doctors missing things that turn out to be serious.

GP We have spent quite a bit of time looking into the cause of your headaches, but that doesn't seem to be helping you to feel any better.

Victoria Well, I can't stop thinking that they might mean something really bad.

GP I wonder if, as well as continuing to treat your headaches, we should spend some time trying to help you feel less anxious when you have one. This doesn't mean that we stop giving you the medical care that you need. But, it might also be helpful to spend some time understanding why they are causing you so much worry, despite all the negative tests.

Victoria Tests can be wrong! I would feel better if I could be sure that there is nothing bad causing them, or get rid of them altogether.

GP It is very common to get headaches, so it may not be possible to get rid of them altogether. And feeling anxious and stressed about having them might actually make them worse.

Victoria I suppose that's true. But mine are really bad.

GP They sound very distressing. Would you be prepared to make an appointment in 2 weeks, to fully review your headaches and how they are affecting your life?

Victoria Yes, I would be glad to come and talk about this. It's really starting to get me down.

Review and summarise the patient's notes

Before you see the patient it can be helpful to read and summarise the patient's prior history, investigations and treatments including:

- previous disease episodes and clusters of symptoms
- hospital letters and discharge summaries
- tests and results
- mental health problems and psychosocial triggers
- patterns of disease and symptom severity over time in relation to external stress and events in the patient's life.

This summary should be highlighted in the medical records for anyone who might see the patient. Although it may seem like a time-consuming exercise,

this information can save a huge amount of time and enable far better clinical decision-making.

Carry out a longer 'status consultation'

The next step is to arrange a longer 20–30 minute initial consultation with a patient with MUS. Start with a thorough review of the patient's physical symptoms and carry out a physical examination if needed. Use this session as a 'fact-finding mission' and try to avoid offering diagnoses, opinions or suggestions at this stage. Make a written list of key symptoms and ask about a typical day or for specific examples of when symptoms were particularly troublesome. Don't rush this step. It may take the entire first consultation to review the physical symptoms.

The aim is to build a relationship and ensure the patient feels understood and listened to, using empathic and reflective statements to acknowledge the reality and distressing nature of the symptoms. The next step is to explore all five areas of the cognitive behavioural model (see *Figure 15.2* which includes some useful questions).

Thoughts	**Feelings**
"What went through your mind when you noticed the symptoms?" *"What is your biggest concern or fear that these symptoms might mean?"* *"What troubles you most about your symptoms?"*	*"How does it make you feel to have these symptoms?"* *"How do you feel when you think, 'It might be cancer'?"* *"These symptoms seem to be causing you a great deal of worry..."* Include empathic statements: *"That must be very difficult..."*
Behaviour	**Physical symptoms**
"What do you do when you notice the symptoms?" *"What do you do to make yourself feel better?"* *"Do you test or check your health in any way?"* *"Do you talk to others or read up about your health?"* *"What are you doing differently now? Is there anything you are no longer doing?"*	*"Tell me about the physical symptoms that trouble you the most"* *"Are there any other important symptoms?"*
Background, environment and triggers	
"Is there anything else going on in your life that is making the symptoms difficult to cope with?" *"Was anything going on at the time that they first started?"* *"Has anything happened in your life to make you particularly concerned about your health?"*	

Figure 15.2: Questions to explore the five areas of the CBM in health anxiety

Figure 15.3: Ex

Some patients with MUS have difficulty in discussing emotional factors, and may hold unhelpful beliefs about expressing emotions. In this case, do not overemphasise emotional aspects of the problem, and instead focus on discussing physical and behavioural issues.

Finish by summarising what you have heard and checking that the patient understands and agrees with you. Gently highlight any links or vicious cycles (see *Figure 15.3*) that you have noticed:

> *"You mentioned that when you think 'It might be cancer,' you start to feel quite anxious."*

Always follow a summary with a handover question which encourages the patient to reflect on the discussion.

> *"What do you make of this? Is there any way we can use this information to help you?"*

Provide empowering explanations for key symptoms

Giving clear, concrete and tangible explanations of symptoms can help to reduce health anxiety. Avoid jargon and link your explanation to any specific fears or health beliefs held by a particular patient. If there is no easy medical explanation, then give clear reasons why the symptoms do not fit with something serious.

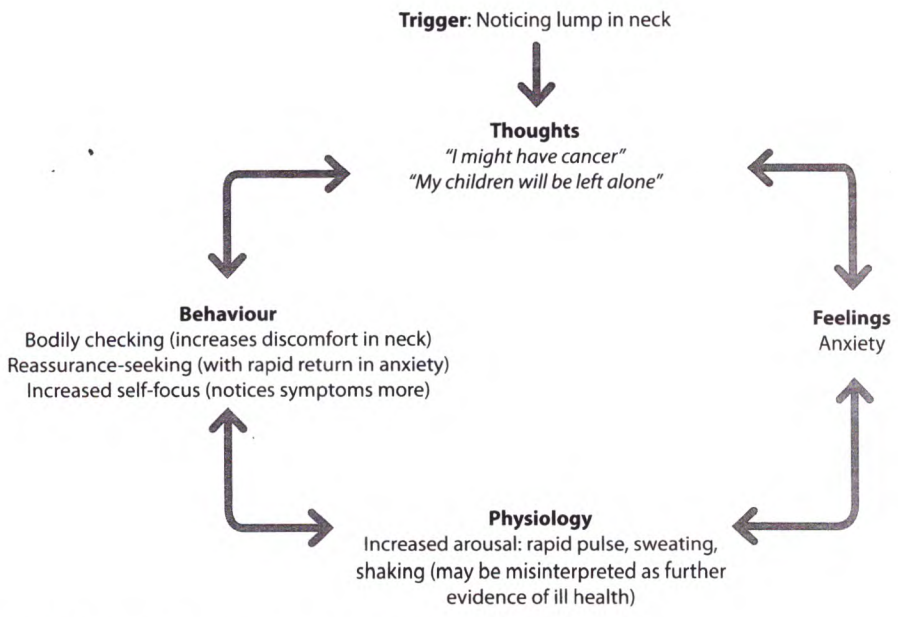


Figure 15.3: Example of a vicious cycle in a patient with health anxiety

It is helpful to provide written information, but simply handing the patient a leaflet does not constitute an empowering explanation! Try to provide the information in the form of a dialogue, checking understanding as you proceed.

Explicitly acknowledge that the patient's symptoms are real and a source of major concern and distress. However, you can also emphasise that the severity of symptoms is not necessarily an indicator of the seriousness of the underlying condition.

> *"I know that you are worried that your pain is due to a problem with your heart, but I believe that it is coming from the muscles in your chest wall. When these muscles go into spasm it can be extremely painful. However, having severe pain does not necessarily mean a serious or dangerous underlying cause."*

If possible, include options for self-help or self-management of the symptoms (*Box 15.3*).

Box 15.3 **Empowering explanations of symptoms**

- Physical tension or anxiety can lead to pain.
- Stress at home causes tension in the muscles of your back and this can lead to pain.
- Depression lowers the pain threshold and makes pain worse (see *Chapter 12*).
- When you feel low or depressed your body becomes more sensitive to pain so it feels more intense. Could that be true for you?
- Thinking about symptoms makes them worse.
- Constantly thinking about or touching the affected area makes it feel even worse.

Coping with uncertainty

Health anxious patients often say that they would like to be 100% *certain* that nothing serious is wrong. However, it is impossible to completely eliminate the risk of developing any disease, no matter how rare it may be. Constantly thinking about the worst case scenario does not reduce the risk of it occurring and life becomes filled with anxiety and stress. Instead, emphasise living in the 'here and now'.

> *"I understand that the idea of having a heart problem makes you feel very anxious and that you would like to feel certain that your heart is 100% healthy. All the tests do confirm that. However, we all live with some uncertainty about health because we can never guarantee that we will not*

become ill in the future. Worry will not prevent this. It is important that the fear of becoming ill does not prevent you from living a fulfilling and enjoyable life. How much time do you spend worrying about developing an illness? Do you think this is helping you? Suppose you spend the next 10 years worrying about getting cancer but do not develop it? Would this worry have been a good use of your time?"

Rather than continually reassuring the patient, try to share the uncertainty with them. People are often more willing to accept uncertainty about a diagnosis if you provide assurance that you will keep an open mind and their symptoms will be taken seriously and reassessed in future if things change.

"I take your health very seriously and I will be happy to review this again if needed."

Broaden the agenda

The next stage is to broaden the patient's perspective to incorporate the idea that their problem is not purely an undiagnosed physical health condition, but also includes caring for emotional wellbeing and finding ways to live a fulfilling and meaningful life despite the presence or absence of physical symptoms.

Avoid black and white perspectives of the problem being *either* medical *or* psychological in nature. Instead, reassure the patient that you will continue to treat physical health problems with a holistic approach which includes medical treatment as well as additional strategies which may help them to cope more effectively with their symptoms.

"It also strikes me that the worry and stress about your symptoms is causing as much problem as the symptoms themselves, what do you think...?"

"You've been suffering from this for a long time. Doing tests and referrals doesn't seem to be helping you to feel better. Perhaps we could try a different approach...?"

"It seems that the symptoms are having a major impact on your life. Perhaps we could look at some ways of helping to improve the quality of your life, even if the symptoms are still present..."

Avoid falling into the trap of continually debating the cause of symptoms, or trying to convince the patient that their problems are *really* psychological in nature. Instead, try to explore and acknowledge the patient's fears about the meaning of symptoms.

"I see that you are worrying about your symptoms again. What thoughts are going through your mind? That must be very distressing."

Negotiate the next steps (medical and non-medical treatments)

Primary care management of health anxious patients is likely to involve a variety of approaches including medication, investigations, referrals and psychological strategies. Involve the patient in decision-making wherever possible. The main focus should be on managing symptoms and improving functioning. Remember also to proactively screen for and treat mental health disorders such as depression according to guidelines.

Primary care management involves investigating symptoms appropriately and thoroughly but without excessive repetition of tests or referrals simply 'for reassurance'. Telling a patient beforehand that you are expecting a normal result may help them to feel more reassured by a negative test. Try to minimise the use of medication, particularly if it is potentially addictive or has serious side-effects. Relevant information to include in a referral letter is shown in *Box 15.4*.

Positive risk management involves balancing the risk of over-investigation with that of missed diagnoses. Avoid making assumptions and use your clinical judgement to assess and manage any new or changing symptoms. Inform and document clearly about 'red flag' symptoms and signs.

Box 15.4

Key information to include in referral letters for patients with MUS

- Inform the specialist that you suspect possible MUS.
- Be clear what you are asking them (e.g. to rule out a specific illness).
- Include details of relevant psychosocial factors.
- Provide a detailed past medical history including MUS syndromes and mental health problems.

Check patient understanding

Always finish by checking what the patient has understood from the consultation. Remember, she may believe that you said she has a serious physical illness. Try to respond without being defensive.

> *"I'm glad you were able to share that with me because that wasn't the impression I was hoping to give you. In fact, I don't think it is likely that your symptoms are due to cancer. I believe that they are due to an unpleasant but harmless condition called irritable bowel syndrome..."*

CBT strategies for managing MUS

The main aims for managing MUS in primary care should be to improve function and quality of life, even if symptoms are persistent and remain unexplained.

Behavioural strategies in health anxiety

Promoting behavioural change is possibly the most important and realistic strategy for dealing with health anxiety in primary care. This includes changing unhelpful patterns of behaviour and setting goals to increase meaningful and enjoyable activities despite the presence of symptoms.

Graded exercise and relaxation

A graded stretching and exercise programme can be extremely effective at improving fitness and reducing symptoms such as fatigue and muscle pain. This should follow principles of paced activity to avoid 'boom and bust' patterns of behaviour. Try to encourage the patient to draw on social support to maintain exercise over time; for example, walking with friends or a local group. This will help to motivate them to keep up the changes and the increased social interaction may also help to lift their mood.

Relaxation and mindfulness may also be very helpful for improving symptom control.

Goal setting

It is important for patients to gradually resume their normal daily activities. This is likely to boost mood, increase the level of enjoyment in life, give an increased sense of satisfaction and take their minds off negative thoughts and worries.

The next step is to jointly plan some goals for improving life, even if symptoms remain. Goals should relate to the patient's values and important life areas (see *Chapter 8*). Ask the patient:

> *"What was life like before you developed these symptoms? What did you used to enjoy?"*
>
> *"What matters most in your life? What activities might be important for you to build up again...?"*
>
> *"What would you do differently if you felt better?"*
>
> *"Could you try any of these in very small steps...?"*

It can be helpful to monitor current activity levels and plan future changes using a behaviour monitoring chart (see *Chapter 7*).

Reducing reassurance-seeking behaviour

Health professionals should try to avoid getting drawn into constant demands for reassurance from health anxious patients. It is often more helpful to reflect back what they say with an empathic statement:

Patient *I just need to be sure it is not cancer*
GP *It sounds like you are worrying about cancer again. That must be very difficult.*

Reducing reassurance-seeking behaviour should be planned collaboratively with the patient, and involve both family members and health professionals. Instead of asking for reassurance, the patient could try an alternative activity or distraction exercise. They could also try reviewing some pre-written information, such as a thought record, reassuring statements, pie chart or written strategies for how to cope with anxiety-provoking situations.

Reducing monitoring and body-checking

Ask patients to record in a journal how often they check a particular aspect of their physical health each day. The next step is to agree how much body-checking is *helpful* for the future. For example, if the patient fears cancer, then checking once a month is more appropriate than several times an hour.

It is often difficult to stop body-checking, which may have become an ingrained habit. Techniques such as distraction or using thought records to find alternatives for negative thoughts can be useful. Patients can also remind themselves that body checking is increasing their anxiety in the long term.

From *theory* to *practice*...

Investigating the effect of reassurance
Ask patients with health anxiety to observe the effects of other people's reassurance on their anxiety. Does reassurance reduce their anxiety? How long does this last for?

Does being reassured reduce any of their physical symptoms? How can they explain this? Would a serious diagnosis be likely to go away simply with reassurance?

Is there any way that you could *permanently* reassure them? Why not? What does this tell them about the nature of their worry?

Monitoring and body-checking behaviour
Ask patients to notice what happens when they focus internally on symptoms or their body state. How does this alter their thoughts or anxiety levels? What is the impact of continually poking and prodding the skin or of continually taking forced, deep breaths? How might this contribute to their anxiety problems?

Cognitive strategies for health anxiety

Using a pie chart to generate alternative ideas for symptoms

A pie chart can be a powerful visual tool which encourages the patient to keep in mind the most common and likely causes of particular symptoms. Use guided discovery to encourage patients to think up a range of possible causes and to draw their own conclusions from the exercise.

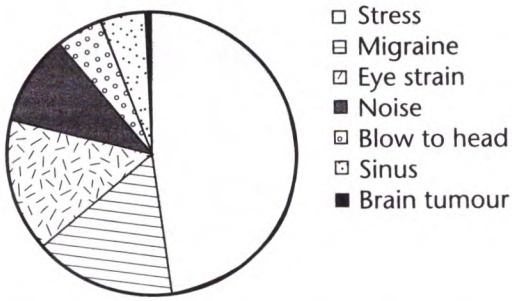
Case Example 15.2: *Continued*: using pie charts to look for alternative explanations for symptoms

Let's return to the example of Victoria, the young woman with headaches and health anxiety.

Her GP encourages her to generate a list of common causes for headaches:

- stress and tension
- migraine
- eye strain / bright light
- loud noise
- bang on the head
- blocked sinuses
- brain tumour

Next, Victoria's GP draws a large circle and asks Victoria to divide up the 'pie' into slices. Each slice represents how common the different causes are and how likely to have caused headaches in a woman of her age. She leaves her most feared cause (a brain tumour) until *last* to put on the chart. She draws the following pie chart:



After this exercise, Victoria's GP asks her, *'What do you make of this chart?'* Victoria replies that it is helpful to think about all the possible causes of her illness rather than focusing on the one or two, most serious possibilities.

Note: the sections of the chart need only be approximate. However, if the patient is vastly overestimating the likelihood of one particular cause, it may be helpful to discuss this openly.

Looking for evidence for and against specific, feared diagnoses

Written thought records (*Box 15.5*) can be used to look for evidence for and against particular negative thoughts or feared diagnoses.

Box 15.5 **Using thought records to test out unhelpful thoughts in health anxiety**

Thought to test out	
My headaches are due to a brain tumour.	
Evidence *for* having a brain tumour	**Evidence *against* having a brain tumour**
The headaches I get are very severe. I have had them for a long time. Doctors do make mistakes and sometimes miss serious illnesses.	Brain tumours are very rare – there are many other causes of headaches and most are not serious. I have had lots of tests, including a brain scan. These were all normal. The headache gets better if I lie down and rest – brain tumours would not get better so easily. My headaches are worse when I am stressed or anxious – this does not fit with a brain tumour. The doctor says that I do not have any other signs that would indicate a brain tumour.
Alternative/balanced thought to replace the hot thought	
My headaches are more likely to be due to tension and stress. Worrying about my headaches makes them worse and makes me feel very anxious.	

Theory A and Theory B method

- Theory A: this is a worry I have about my symptoms and when I worry and pay attention to them they get worse.
- Theory B: the symptoms are dangerous and serious.

Discuss both theories openly with the patient. Look for evidence for both and write them down or talk through them to decide which theory best fits the facts.

Other methods of coping with health anxiety and worry

- Encourage acceptance of uncertainty about health, which enables people to face up to scary thoughts and make more positive choices and develop coping strategies.
- Use distraction to focus the mind on other things.
- Focus on coping strategies rather than fears. Use a 'then what..?' approach to identify ways to cope with feared outcomes. For example, discussing how to cope if they did develop a particular disorder.
- Use mindfulness to distance from scary thoughts, difficult emotions and unpleasant symptoms ('See your thoughts, don't be your thoughts').
- Plan a designated 'worry time' each day (as for generalised anxiety disorder, see *Chapter 14*).

Key learning points

Summary of the cognitive behavioural model for health anxiety:

Unhelpful core beliefs and rules about health	
"I am vulnerable to illness"	
"Being ill means that something serious is likely to happen"	
"If I can't do my job through ill-health then my life is ruined"	
Thoughts	**Feelings**
Serious illnesses are more likely than in reality	Anxiety and worry
Harmless symptoms viewed as evidence of ill-health	Irritability, anger, frustration
Belief that unable to prevent or cope with the illness	Low mood and depression
Constant thinking about health (preoccupation with health)	
Ignore evidence of good health	

Behaviour	Physical symptoms
Frequent visits to multiple health professionals Reassurance-seeking and avoidance Excessive talking and reading about health Body-checking and scanning Illness behaviours	Physical symptoms associated with benign conditions Anxiety-related somatic symptoms Tiredness and fatigue due to reduced activity Side-effects from medication
Environment and background	
Maternal overprotection, lack of parental care or affection except when unwell; past experiences of unsatisfactory medical treatment Critical incident activates health anxiety (e.g. unexpected illness in self or others)	

- Health anxiety arises from a persistent fear of serious illness. Patients experience genuine physical symptoms but overestimate the likely severity of the cause.
- A patient with a health anxiety disorder will feel anxious despite negative physical examinations, tests or medical reassurance, so try not to feel frustrated, but view it as an understandable response based on a psychological model of the disorder.
- Work on developing effective and trusting relationships between GP and patient. Listen and acknowledge the reality and distressing nature of symptoms.
- Try not to contribute to the vicious cycle of worsening health anxiety with inappropriate investigations, unsatisfactory explanations or excessive reassurance. Consider psychological referral.
- Be realistic with your goals. It may be most appropriate to aim to prevent further deterioration or iatrogenic harm.
- The main focus for change should be to encourage improved function and wellbeing despite the presence of persistent symptoms. Encourage graded increase in meaningful and valued activities, particularly involving exercise and social interaction.

Chapter 16

Chronic ph

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