COGNITIVE BEHAVIORAL CASE CONFERENCE

Challenges in the Assessment and Treatment of Health Anxiety: The Case of Mrs. A.

Randi E. McCabe and Martin M. Antony, *McMaster University* and *St. Joseph's Hospital*

Health anxiety can present a challenge for clinicians, both from the perspective of assigning a DSM-IV *diagnosis and in developing an appropriate treatment plan. The case of Mrs. A. illustrates some of the complexities that arise in the diagnosis and treatment of health anxiety. Mrs. A. is a 60-year-old retired teacher who presented to a specialized anxiety clinic with a wide range of health anxiety symptoms. The details of Mrs. A.'s case are presented along with information obtained during her assessment. Issues related to conceptualization and potential obstacles to treatment are highlighted. This case is discussed by a number of experts in the field of health anxiety who provide different cognitive-behavioral perspectives on conceptualization and treatment planning.*

HEALTH ANXIETY presents a diagnostic challenge for clinicians in that a number of different *DSM-IV* categories may include anxiety about health as a key feature. In many cases, the symptoms of health anxiety may lead to diagnosis of an anxiety disorder such as specific phobia (e.g., specific fear of contracting an illness), panic disorder (e.g., fear of arousal sensations precipitating a negative health outcome), generalized anxiety disorder (e.g., uncontrollable worry about health and other life domains), or obsessive-compulsive disorder (OCD; e.g., a fear of contracting cancer through contamination and compulsive hand washing). In other cases, a diagnosis of a somatoform disorder such as hypochondriasis may be warranted, particularly when an individual mistakenly believes that he or she has a serious illness, based on the misinterpretation of bodily symptoms. Finally, in cases where an individual is absolutely convinced that he or she has an illness, a diagnosis of delusional disorder or another psychotic disorder may be appropriate. These diagnostic issues surrounding health anxiety have been highlighted in the literature (e.g., Noyes, 1999; Otto, Pollack, Sachs, & Rosenbaum, 1992).

The diagnostic challenges associated with health anxiety are particularly evident in clinical practice. In this article, the case of Mrs. A. is presented. Mrs. A. was referred to the Anxiety Treatment and Research Centre, a specialty anxiety disorders clinic located in a general teaching hospital, for assessment and treatment of a range of health anxiety symptoms. Following the case description, issues related to conceptualization and potential obstacles to treatment are highlighted. Our goal in this case presentation is to facilitate discussion regarding the conceptualization and treatment of health anxiety from a cognitive-behavioral perspective.

Mrs. A. is a 60-year-old retired teacher who lives alone. She retired from teaching 2 years ago. She has been divorced from her husband for 26 years and has three adult children who are married and have families of their own.

Presenting Problems

Mrs. A.'s main concern was what she described as "constant" anxiety about her health. She reported many somatic symptoms, fears of having an illness that has not yet been diagnosed (e.g., bone and colon cancer, a heart condition) based on misinterpretation of bodily sensations, fears of contracting an illness (e.g., AIDS), fears of experiencing a catastrophic medical event (e.g., heart attack or stroke), and a fear of dying. When asked about the specific content of her fears of death and dying, Mrs. A. reported that she fears the unknown and worries that her religious beliefs about an afterlife may not be true.

As a result of her fears, Mrs. A. reported significant avoidance of situations associated with a perceived risk of contracting an illness. For example, Mrs. A. avoids flying on airplanes due to possible risks associated with breathing "recycled air." She also reported engaging in a variety of safety behaviors to prevent the onset of illness, to detect an illness that may be present, and to ward off death. For example, Mrs. A. wears gloves to church to prevent direct hand contact with others. Mrs. A. also carries nitroglycerin spray that was prescribed to her for chest pain. Despite having never used the spray, she takes her purse with her when she goes upstairs in her house to ensure that she has the nitroglycerin with her in case she needs it. When Mrs. A. walks upstairs she goes very slowly and pauses periodically to prevent having a heart attack. Mrs. A. requests to have her blood checked regularly and compares her levels to recommended ranges. When Mrs. A.

Cognitive and Behavioral Practice 11, 102–106, 2004
1077-7229/04/102–106$1.00/0

experiences symptoms such as chest pain, she checks medical books to compare her symptoms with the symptoms of a heart attack. Mrs. A. seeks reassurance from her doctors and family members but reports that her fears are only temporarily allayed. Her fears also persist despite the lack of evidence from medical tests to support her fears. Both her doctors and family members have told Mrs. A. that her health anxiety is excessive. Mrs. A. reports that she has worried since she was a child but that her fears have intensified in the past 5 years, especially since retiring and having more time to dwell on her worries.

Mrs. A. reported that her fears are both distressing and impairing, preventing her from living her life the way she would like. However, Mrs. A. displayed poor insight into the excessive nature of her fears, stating that she knew she worried a lot but felt that she needed to worry in order to prevent a health catastrophe. In addition, Mrs. A. refused to consider taking any medications that might help to alleviate her anxiety as she felt that the medicine might mask physical symptoms that might otherwise warn her of a potential catastrophe. Mrs. A. has never received specific treatment for her health anxiety.

Personal History

Mrs. A. reported several past events that she links to her fears of illness and her distrust of medical doctors and medical tests. Mrs. A. reported being sick a lot as a child (age 10 and under), with a variety of illnesses (e.g., chronic bronchitis, measles, chicken pox, mumps). She reported that her illnesses "seemed to last longer than others' did." In addition, Mrs. A.'s brother had heart problems as a child and Mrs. A. remembers being kept in her bedroom a great deal of the time so that she didn't expose her brother to her illnesses. In her early 30s, Mrs. A. gave birth to a full-term baby daughter who was stillborn, despite a normal pregnancy. When Mrs. A. was in her mid-30s, her mother died (age 62) from a coronary event despite having seen a physician for chest pain in the days preceding her death. Her mother's death was particularly difficult because Mrs. A. had been worrying that her mother might be ill, especially when she could not contact her mother by telephone. Her fears were placated by family members and friends who told her that she was "overreacting." However, when Mrs. A. finally went to see her mother, her fears were confirmed as she found her mother had passed away while she was sleeping.

Medical History

Mrs. A. reported many somatic symptoms (e.g., rib pain, chest pain, rectal pain, headaches, blurry vision, tingling sensations) that have led to extensive medical investigation (e.g., chest X-rays, endoscopy, colonoscopy, blood work, stomach and bowel investigations, CAT scans). Other than a low iron level, findings from medical tests have been negative. Mrs. A. has been tempted to accept offers to have additional tests (e.g., bone scan, heart stress test), but she has avoided these investigations for fear of dying from procedure-related complications (e.g., side effects of the injection necessary for the bone scan; radiation effects from an MRI).

Diagnostic Conceptualization

As part of the assessment process, Mrs. A. was administered the Structured Clinical Interview for *DSM-IV* (SCID-IV; First, Spitzer, Gibbon, & Williams, 1996). Below, we present the findings for relevant disorders to illustrate the difficulties with establishing appropriate diagnoses.

Specific Phobia, Other Type (i.e., Contracting an Illness)

Mrs. A. reported excessive fear of objects and situations from which she might contract disease. As mentioned previously, she will not fly because of the risk of contracting a disease from the recycled air. She also avoids having to stay in a hotel for fear of catching a disease from prior hotel room occupants. If she must stay in a hotel she reports feeling extremely anxious and she must bring her own bedding. Given that there is not just one specific object or situation that Mrs. A. fears, it would seem that a diagnosis of specific phobia is not warranted and these fears may be better accounted for by another diagnosis.

Obsessive-Compulsive Disorder

Mrs. A. reported recurrent intrusive thoughts about death and dying. For example, Mrs. A. was invited to a wedding and the thought popped into her mind that someone would die before the wedding. She began to ruminate about who would die and how terrible it would be. She reported being unable to ignore or suppress the thought. Mrs. A. also reported obsessing about potential dangers in her house (e.g., a gas leak). In addition, Mrs. A. described excessive thoughts about contamination and she engages in avoidance to prevent being contaminated (e.g., avoiding air travel, wearing gloves at church). Mrs. A. also experiences excessive doubting. She doubts the results of medical tests, the advice given to her by doctors, and the safety of medical tests. She also ruminates about what will happen to her after death. She has spoken with her priest, who reassured her that she will go to heaven. However, Mrs. A. doubts whether this is true. Mrs. A. denied any obsessions related to nonsensical impulses, aggressive impulses, sexual obsessions, religious or satanic thoughts, accidental harm to others, horrific images, or nonsensical thoughts/images.

With respect to compulsions, Mrs. A. reported engaging