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# Using functional analysis to disentangle diagnostic complexities: A case of mucus-related health anxiety<sup>☆</sup>

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## ABSTRACT

This case report examines the unusual symptom presentation of a middle-aged, Caucasian man referred for treatment of intrusive somatic concerns and behaviors involving mucous sensations. Although the patient's symptoms overlapped phenomenologically and functionally with multiple disorders, including obsessive-compulsive disorder, hypochondriasis, panic disorder and tic disorder, the patient did not meet criteria for any one. This case challenged the *DSM-IV* nosology and supports the shift to conceptualize obsessive-compulsive disorder and other related disorders as comprising a spectrum or family of disorders. Despite complexities in diagnosis, treatment was tailored to the patient's unique symptom set and employed cognitive behavioral therapy with exposure and response prevention. Across 16 sessions of treatment, the patient's somatic obsessions and intrusive safety and reassurance seeking improved. His total score on the Yale-Brown Obsessive Compulsive Scale – Second edition decreased from 43 at the start of treatment to 17 at the end of treatment, with gains maintained at one-month follow-up. Frequency of emergency-room visits decreased, respectively, from 22 to 0 in the month preceding and following treatment. This case highlights the importance of continued examination of uncommon cases to further advance conceptualization and treatment of obsessive-compulsive related disorders.

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## 1. Theoretical and research basis

Health anxiety has been conceptualized as occurring on a continuum, with hypochondriasis as most severe (Salkovskis & Warwick, 2001; Taylor & Asmundson, 2004). Health anxiety and hypochondriasis are characterized by fears of having a serious illness associated with misinterpretations of bodily sensations. The somatic preoccupations in hypochondriasis are repetitive and intrusive and can cause significant distress and impairment (Fineberg, Sazena, Zohar, & Craig, 2007). Distress from the somatic fears is neutralized through performance of safety behaviors, negatively reinforcing their use (e.g., Abramowitz & Moore, 2007; Salkovskis, 1991). In hypochondriasis, for example, distress

is often alleviated through medical evaluations, reassurance seeking, and information gathering (e.g., Internet searches), which also strengthen the somatic beliefs. The relief achieved by safety behaviors is often fleeting, however (Salkovskis & Warwick, 2001), as the health-related fears persist in the face of medical evaluations and reassurance (APA, 2000).

Health anxiety and hypochondriasis overlap with other anxiety disorders such as generalized anxiety disorder and panic disorder (Marcus, Gurley, Marchi, & Bauer, 2007), as well as delusional disorder, somatic type (APA, 2000; Hart & Bjorgvinsson, 2010). Moreover, health anxiety and hypochondriasis have phenomenological and functional similarities with the obsessive-compulsive related disorders (OCDs; Hollander, Kim, & Zohar, 2007; Hollander, Zohar, Sirovatka, & Regier, 2011; Phillips et al., 2010). These putative OCDs are characterized by intrusive, repetitive behaviors and/or thoughts, with symptom clusters ranging from being primarily motoric (e.g., tic disorder) to cognitively based (e.g., body dysmorphic disorder; Hollander et al., 2011; Phillips et al., 2010).

Similar to the OCD and OCDR psychotherapy literature, cognitive-behavioral models of treatment have been examined in alleviating health anxiety and hypochondriacal concerns. Specific cognitive-behavioral interventions found to be effective have included psychoeducation, exposure and response prevention, stress

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management, and cognitive restructuring (e.g., Barsky & Ahern, 2004; Bleichard, Timmer, & Reif, 2005; Bouman & Visser, 1998; Clark et al. 1998; Visser & Bouman, 2001). These treatments can target selective attention and catastrophic interpretation of somatosensory stimuli, intolerance of uncertainty, and emotional distress through several avenues. Psychoeducation can help provide corrective information about benign “body noise,” faulty health beliefs, and maladaptive coping behaviors (Barsky & Ahern, 2004). Anxiety from health-related fears can be extinguished through exposure to health-related triggers (e.g., television programs on health topics, “body noise”) and prevention of safety behaviors (e.g., medical evaluations, reassurance-seeking).

Although the health anxiety and hypochondriasis literature has advanced significantly over the past three decades, much remains to be learned by studying less common or “non-classic” cases that do not fit neatly within existing diagnoses. The current report describes a patient whose symptom presentation highlights the relationships among health anxiety, OCD and related disorders and challenges the current diagnostic classification system.

## 2. Case presentation and presenting complaints

Demographic information was altered to maintain confidentiality of the patient. Tony was a White, middle-aged, male Veteran who was married with three children. He graduated high school and served in the US military for approximately ten years. A routine military medical evaluation revealed that he had high blood pressure, which resulted in subsequent problems with renal insufficiency. Upon leaving the service in his early 30s, Tony attempted to attend college and retain stable employment, but he encountered difficulties because of problems with learning and performance. He was repeatedly fired from jobs because of slow learning and was diagnosed with an unspecified cognitive disorder in his mid-30s. Tony remained unemployed from his late 30s onward and received compensation for service-connected conditions. He had multiple health problems, including kidney disease and an aortic aneurysm. Results of brief neuropsychological testing in his early 40s indicated that his ability to learn new information was impaired, but long-term memory was intact. No general index of intellectual functioning was obtained.

During a two-year period, Tony was referred by his psychiatrist for two separate courses of individual therapy and one course of group therapy targeting two discrete, somatically focused forms of anxiety. This report describes both forms of anxiety (see Section 3), yet focuses on the second course of treatment because of the challenges it entailed.

At the time of Tony's second referral for therapy, he reported significant distress related to concerns about mucous sensations. He was experiencing increased frequency of mucous sensations in his throat and experienced significant distress when he perceived the mucus was “stuck.” When unable to easily eliminate the mucous sensation, Tony coughed repetitively and forcefully, sometimes for hours, to clear his throat. The constant coughing caused breathlessness, which he believed was evidence that mucus was accumulating and that he was obtaining insufficient oxygen. This, in turn, led to fears that he was suffocating or going crazy. Tony attempted to reduce his anxiety by using nasal rinses, over-the-counter vapor rub and humidifiers, drinking warm liquids or lemon juice, using cough drops and decongestants, and reducing the quantity of food he consumed.

Tony's self-reported “best tool” for managing episodes was speaking with providers. He called existing providers as well as local, regional, and national support lines, nursing triage lines, and suicide lines (despite denied suicidal ideation, intent and plan). He circulated among five large hospital systems and frequented

urgent-care clinics. In addition to primary and emergency care, he sought evaluations from multiple medical specialties, including ear, nose and throat; pulmonary; allergy; and nephrology in the private and Veterans Affairs sectors. Multiple types of procedures and imaging were unable to detect mucus or other organic abnormalities, and medication changes did not affect recurrence of these sensations and resultant episodes.

Tony was frustrated with the perceived incompetence of his medical providers in eliminating his somatic concerns; and his providers were concerned with Tony's persistent, recurring contact. He was confronted by his primary care physician and psychiatrist about over-utilization of services and was told by national support and crisis-line employees that limits on his call usage were being enacted such that he was permitted to call only once per week, for a maximum of 10 min. Tony acknowledged that “something had to change” when he received 22 bills for emergency-room visits that he had accrued over four weeks.

Overall, Tony appeared motivated to change, arrived to his appointments promptly, and provided notification when scheduling conflicts arose. During sessions he was polite and cooperative. He spoke clearly, with normal rate, rhythm, spontaneity, and volume, and made appropriate eye contact. Tony's mood was generally calm, with range of affect somewhat limited. He denied problems with depressed mood. When given the opportunity to talk about his symptoms, he became more animated and demonstrated a broader range of affect. Overall, Tony's affect was not labile and mostly congruent to content. His thought processes were coherent, although circumstantial at times. His insight and judgment related to his presenting symptoms were poor, and abstract reasoning appeared below average. When the clinician provided lengthier reviews of concepts or multi-step instructions, Tony tended to adopt an absent expression and efforts were made to speak slower and use briefer statements. Circumstantiality and chronological inconsistencies, all of which seemed unintentional and more likely related to his history of cognitive difficulties, characterized Tony's report during the assessment interview and throughout treatment.

## 3. History

Tony, the youngest of five children, was raised by his parents. His father died when he was a teenager, and his relationships with his siblings were not particularly close. Soon after graduating high school, Tony enlisted in the US military and served for approximately ten years during a peace-time era. He left the service shortly after being diagnosed with severe hypertension. He inconsistently took his hypertension medication and engaged in heavy nicotine (one pack of cigarettes per day) and alcohol use (one pint of liquor per day) for over ten years. During this same time, he began receiving pharmacological treatments and supportive therapy for anxiety-related problems and received a diagnosis of panic disorder. Onset of his concerns about mucus occurred after a medicine he was taking caused excessive postnasal drainage. His treating physician at the time changed his medication, and his concerns subsided for several months. In his early 40s, Tony started dialysis and spent one month in the hospital for a worsening of his aortic aneurysm. These health events caused him to discontinue use of nicotine and alcohol and increase his medication compliance. His health stabilized over the next ten years, while his anxiety about focalized somatic sensations, which included concerns about mucus and burping, increased; although no specific time of onset is known for the latter. Tony's daily schedule was dedicated to receiving medical care for chronic health conditions, and his attention was frequently directed toward monitoring symptoms and bodily sensations. He consistently denied anxiety

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