

ANXIETY ABOUT HEALTH is something we all experience at various times in our lives. In its mild forms health anxiety is adaptive, serving as a motivator for seeking appropriate health care and for avoiding things that are harmful to health. Severe forms of health anxiety are less common in the general population, but are often encountered in clinical practice, particularly by clinicians working in anxiety disorder clinics and in consultation-liaison services in general hospitals. The case of Mrs. A. is useful because it raises many of the important issues that clinicians encounter when assessing and treating people with severe health anxiety.

Mrs. A. presents with long-standing health anxiety, which has worsened in recent years. Her main problems are as follows: various somatic symptoms (e.g., pain in various bodily regions), numerous health-related fears (e.g., fears of having serious, undiagnosed diseases), chronic anxiety and health-related worries (e.g., worry that doctors are not sufficiently competent to make a correct diagnosis), and health-related safety behaviors. That is, behaviors intended to avoid or escape aversive stimuli (e.g., walking slowly up the stairs in order to avert a heart attack; seeking reassurance from doctors to allay her health concerns; avoiding air travel because of the perceived risks of breathing “recycled air”). She also seeks out various safety signals to reduce her health concerns. That is, stimuli she associates with the absence of health-related danger (e.g., carrying nitroglycerin spray that she could use in the event of a heart attack). Extensive medical testing has been unable to explain her somatic symptoms and has not reduced her health anxiety. She has poor insight into the excessive nature of her concerns.

Diagnostic Issues

A diagnostic formulation is insufficient for understanding the causes of Mrs. A.’s problems and is insufficient for planning treatment. Nevertheless, the process of making a diagnosis is an important first step for understanding and treating her problems. The task of assessing *DSM-IV* Axes I and II encourages the clinician to look beyond the patient’s most salient problems. This helps the clinician identify psychiatric problems that might otherwise be missed. Diagnoses also facilitate communication among health-care professionals. That is, diagnoses represent a common language that can be used to communicate information about the patient’s primary problems. In the case of Mrs. A., diagnoses are important for communicating whether her problems are due to a general medical condition in need of a surgical or pharmacological intervention, or whether her problems are psychological in nature and therefore in need of some kind of psychotherapeutic or psychopharmacological intervention.

I agree with much of the diagnostic formulation offered by McCabe and Antony (2004). The authors make a good case for ruling out various disorders such as specific phobia and generalized anxiety disorder. I agree that Mrs. A.’s primary problem is hypochondriasis. In fact, she has a textbook case hypochondriasis. But is it useful or necessary to assign an additional diagnosis of obsessive-compulsive disorder (OCD)? McCabe and Antony believe so. These authors point out that Mrs. A. has symptoms suggestive of OCD: i.e., recurrent intrusive thoughts, rumination and doubting, and compulsions. But all of these symptoms are health-related. Her intrusive thoughts are about death and dying, her rumination and doubting are about health-related threats (e.g., doubts about the accuracy of medical tests), and her compulsions involve the search for reassuring health-related information or efforts to avoid health risks (even her concern about a gas leak at home is health-related). Mrs. A. does not appear to have any nonhealth-related obsessions or compulsions.

An additional diagnosis of OCD does not enhance our understanding of Mrs. A.’s problems or facilitate treatment planning. Her putative OCD symptoms are commonly associated with hypochondriasis (Asmundson, Taylor, & Cox, 2001; Kellner, 1986). In fact, inventories designed to measure the major facets of hypochondriasis include subscales and items assessing these symptoms; e.g., subscales assessing recurrent thoughts of death, doubts about medical tests, and excessive reassurance seeking (Asmundson et al., 2001). Contemporary cognitive-behavioral therapy (CBT) for OCD is in many ways similar to contemporary CBT for hypochondriasis (compare, for example, the hypochondriasis protocols in Taylor & Asmundson, 2004, with the OCD protocol in Taylor, Thorndarson, & Söchting, 2001). So, for Mrs. A., an additional diagnosis of OCD does not indicate any interventions that we would not already use in the treatment of hypochondriasis. In fact, a diagnosis of OCD may be more hindrance than help. Such an additional diagnosis carries the implication that Mrs. A. has nonhealth-related obsessions or compulsions, thereby misleading clinicians who receive information about her disorders. An additional diagnosis of OCD is also inconsistent with *DSM-IV*. According to *DSM-IV* (and the text revision, *DSM-IV-TR*), Mrs. A. does not qualify for an additional diagnosis of OCD because all her symptoms are health-related:

Individuals with Hypochondriasis may have intrusive thoughts about having a disease and also may have associated compulsive behaviors (e.g., asking for reassurances). A separate diagnosis of Obsessive-Compulsive Disorder is given only when the obsessions or compulsions are not restricted to concerns about illness (e.g., checking locks). (American Psychiatric Association, 2000, p. 506)

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