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Health anxiety disorders: A cognitive construal

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ABSTRACT

The features of severe health anxiety, intense and persistent anxiety about one's present and future health, are described. In common with other anxiety disorders such as GAD, PTSD and OCD, the core of HAD is distressing, uncontrollable anxiety, and is classifiable as an Anxiety Disorder, Health Anxiety Disorder (HAD). The cognitive construal of HAD proposes that health anxiety is caused by catastrophic misinterpretations of the significance of sensations and/or changes in bodily functions and appearance (such as swellings, pain, loss of energy, dizzy spells). The nature, causes, triggers, persistence, assessment and treatment of HAD are reviewed, and the present status of the cognitive model is appraised. Suggestions are made for future research and clinical applications, and the need for incisive evaluations of the main premises of the model is emphasized.

Introduction

The phenomenon of *health anxiety* described by Salkovskis and Warwick in 1986 provided a foundation for the concept of Health Anxiety Disorders, which is now classifiable as an anxiety disorder in association with PTSD, OCD, SAD, PD and GAD (Noyes, 1999; Salkovskis & Warwick, 1986). The common element that links the various anxiety disorders is the presence of excessive anxiety. In health anxiety the excessive anxiety is focused on one's present and future health. Fig. 1

Salkovskis (1989; Salkovskis & Warwick, 2001) proposed that health anxiety is caused by catastrophic misinterpretations of sensations and symptoms. In common with all of the anxiety disorders, health anxiety is construed as occurring along a continuum from minimal to excessive anxiety (and clinically significant). The aim of the present construal is to collect and arrange disparate information and ideas pertaining to health anxiety, including the nature, causes, persistence, safety behaviour, assessment and treatment of HAD.

The application of a cognitive approach to construing health anxiety was a crucial step. "The cognitive theory states that in severe health anxiety…bodily signs, symptoms, variations, and medical information tend to be perceived as more dangerous than they really are, and that a particular illness is believed to be more probable than it really is" (Salkovskis, 1996, p. 65). The tendency grossly to overestimate the probability of becoming ill and the seriousness of the dreaded illness, is persistent. "Anxiety focused upon health is an almost universal phenomenon…and persistent anxiety about health is common both in the community and in the clinic" (Salkovskis & Warwick, 2001, p. 46). The anxiety is provoked by perceived changes in bodily appearance or functioning, exposure to negative information about health that is personally significant and/or by experiences that are catastrophically misinterpreted (e.g., disturbing intrusive images).

The sensitivity to changes in bodily functions and appearance tends to be heightened during an illness. Notably, health anxiety is not suspended when a person is actually ill, and the overestimations of the probability and seriousness of threats to one's health continue to operate (Salkovskis & Warwick, 2001).

The present construal arose out of the infusion of cognitive concepts into clinical psychology, and emerged from the success of the cognitive model of panic formulated by Clark (1986), and Salkovskis's (1985) cognitive model of obsessive compulsive disorders (OCD). The essence of Clark's model is that episodes of panic are caused by a catastrophic misinterpretation of certain bodily sensations, such as a pounding heart. 'My pounding heart means that I am about to have a heart attack'. The danger is *imminent*.

The panic model did not address the catastrophic misinterpretations of sensations or signs that signal a *future* danger to one's health, such as developing cancer. This important difference was

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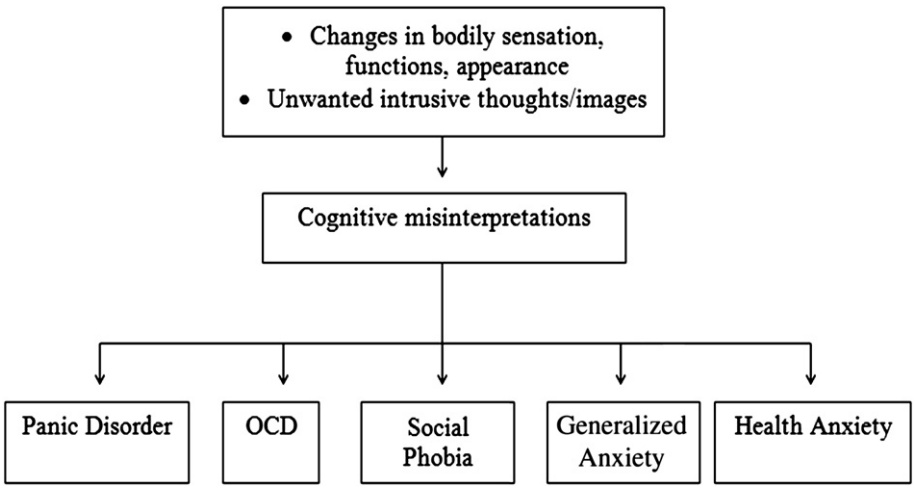

Fig. 1. The relation of health anxiety disorders to other types of anxiety disorder.

a spur to the formulation of the health anxiety concept. Salkovskis's (1985) cognitive analysis of OCD led him to connect important features of that anxiety disorder with serious fears of dangers to one's health. The cognitive model of health anxiety absorbed some aspects of hypochondriasis, and then expanded the definition, scope, classification, nature and treatment of severe health anxiety. Health anxiety disorder is a positive 'diagnosis' or rather, a positive classification of a psychological problem within the existing group of anxiety disorders.

Hypochondriasis

Severe health anxiety, the extreme end of a continuum of health anxiety, is often termed hypochondriasis. At times the two terms, hypochondriasis and severe health anxiety, are used interchangeably, but a clear distinction would be helpful.

'Hypochondria' is an anatomical term. It describes "those parts of the human abdomen…which lie immediately under the ribs… [where] the viscera [are] situated… the liver, gall-bladder, spleen etc." (Compact Oxford English Dictionary, 1971, p. 507). They were believed to be the source of melancholy fumes "low spirits for which there is no real cause" (p. 507). Over time the meaning of hypochondria expanded into "a disorder of the nervous system-…chiefly characterized by the patient's unfounded belief that he is suffering from some serious bodily disease" (p. 597). Hypochondria is currently classified as a mental disorder (DSM-IV, 2005; see Asmundson, Taylor, and Cox (2001) for an account of the various iterations of 'hypochondria' in the DSM).

The diagnosis of hypochondriasis is categorical: a distorted belief that one is suffering from a serious disease despite all the medical and other evidence against the belief; a disease conviction. Hypochondriacal beliefs are resistant to disconfirmation. Unlike health anxiety, in which future dangers are anticipated, in hypochondriasis the danger is present and active, and the belief is fixed. The diagnosis of hypochondriasis has been criticised (e.g., Abramowitz & Moore, 2007; Asmundson et al., 2001; Creed & Barsky, 2004; Deacon & Abramowitz, 2008; Olatunji, Deacon, & Abramowitz, 2009; Schmidt, 2004; Warwick & Salkovskis, 1990; Wells & Hackmann, 1993; Wise & Birket-Smith, 2002).

The cognitive model

The cognitive construal of health anxiety has promoted a substantial increase in knowledge about fears pertaining to one's current state of health and future health (Asmundson et al., 2001; Marcus, Gurley, Marchi, & Bauer, 2007; Salkovskis & Warwick, 2001; Warwick & Salkovskis, 1990). Attention has been paid to the cognitions involved in anxiety about one's health. The inflation of vigilance and the triggers for heightened anxiety have been incorporated in the model. The concept of health anxiety now leads to the inclusion of fears of *mental* illness as well as physical illness. A good deal of attention has been paid to the operation of cognitive biases (such as ex consequentia reasoning; Arntz, Rauner, & van den Hout, 1995; thought–action–fusion; Shafran & Rachman, 2004; confirmatory biases; Salkovskis & Warwick, 2001; the overprediction of fear; Rachman & Bichard, 1988; overprediction of pain; Rachman & Arntz, 1991). Given the recent reconsideration of the nature of safety behaviour (Rachman, Radomsky, & Shafran, 2008), the role of the compelling search for reassurance in patients with health anxiety (Salkovskis & Warwick, 2001) has been expanded to include positive safety behaviour. Arising out of the cognitive model of OCD the powerful effects of intrusive images in health anxiety are now under investigation (see below). Specific forms of cognitive behaviour therapy (Clark et al., 1998; Sorensen, Birket-Smith, Wattar, Buemann, & Salkovskis, 2011; Warwick, Clark, Cobb, & Salkovskis, 1996) have been deduced from the model and are being subjected to controlled evaluations.

Evaluating the effects of therapy can be confusing when the terms hypochondriasis and health anxiety are used interchangeably (e.g., Clark et al., 1998; Nakao, Shinozaki, Ahern, & Barsky, 2011; Sorensen et al., 2011; Visser & Bouman, 2001; Warwick et al., 1996). The criteria for selecting participants vary from trial to trial (hypochondriasis or severe health anxiety), as do the methods of assessment and the treatment protocols. However, it should be possible to avoid some of the obstacles that have impeded collection of data about prevalence. HAD is dimensional and a range of promising psychometric and other methods of assessment are available or in progress of development (see below).

HAD cognitions

The affected people are morbidly preoccupied with their health and greatly overestimate the probability that they have a serious illness and/or that they are at risk of developing a serious illness. They also overestimate the seriousness of the dreaded illness; they fear that it will be extremely disabling and not infrequently people fear that it will be fatal. Changes in bodily sensations, functions, appearance, and unwanted disturbing intrusive thoughts/images