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Hypochondria, from gut to brain

ESSAY

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Caroline Crampton has been seriously ill. She is also a hypochondriac. In her book *A Body Made of Glass. A History of Hypochondria,* she tells her personal story about what it feels like to be constantly imagining that you are ill and describes the social history of this condition. The title refers to the fact that when glassmaking became a reality in the late 15th century, this gave rise to a misconception that the human body could also be turned into glass – fragile and transparent.

The Imaginary Illness (1860–62), Honoré Daumier (1808–79). In public ownership.

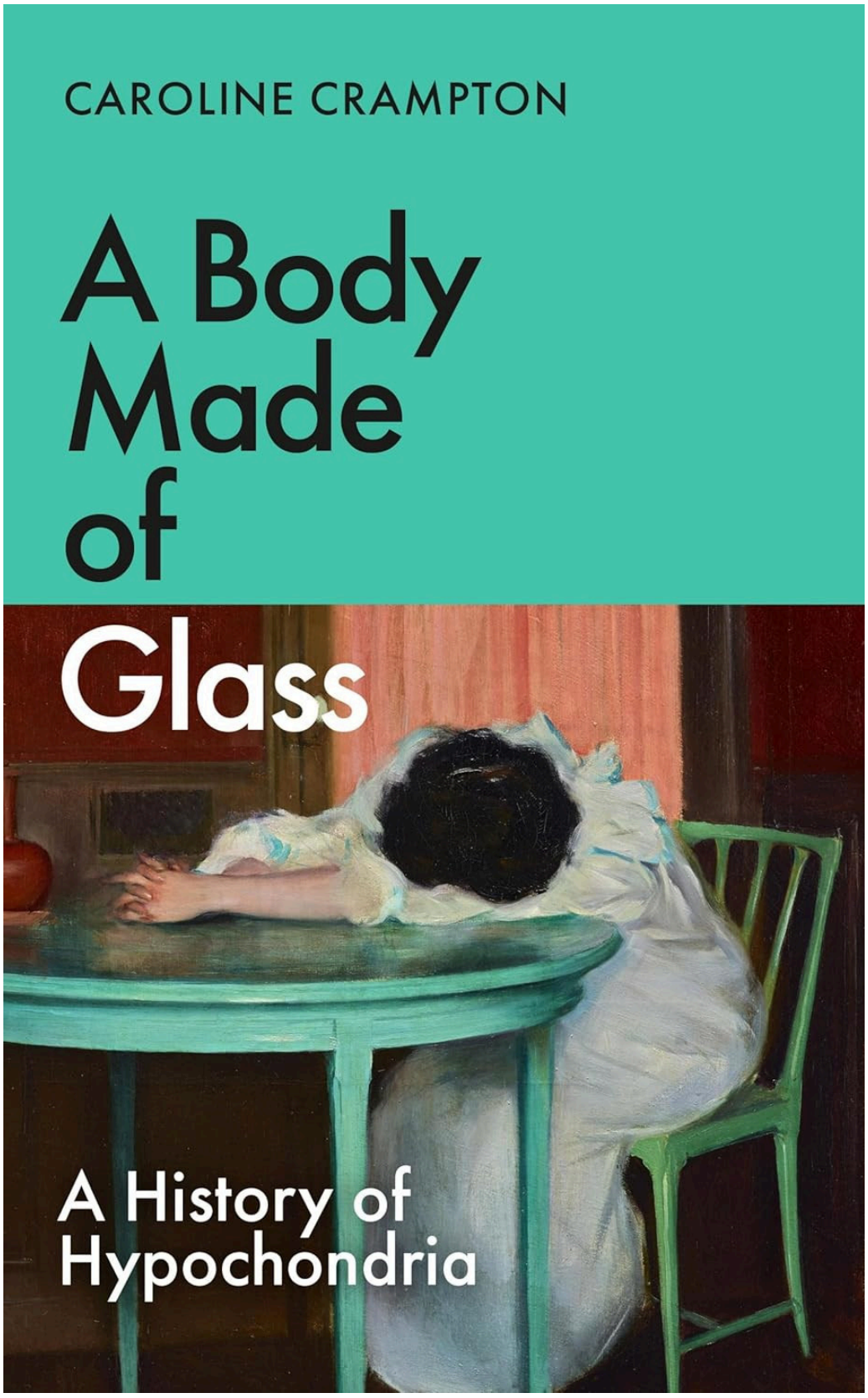
The author's story

As a 17-year-old, the author developed a large lump on her throat, just above her left clavicle. She was diagnosed with Hodgkin lymphoma. The prognosis was good, and after a few months of treatment she was declared fit and healthy. A year later, she discovered another lump on the site of her surgical wound.

After several periods of uncertainty, a relapse was confirmed. She received radiation therapy, chemotherapy and a stem cell transplant.

Several years of monitoring followed, and at the age of 22 she was declared to have fully recovered. She was told that her body was free from cancer, but she did not feel free. No-one could give her the guarantee she was looking for, and she continued to live with her unanswered questions. She developed a habit of routinely scanning her body on the lookout for something wrong, and the normal but to her extremely personal and frightening question of 'what if ...' became a constant companion. For the first 2–3 years after her latest period of illness, she considered this anxiety to be normal and functional, since her focus was on checking her body for signs of lymphoma recurrence. But then her concerns spread to the whole body and other serious diseases.

> ***«Crampton describes the shame of seeking medical advice for something that is not a real, physical illness, or even worse, seeking medical advice and discovering that the problem is in fact real»***



Book cover. Facsimile: Granta Books

In *A Body Made of Glass* (1), Caroline Crampton describes the shame of seeking medical advice for something that is not a real, physical illness, or even worse, seeking medical advice and discovering that the problem is in fact real. Even *the glass people* can offer her comfort because they put words to how vulnerable and fragile we are: misunderstood, ridiculed and ignored. Only those with proper illnesses are taken seriously. She clearly describes how

dealing with the cancer was easier, because this had a beginning, a treatment phase and an end. There is no end to hypochondria. Although she knows it is irrational, she is constantly seeking reassurance that she is healthy. Uncertainty is the big scourge; there is always room for doubt. She also developed symptoms of post-traumatic stress disorder, with flashbacks to painful examinations and treatment, and invasive thoughts.

When interviewed in the podcast *The Loss Encounters* (2), Crampton describes her despair over never being fully reassured. Questions like 'Is this normal?' 'Is this serious?', crop up on a daily basis. The author gives a vivid account of her vulnerability to stories in the media. If she read about iron-deficiency anaemia, she would immediately feel compelled to check if she also suffered from this condition. Crampton's book presents a wide perspective on health anxiety, and is critical of today's quest for the perfect, healthy, fabulous body. She realised after a while that her obsession with the fluctuating symptoms she felt was not normal. Her worries had become a problem in themselves, a 'fear of anxiety'. After 20 years of severe hypochondria, she eventually received help from a psychologist and cognitive therapist, Becky Spelman. Nevertheless, although the author received help, she writes towards the end of her book: 'I am still the same anxious, health-obsessed person I was when I began writing my story' (1).

Finding solace in literature and films

Caroline Crampton finds a degree of comfort in the fact that others have already put words to what she feels. The poet John Donne (1572–1631) wrote in his work *Devotions upon Emergent Occasions* about the constant, slow, gradual descent of the mortal body into the grave. She also mentions many examples from fiction where hypochondria is a central theme, e.g. the novels of Jane Austen (1775–1817), which are crowded with characters with hypochondria. This was because Jane Austen's mother for large parts of her life suffered from a disease which Austen believed was 'in her head'. Austen was particularly concerned with how hypochondriacs weaponise their own anxiety to make people do their bidding. In my opinion, her mother suffered from somatisation disorder rather than hypochondria, which rarely offers secondary gain. Most hypochondriacs suffer in silence, because an imaginary illness seldom elicits empathy and care.

Among present-day fellow sufferers is the author John Green (b. 1977), who describes how his mind and body are like two old friends who have drifted apart, but who nevertheless must spend all their time together. Woody Allen (b. 1935) portrays a classic hypochondriac in his film *Hannah and Her Sisters*. After a CT scan shows he has no brain tumour, he is happy for a few minutes and he starts skipping down the pavement, until he suddenly stops. He is not going to die today, but what about tomorrow?

A historical perspective

Hypochondria takes its name from anatomy. *Hypo* means below, and *chondria* refers to the area below the rib cage. In the Hippocratic tradition (Hippocrates, 460–370 BCE), diseases, including personality variations, were explained as an imbalance of the four bodily fluids: phlegm, yellow bile, black bile and blood: so-called humoral pathology. For a long time, hypochondria was considered to be the same as melancholia, which was believed to be caused by an excess of black bile. Even if this theory was scrapped a long time ago, the treatment was not dissimilar to present-day therapy as it focused on diet and physical exercise. It was not until the 18th century that hypochondria came to be described as a disease in terms that are similar to our current understanding.

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However, severe health anxiety is not a new concept. Crampton's book refers to 3000-year-old Egyptian papyrus scrolls that describe mysterious conditions – conditions that are not palpable to the touch like fractures, or visible to the eye like jaundice, weight loss or similar. The first written accounts of conditions resembling hypochondria appeared in Babylonia, present-day Iraq, in the second century BCE. These texts describe symptoms that could not be cured by normal medical interventions, which at the time tended to be exorcism of evil spirits or magic. The link between body and soul was key to philosophers like Plato (428–347 BCE), who believed there was a link between our digestive system and our emotions. Little did he know about today's research on microbes and the gut-brain axis! Plato viewed the soul as a wild animal chained to the liver.

The 17th century was a period of transition from an era of superstition to an era of reason. Book printing was introduced at this point, and there were worries that 'information overload' might explain the affliction, not dissimilar to today's theories about social media and googling. Robert Burton's work *The Anatomy of Melancholy* (published in 1621) was written at a time when melancholia covered a range of mental health conditions and disorders, such as anxiety, depression, grief, phobias, delusions etc., and these were accompanied by a variety of physical ailments due to the humoral imbalance, which was still a live tradition.

One of Burton's contemporaries was the physician William Harvey (1578–1657), who wrote about blood circulation. He explained the blood circulatory system in terms of hydraulics, with the heart acting as the pump. This was a departure from the old theory about bodily fluids, where blood was formed in the gut and then absorbed by other organs. Like most other people in the 17th century, he distinguished between body and soul. Harvey believed they were linked by nerves, and he described the nervous system in a way that is similar

to today's descriptions. At the time, the uterus, *hystera*, was considered the seat of hysteria, while the liver and the spleen were associated with hypochondria. Gradually, hypochondria moved from the gut to the brain. Thomas Sydenham (1624–89), a physician known as 'the English Hippocrates', wrote what became the most widely used medical textbook for two centuries. He described hypochondria and hysteria as two similar disorders. While women would tend to develop hysteria, on account of having a uterus, men were more likely to develop hypochondria.

Views on hypochondria changed in the 18th century. It continued to be considered a physical disorder, but with a significant mental component. Hypochondria was described as a civilisation illness, an ailment that plagued the elite who by now had moved away from a simple lifestyle to a rich diet and sedentary living. In 1766, botanist Sir John Hill (1714–75) published his book *Hypochondriasis. A practical treatise on the nature and cure of that disorder; commonly called The Hyp and Hypo*. He was convinced that hypochondria was a physical affliction, which he personally suffered from, but he admitted that certain mental elements could aggravate the blockage in the spleen, which by now was the main hypothesis. Grief and love could both aggravate the symptoms, as could too much rest or excessive activity.

In the 19th century, hypochondria was considered a mental illness, not least thanks to the French psychiatrist Jean-Pierre Falret, who wrote the book *De l`hypochondrie et du suicide*. Here he describes many of the symptoms experienced by hypochondriacs, like excessive focus on the body, imaginary symptoms and a strong interest in medical texts and news. He explained to his patients what his predecessors did not know about the key significance of the brain to our symptoms.

As psychoanalysis developed towards the end of the 19th century, represented by Jean-Martin Charcot (1825–93) in France and William James (1842–1910) in the United States, attention focused on how past experiences could cause problems in the present. Charcot, who was a professor at the Salpêtrière Hospital in Paris, distinguished between hysteria, which he classified as a purely mental disorder, and hypochondria, which remained a confusing and indeterminate condition. Sigmund Freud (1856–1939), a student of Charcot, believed that hypochondria was a mental disorder with physical manifestations. However, he found no link to earlier traumas, and consequently psychoanalysis could not be used to treat hypochondria. Freud was also concerned with his own tendency toward hypochondria. He had palpitations and an irregular pulse, stabbing pains and a burning sensation. He consulted his friend Josef Breuer (1842–1925), who much to his annoyance treated him 'like a patient'. The doctor did not listen to him, only told him what he believed Freud wanted to hear, saw him too infrequently and never gave clear answers to questions. Freud stopped smoking cigars, but later wrote that he felt incredibly better after cocainisation of his left nostril. At the time, many believed that the nose was a microcosm of the body, and that cocaine deposited in the right place in the nose could cure diseases that affected other parts of the body.

In her book, Caroline Crampton describes how, during a school visit to Darwin's home, which is now a museum, she discovered that he had led an extremely rigid and structured life. He underwent hydrotherapy, which meant frequent baths and the consumption of set volumes of cold water at set times. He had to take a bath several times a day, and he was wary of things that were unfamiliar to him. He had many health complaints and kept an exact diary of his symptoms over a period of six years, *The Diary of Health*.

> ***«Catastrophising is not the core problem of hypochondria, but the fact that the answer is in the future, which is a closed book»***

My reflections

For 28 years I have been treating patients with hypochondria in the specialist health service. Referred patients must have severe, primary hypochondria, and they must have received psychotherapy to no avail. We have documented that cognitive therapy is effective in most patients, and that they have not relapsed a decade later (3).

Caroline Crampton provides a good description of the eternal problem of hypochondria: uncertainty (4). Her 'what if ...' thoughts keep reappearing, just like in my patients. Those who used to think that the glass people were mad, would have been amazed to know that these days, we are actually able to look inside the body, it *has* become transparent. Nothing within our bodies is hidden from MR and PET scanners, blood tests etc., although our souls and thoughts cannot be captured by anyone. In my opinion, catastrophising is not the core problem of hypochondria, but the fact that the answer is in the future, which is a closed book. I recommend that my patients raise their awareness of their catastrophic thoughts, and because they cannot, even with the best will in the world, find an answer to these thoughts right now, they should practise giving them as little attention as possible. For many, this can be a challenging exercise because they crave an answer. It is liberating to not demand answers that no-one can give, and instead focus on things we can do something about, like our own attitudes and actions. How we choose to relate to uncertainty, thoughts and emotions, life and death, determines whether we are able to find inner peace in a world of turmoil. We cannot wait until we are completely safe; we must choose to believe that we are.

> ***«We cannot wait until we are completely safe; we must choose to believe that we are»***

Caroline Crampton describes herself as a perfectionist. This is a drag if she wants to rid herself completely of her hypochondria, because the variable 'right or wrong' rarely applies. Instead, things tend to be 'smart or less smart', 'helpful or less helpful'.

I agree with the author that hypochondria tends to be a fear of death. The fact that she coped with her real illness better than her imaginary ones, matches many people's experiences. Patients who are told that they have a terminal illness can plan for the time they have left. Besides, we cannot opt out of real illness as it is confined by reality, time and space. Imaginary illnesses can often feel worse than actual illness because they are limited only by our imagination, and our coping mechanisms never get the chance to kick in because the problem is not physical. It is a mere thought. The author is sceptical to our current focus on well-being, and she has personal experience of *cyberchondria*: she has periodically been given to obsessive searching on the internet for explanations to subjective symptoms. She asks: if you search for a symptom, do you increase the chances of acquiring the symptoms, or is it the level of anxiety that increases? She responds, correctly, that the answer to the first question is no, while the answer to the second is yes.

> ***«If you search for a symptom, do you increase the chances of acquiring the symptoms, or is it the level of anxiety that increases»***

The author is fully aware that seeking reassurance about being healthy can provide short-term relief from anxiety, much the same way as avoidance and safety behaviours, but that this will only prolong the problem in the longer term. Sending a hypochondriac for numerous tests will reinforce their anxiety. A full body ultrasound scan produces a momentary image, much the same way as another ECG. Once the machine has been turned off, anything can happen. Another problem is that they reveal things that are not helpful to discover, like kidney cysts, pain-free disk prolapses etc. But occasionally it is necessary to run additional tests to clarify an uncertainty, and while waiting for the results, patients are left to their own devices and their own catastrophising. I outline three possible attitudes that a hypochondriac can choose from while waiting for a test result, or for the future in general. They can catastrophise and take their 'what if' thoughts desperately seriously. This will involve considerable anxiety, sleeplessness and a tough waiting period as they brace themselves for what might come. The second option is to be positive: I am healthy until the opposite has been confirmed. For some, this is far too optimistic an attitude, and for them there is a third option – the agnostic one: I do not know, and for all my ponderings I will never come up with an answer that can only be revealed in the future. They put themselves on hold, in neutral, neither positive nor negative.

The author writes that hypochondria diagnostics have changed, and this is correct. The American diagnostic system DSM-IV included 'hypochondriasis' as a diagnosis, but in DSM-5 this was replaced by 'illness anxiety disorder' and 'somatic symptom disorder'. In Norway, we still use ICD-10, which includes 'F45.2, Hypochondriacal disorder'. ICD-11 has retained the diagnosis of hypochondriasis but lists three subgroups: '6 B23.Z Hypochondriasis, unspecified', '6 B23.0 Hypochondriasis with fair to good insight' and '6 B23.1 Hypochondriasis with poor to absent insight'. The reason why 'hypochondriasis' was removed in DSM-5 was that it could be seen as

stigmatising, old-fashioned or clinically unhelpful. While the diagnosis disappeared, hypochondria as a phenomenon persisted, and I am glad it has been retained in ICD-11.

Towards the end of her book, Caroline Crampton writes that some treatment programmes start by asking patients if they are willing to accept their own mortality. 'What a question. If hypochondria is rooted in a search for certainty, there is no greater certainty than that. I don't think hypochondria will ever leave us, either'. This is probably true. We are all mortal. The question is whether we are willing to acknowledge and accept it. If we are, then we can be free to spend our lives living, rather than dying.

REFERENCES

1. Crampton C. A Body Made of Glass. A History of Hypochondria. London: Granta Publications, 2024.

2. The Loss and Encounter. Caroline Crampton: Overcoming Health Anxiety. Podkast. https://www.thelossencounters.com/episodes/2024-06-06-caroline-crampton Accessed 8.11.2024.

3. Veddegjærde KF, Sivertsen B, Skogen JC et al. Long-term effect of cognitive-behavioural therapy in patients with Hypochondriacal Disorder. BJPsych Open 2020; 6. doi: 10.1192/bjo.2020.22. [PubMed][CrossRef]

4. Wilhelmsen I. Livet er et usikkert prosjekt. Oslo: PAX Forlag, 2000.

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