Prognosis of Hypochondriasis

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People with intense fear of illness, and symptom(s) without evident etiology are frequently encountered by internists. Many of these patients meet criteria for hypochondriasis. Hypochondriasis is defined as a persistent preoccupation (at least 6 months) with unrealistic fears of having a serious medical illness. These fears are based on the person’s misperceptions of bodily sensations, and the fears continue despite appropriate medical evaluation. These patients are seldom referred for psychiatric evaluation (despite high Axis I and Axis II comorbidity) and are usually resistant to such evaluation. This helps explain why most are managed in the general medical sector. Empirical evidence in regard to natural history has been sparse and often inconclusive.

Barsky and colleagues conducted a 4 to 5 year prospective, case-control study of 120 patients with DSM-III-R hypochondriasis and 133 nonhypochondriacal patients. The subjects were recruited by screening consecutive patients attending a primary care clinic. Those selected (both hypochondriacal and control groups) completed measures assessing hypochondriacal symptoms, somatosensory amplification, disability, role impairment, medical and other psychiatric comorbidities. At follow up 63.5% of hypochondriacal patients still met criteria for the disorder. Conversely, 1/3 of the patients no longer met the criteria for hypochondriasis. At follow up the entire hypochondriacal sample was significantly less hypochondriacal, and had less somatization and disability than at inception. The study did not look at treatment of their hypochondriasis. It is
unlikely that many were referred for psychiatric treatment, but the physicians may
have managed the remitting hypochondrical patients differently than the
nonremitting hypochondriacal patients and aided remission. The remitting and
nonremitting group had no differences in baseline major medical or psychiatric
comorbidity. During the follow up period, the remitting group did have
significantly more medical illness than the nonremitting group, but no difference
in other psychiatric illness. Several of the remitting patients noted that their
symptoms had been “legitimized” by the diagnosis. It also serves as a possible
warning that unexplained symptoms may be the harbinger of undetected
disease. The published data did not allow one to distinguish whether the
hypochondriasis diagnosis was in error in those who developed medical
illnesses. This seems unlikely given the persistent presence of subthreshold
hypochondriacal symptoms in remitting patients. The studies prior to this were
limited by smaller patient numbers and shorter follow up periods. By following
this larger number of patients for 4-5 years, Barsky and his colleagues have
contributed much about the natural history of hypochondriasis and added some
optimism in regard to its prognosis.