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Monosymptomatic Hypochondriasis, Abnormal Illness Behaviour and Suicide

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Summary. Two cases of chronic monosymptomatic psychogenic eye pain with abnormal illness behaviour are presented. Both failed to respond to a wide variety of treatments, and despite the accepted low suicidal risk in hypochondriasis both killed themselves. The origin, prognosis and therapy of such behaviour are discussed in this context.

Introduction

The concept of abnormal illness behaviour has been elaborated by Pilowsky (1969) in order to lend unity to the problem posed by the patient with physical symptoms for which no adequate organic cause can be found. He points out that such patients in the past have been subsumed under a wide variety of diagnoses.

Abnormal illness behaviour resides in the patient's aspirations to the benefits of the sick role without sufficient overt reason to adopt such a role. It is the purpose of this article to present the cases of two patients with monosymptomatic hypochondriasis, fortuitously both relating to the eyes, who exhibited this behaviour, with a discussion of some of the issues so raised. It is emphasized that although hypochondriasis in general is said to correlate with a low incidence of suicide both of these patients did kill themselves.

The Patients

Case 1

Miss A., aged 34. She had complained of pain in her eyes for 18 years to many different doctors and first saw a psychiatrist at the age of 22. She had made three suicidal attempts in the preceding three years which had resulted in a two-month psychiatric admission. Following a further overdose she was a patient at the Maudsley Hospital from February to November 1972.

She was the fifth of eight children in a close-knit conservative working-class family with no history of psychiatric disorder. After leaving school at 15 she had a number of jobs before working at the local psychiatric hospital, at first as a waitress and later as a nursing auxiliary. She had many boy friends and was engaged three times. The second engagement was disapproved of by the family. During it, at the age of 31, she had a termination of pregnancy. She had considerable medical contact: three D & C operations; appendicectomy, haemorrhoidectomy and tonsillectomy. She was also diagnosed as having bronchiectasis.

She was greatly concerned with her appearance and was sociable, but had persisting difficulties in relationships.

She was an attractive well-dressed woman with no signs of a depressive illness although she made many histrionic suicidal threats. Her general behaviour was dramatic and she complained continually about her eyes. Her IQ was 86, her vision was 6/5 in each eye, with minimal refractive error, and other investigations gave normal results.

Treatment with tricyclic antidepressants, minor tranquillizers and abreaction was ineffective. She did not co-operate in an operant programme in which social rewards were earned by visual tasks. She was then given modified narcosis and seemed to improve before discharge.

Within three weeks she had relapsed and her GP referred her once again to her local psychiatric hospital out-patients clinic. However, five weeks later she was found dead of barbiturate poisoning.

Case 2

Mr B., aged 38. The patient visited orthoptists from the age of 5 for a mild squint and obtained considerable attention from his mother because of this. From 18 onwards he claimed that his right eye felt dead and appeared dull in the mirror, although he did not complain of impaired vision. He then began

to complain of pain in this eye, though he could not describe this in detail, and plagued local opthalmological departments. His squint was corrected before he entered the Army, with no effect on the eye pain. His first psychiatric referral was at age 32, and subsequently he was admitted six times to local psychiatric hospitals. Treatment included chlorpromazine, imipramine, chlordiazepoxide, benzoctamine, tranylcypramine, intravenous clomipramine, intravenous water, and ECT. Any improvement was transient. He also had interpretative psychotherapy for 18 months. He twice took overdoses. He was admitted to the Maudsley Hospital in August 1973 and remained an in-patient until November.

He came from a working-class family, the eldest of seven children. His father was unsympathetic, but his mother was very concerned. One brother had a squint, another an eye damaged by a firework. There was no psychiatric family history.

The patient left school at 15. He had asthma from 17 and was treated with steroids, and was several times admitted to hospital for this. He was invalided out of National Service after two years because of his asthma and his hypochondriacal complaints about his eye. His work record was poor, and after being dismissed from the Civil Service at 34 he did not work again. He was married at 22 and had two children but was divorced at 36 because his wife could no longer tolerate his hypochondria. His personality was dependent, with some obsessive traits.

In manner he was very aggrieved and demanding and totally preoccupied with his eye pain. He was gloomy about the prospects of a cure for his complaint, but there was no evidence of a depressive illness. His WAIS was 104 (verbal) and 88 (performance). Vision was 6/6 in both eyes with 5° esophoria. He specifically claimed to be unable to engage in eye to eye contact, looking at his own photo or himself in a mirror, watching TV, reading aloud and copying, These particular activities were made the initial target in an operant programme. He made very striking initial progress but at the end of a three-week trial took his discharge before relatives could be involved in the programme. He relapsed almost immediately and was readmitted but would not cooperate with treatment and again discharged himself. After a short readmission to his area hospital he again discharged himself and was found dead the next day. The coroner's verdict was suicide by chloral poisoning.

Discussion

The salient clinical features of these patients were the monosymptomatic nature of their hypochondriacal preoccupation and the abnormal illness behaviour they displayed. There are a number of monosymptomatic delusional and near-delusional conditions in psychiatry; these are in many respects diverse and include conditions such as dysmorphophobia (Hay, 1970), olfactory paranoid syndrome, and dermatological hypochondriasis (Zaidens, 1950). Many of these patients are markedly lacking in social skills, and in many an element of abnormal illness behaviour is discerned. Some of the conditions have strong relationships to schizophrenia, and by and large they are united by their persistence and by a clinical impression of poor prognosis. An exception to this is the circumscribed hypochondriasis of Hanns Schwarz (1929) which seems to be a specific form of manic-depressive psychosis with the prognosis of that condition.

Little has been written on monosymptomatic hypochondriasis. Zaidens (1950) describes a monosymptomatic dermatological hypochondriasis in 11 patients. This group was socially isolated and their symptoms shared many features with dysmorphophobia. Interestingly, both of these patients had dysmorphic symptoms, and Bianchi (1973) has noted this association with hypochondriasis. Katzenelbogen (1942) mentions that two of his female and 'a few' of his male patients were monosymptomatic. There appear to be no references to the prognosis of the monosymptomatic hypochondriac in the literature. Of hypochondriacs in general more may be said. Greer and Cawley (1966) found that hypochondriacal patients have the worst prognosis of any neurotic group. In general, in the absence of an affective component the prognosis is dependent on the previous duration; the no-improvement group of Richards (1919) had a mean prior duration of 11·5 years, the improved group 4·1 years. Only 12 of Katzenelbogen's (1942) patients had had symptoms for less than two years. To an extent, such figures are the result of selection: short-lived symptoms do not readily become the object of study.

Suicidal risks in hypochondriacal patients appear low (briefly reviewed in Stenback *et al*, 1965), more particularly in those cases showing the 'disease phobic' component derived by

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Bianchi (1973), and this perhaps parallels the finding that depression in hospital in-patients with physical illnesses does not carry a high suicidal risk (Moffic and Paykel, 1975). The 'disease conviction' component as in these patients may, however, be associated with suicidal tendencies. Many people in this category are significantly depressed, and in them, not surprisingly, the risk is increased. Pilowsky (1970) found a history of suicidal attempts in 3 of his 66 cases of primary hypochondriasis and in 12 of his 81 secondary cases. Of Ladee's (1966) 225 cases 5 committed suicide, 3 of these being melancholic. Depressive illness was not a feature of either of the cases reported here. It should also be emphasized that both were still complaining strongly of eye pain at the time of the last medical contact, very shortly before death.

In recent years, two advances have been made in our understanding of the genesis of hypochondriasis. The first is the concept of abnormal illness behaviour; the second is that of interoceptive set, 'perceptual reactance' or 'stimulus augmentation'.

The concept of abnormal illness behaviour was first formulated by Pilowsky (1969) and derives from sociological models of the sick role developed by Sigerist (1932), Parsons (1951) and Mechanic (1962). People respond to the presence of a noxious internal stimulus in a continuum from the stoical to the hypochondriacal. The extent to which people attend to such a stimulus has been called perceptual reactance by Petrie (1967), and Bianchi (1971) has used this concept as the basis of his model of disease phobia. He claims that stimulus augmentation may be programmed—the result of early learning—or current—the effect of interoceptive focusing caused by anxiety or depressive illness.

Having perceived the interoceptive stimulus a person may respond in a normal or deviant fashion. The ideal response is one which leads to the rapid attention of others, including the physician, and, it is hoped, to the removal of either symptom or cause. Illness behaviour deviates from this norm if it has ends other than these. When a patient enters the sick role he becomes, as Sigerist (1932) points out, passive, the object of duties: 'sickness dispensates'. He does acquire one obligation, that of seeking health. As Parsons has said (1951), sickness is socially defined as undesirable, to be escaped from as soon as possible. However, some patients behave as though they do not accept the desirability of health, as though their object is not cure but care. To seek care by deviant means puts such patients in an ultimately impossible situation, but unfortunately the behaviour is sufficiently effective to establish itself and to render it extremely resistant to extinction. Indeed, the patient may come to have no other way of dealing with the world. Interestingly, Meares and Horvath (1972) have established distinct categories of acute and chronic hysteria, the latter patients showing much greater problems of adjustment and relationship. It appears, therefore, that some people display abnormal illness behaviour only in response to great stress, while for others it is continually triggered by the smallest difficulties. This latter pattern was much in evidence in both the cases here presented. The combination of absence of alternative behaviours and social rejection would seem to be fertile ground for suicide, and it is of interest that in cases of chronic physical disability the unexpected restitution of health may have adverse effects on the patient. There are now, for instance, a number of reports of suicide and attempted suicide following the restoration of sight (Lester, 1972). Penman (1954) noted the onset of neurotic complaints following successful operation for trigeminal neuralgia.

Abnormal illness behaviour often has its origins in childhood: illness commands attention likely to be otherwise limited in large families such as these patients came from, and we are specifically told of Mr B's mother's concern over his ocular difficulties.

The treatment of hypochondriasis is difficult. As Reusch (1951) points out, only in cases where inappropriate meaning is given by the patient to the symptom does simple psychotherapy on educative lines appear successful. Many have noted, by and large, the non-response of abnormal illness behaviour to interpretative therapies (e.g. Ladee, 1966; Mead, 1965) though there have been occa-

sional reports of success (e.g. Hopwood, 1965; Ladee, 1966 (p 376)). Fordyce (1968) reported success with operant techniques maintained at five-month follow-up. The family were involved in treatment. However, neither of our patients would co-operate in such treatment, though one showed striking early gains. The use of anti-depressant medication and of ECT are obviously to be considered in cases of hypochondriasis secondary to depressive illness, but their role is less obvious in cases where no depression is evident on detailed clinical inquiry. Certainly, in neither of the present cases did they prove effective. Likewise, psychosurgery is not felt to offer great hope of benefit (Freeman, 1959), although single successful outcomes have been reported by Elithorn and Beck (1955) with leucotomy, and more recently by Andy (1973) using unilateral anterior thalamotomy.

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