Management of Grief in the Hypochondriac

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This paper illustrates the presentation and management of a grief reaction in a chronic hypochondriacal patient seen in a family medicine office. The manifestations of grief in the hypochondriacal patient are influenced by the unique characteristics of the chronic, somatic complainer in whom the grief reaction appeared as an intensification of the chronic complaints. The treatment of the grief reaction in these patients should take into account the techniques for managing the hypochondriacal patient.

Two clinical situations which every family physician encounters are grief reactions[1] and hypochondriacal patients.[2] The process of mourning can be managed by the family physician provided he/she knows how grief is manifested and has an interest in psychological care. Ideally, the management of the hypochondriacal patient involves long-term supportive care under one physician, with referral to a psychiatrist usually being unsuccessful.[3]

Grief is a natural reaction to the loss of a significant person. Freud recognized that grief is nonpathological and that any attempt to alter its course is useless and can even be harmful.[4] Lindemann described the acute symptoms of normal grief lasting one to two months: sensations of somatic distress (shortness of breath, palpitations, weakness, sighing, and apprehension), preoccupation with the image of the deceased, feelings of guilt and hostility, and a lapse in one's social capacities.[5] Two deviations from this pattern were labeled by Lindemann as morbid grief reactions. One of these, a delayed grief reaction, may develop months or years after the death and frequently on the anniversary date of the lost one. A distorted grief reaction may take several forms: hyperactivity or increased anger without a sense of loss, apathy, self-destructive behavior in the bereaved, depression, and acquisition of symptoms of the last illness of the deceased.

Clayton has shown in studies of the widowed that there are three main symptoms of grief: depressed mood, sleep disturbances, and crying spells.[6] Also observed but less frequent are weight loss and anorexia, loss of concentration and interest, irritability, anxiety attacks, and fatigue. Maddison has commented on the deterioration in the health of 28 percent of widows he studied during the first year of their bereavement.[7] DeVaul and Zisook have stated that the usual pattern of grief in an adult is affected by the bereaved's premorbid personality.[8] Parkes feels that the grief in the widowed depends on the intensity of the attachment to and love of the lost spouse and the reliance of the bereaved upon the marital relationship.[9]

A definition of hypochondriasis is an acute or chronic persistent preoccupation by nonpsychotic patients with their physical health without any

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reasonable basis, or an excessive preoccupation with existing physical illness out of proportion to its seriousness.[10] In the acute form, the patient develops functional somatic complaints in order to cope with stress and the complaints subside as the stress becomes less intense.[11] The patients who develop chronic concern about physical illness without justification from physical findings usually have long histories of being "sick" without obtaining relief from their maladies despite frequent doctor visits and medical evaluations. Several authors have noted the limited capacity for these individuals to form meaningful interpersonal relationships outside their "sick role."[12,13] They maintain themselves in a state of suffering and self-sacrificing.

Clinically, hypochondriacal patients present multiple complaints with much concern and conviction. They tend to verbalize only what they perceive is physically wrong with them, to the exclusion of the status of their life outside their "illness." They tend to dominate the interview with their physical complaints; any attempt on the part of the physician to explore their emotional or interpersonal stresses is met with further preoccupations with their bodily complaints.

The following case illustrates the presentation and management of a grief reaction in a chronic hypochondriacal patient under the care of a family physician.

Case Report

Mrs. E. is a 57-year-old Caucasian widowed woman who has been a patient at the Duke-Watts Family Medicine Center (FMC) for the past four years where she has been under the care of several family practice residents. Her most recent physician (L.J.) has managed Mrs. E. during the past year in consultation with a liaison psychiatrist (R.F.).

Mrs. E.'s active medical problem list includes mild diastolic and systolic hypertension, minimal osteoarthritis involving the proximal and distal interphalangeal joints bilaterally, and, on occasion, documented urinary tract infections. Less defined symptoms presented with much concern and anxiety in the past and present include chest pain, persistent dysuria, headaches, dizziness, upper and lower abdominal pain, cancer phobia, various bone and joint complaints, and "allergy to mycins." All of the latter symptoms have been far in excess of physical signs, laboratory and x-ray data, and procedural findings, including a negative coronary angiogram. Present medications include hydrochlorothiazide, potassium chloride replacement, diazepam, and codeine. The latter two drugs are carefully dispensed for use as needed.

Mrs. E.'s past medical history is extensive. Some significant data include her recalling a bladder infection with severe dysuria at age three, "rheumatic fever" at age four, and a delay in her full-time enrollment in school until age nine because of her small stature. Due to "nerves" and "passing out spells" she was told by doctors to drop out of school at age 13. A vaginal hysterectomy for leiomyomas at age 39 has been her only major surgery. She has had multiple admissions as an adult to local hospitals for various complaints; however, no definite additional diagnoses have been established.

The youngest of four children, Mrs. E. has one surviving sister. Two brothers have died of cancer, one at the age of 45 with some form of intestinal cancer and the other at age 51 with lung cancer. Her parents both lived to an advanced age. The older sister remembers Mrs. E. as always being "sickly," even since childhood.

Mrs. E. married at age 15 to a man fifteen years her senior. Together they had three children, all of whom are living. She stated that they had a "happy marriage" and her husband "cared for her when she was sick." Early in her marriage Mrs. E. worked in a local factory; however, because of "always being sick," she eventually remained home as a full-time housewife.

Approximately 1½ years ago, Mr. E. died rather suddenly following the dissection and rupture of an aortic aneurysm. In the weeks immediately following, Mrs. E. was seen in the FMC where, according to physician's notes, she was able to express appropriate grief. At this time, her other chronic symptoms, for which she frequently visited the FMC, seemed of lesser importance. Some two months after her husband's death, however, there was recorded a return to her chronic symptomatology with very little mention of the loss of her spouse of 40 years. It was in the ensuing months that her most recent family physician (L.J.) assumed her medical care at the FMC. Efforts to facilitate Mrs. E.'s talking about her feel-

ings were met at first with her recalling only "pleasant memories" or limiting her conversations to her physical complaints. She insisted that although she missed her husband, "his life is in God's hands" and "we've all got to go sometime." The management of her case during this time included long-term support for a multiple complainer and working toward resolution of her delayed grief reaction.

Nine months after her husband's death Mrs. E.'s health began to deteriorate drastically. Anorectic, she lost 15 percent of her body weight in four months, and on visits to the FMC the intensity of her somatic complaints were greatly magnified. Particularly distressing to her were the chest and abdominal pain; the question "do I have cancer?" was frequently asked. She said the pain she had was much like that of her brother who had died 15 years earlier of intestinal cancer. Management of Mrs. E. during this period was very difficult. With the intensification of her symptoms, she increased her use of medical services and occupied much of the physician's time. Except for growing evidence of weight loss and a chronically ill appearance, there were no other changes in meticulous serial physical examinations. Routine as well as screening blood studies were noncontributory. The possibility of an occult malignancy was certainly considered.

A break in the moribund pattern occurred on a visit to the FMC after six weeks of clinical deterioration. Repeated invitations to talk about Mrs. E.'s husband were finally met with the patient openly grieving and expressing that she was dreading an upcoming holiday and the anniversary of her husband's death. The feelings were further discussed; it was emphasized that these sentiments were normal and, dramatically, Mrs. E.'s physical and emotional health began improving. She began gaining weight and going out socially, and there was a marked lessening of somatic symptoms, particularly her chest and abdominal pain and cancer phobia. She was able to get through the holiday season withoug an intensification of her chronic problems. The case management since has included not only long-term support but also reminders that the feelings of grief are normal, that they take time to work out, and that being able to cry is a quite effective way to eventually feel better. On a six-month follow-up, she had regained the weight she had lost and exhibited no evidence of the emaciated appearance she had in the year following her husband's death.

Discussion

This case illustrates the manifestations of grief in a hypochondriacal patient. Mrs. E. was able to acutely mourn her husband during the month after his death. After this period there was no self-acknowledgement of her grief. Some eight months following her husband's death there was a significant increase in her chronic symptomatology with the addition of weight loss. It has been pointed out that weight loss and anorexia occur in 50 percent of the widowed.[14] Mrs. E.'s symptoms bore no similarity to her deceased husband's nor did any new symptoms appear. Reviewing her past medical record showed she had voiced her present complaints for 15 years, and the frequency of office visits for these complaints had doubled.

From the history and clinical description, this patient can be classified as a chronic hypochondriacal patient. Comparing the dependent relationship this patient had with her husband and the relatively short period of mourning, both her family physician and the liaison pyschiatrist felt that the intensification of her chronic symptoms was the result of a delayed grief reaction.

The management of her hypochondriacal behavior included: careful listening to the patient, establishing a stable, consistent physician-patient relationship, limiting detailed evaluations and invasive procedures, allowing the patient to keep her "sick role," and encouraging her to verbalize her current life situations.[2] When she was demanding and controlling, especially concerning her medications, the physician responded by negotiating with her. At other times, Mrs. E. assumed a helpless, dependent role and looked to the physician for direction and guidance, which he gave.[13]

When it was realized that the intensification of her complaints was an unresolved grief reaction, the treatment approach outlined above was continued with increased emphasis on her ventilating her feelings surrounding her husband's death. In the beginning this met with limited success. She continued to dominate the visits with anxious concern for her problems. Each complaint was evaluated by physical examination and appropriate screening laboratory tests when necessary. After this was done the physician shifted the focus from

her physical complaints to discussing her home situation. The physician placed attention on how she was managing her life since her husband's death. When the content of the visit reached this level the physician then supported her further talking about her feelings related to her deceased husband. At each office visit the issue of her grief was addressed and she was told that grief reactions are normal and produce certain feelings in the bereaved. After several months she was able to acknowledge her sadness and loneliness. With expression of these emotions, the intensification of her chronic complaints and the frequency of office visits returned to their pre-grief levels.

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