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Clinical study of illness anxiety disorder in medical outpatients

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Summary

Aims: To find out the prevalence of illness anxiety disorder (hypochondriasis) in medical outpatients as well as the associated risk factors and psychiatric comorbidities.

Method: 400 consecutive medical outpatients were asked about sociodemographic characteristics and risk factors associated with illness anxiety and filled in the Short Health Anxiety Inventory (SHAI). Psychiatric comorbidities were assessed using the Mini International Neuropsychiatric Interview (MINI). A score of 18 or above on SHAI indicated illness anxiety disorder (IAD), which was then confirmed using DSM-5 criteria. Data were analyzed using SPSS version 17, Chi squared and Student's *t*-test.

Results: The prevalence of IAD in the sample was 7%. Around 18% of patients with IAD had positive family history for hypochondriasis; 32.1% had a history of abuse in childhood; 71.4% of patients had psychiatric comorbidities – 25% had depression and 28.6% had anxiety spectrum disorder.

Discussion: The prevalence of hypochondriasis ranges from 0.4 to 14% in various studies and it is more common in the third and fourth decade of life. Significant risk factors include divorce, family history and history of abuse. Between 65 and 88% of patients with hypochondriasis have psychiatric comorbidities such as depression and anxiety disorders. Managing psychiatric comorbidities and early treatment of both will lead to better prognosis.

Conclusion: The anxiety of having a serious medical illness is reasonably high in patients attending medical outpatients departments. About three-quarters of these patients had a comorbid psychiatric condition, mostly depression and anxiety disorder.

illness anxiety disorder, hypochondriasis, illness anxiety disorder prevalence, illness anxiety disorder risk factors

INTRODUCTION

The concept of dividing hypochondriac patients into those who misinterpret prominent somatic symptoms and those with predominant anxiety about the illness in the absence of prominent somatic symptoms is very recent (DSM-5, 2013) [1]. Hypochondriasis and several related conditions have been replaced by two new, empirically derived concepts in DSM-5: illness anxiety disorder (IAD) and somatic symptom disorder [2]. Patients with IAD may or may not have a medical condition but they have heightened bodily sensations, are intensely anxious about the possibility of an undiagnosed illness, or de-

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vote excessive time and energy to health concerns, often obsessively researching them. IAD can cause considerable distress and life disruption, even at moderate levels.

Hypochondriasis has been eliminated as a disorder, in part because the name had negative connotations and was not conducive to an effective therapeutic relationship. According to DSM-5, individuals with high health anxiety without somatic symptoms would receive a diagnosis of illness anxiety disorder (unless their health anxiety was better explained by a primary anxiety disorder, such as generalized anxiety disorder). Most individuals who would previously have been diagnosed with hypochondriasis have significant somatic symptoms in addition to their high health anxiety, and would now receive a DSM-5 diagnosis of somatic symptom disorder – Kaplan & Sadock [2] People who have reasonable health concerns will not receive the diagnosis as, by eliminating the concept of medically unexplained symptoms, the DSM-5 prevents the easy assumption of a psychiatric diagnosis in patients who present with medical symptoms of unclear etiology. The change is welcomed by patients, as health anxiety and body vigilance are much more understandable to patients who experience anxiety about their health despite medical findings that do not support these concerns. The change is also welcomed by the doctors as now they can acknowledge that a patient's preoccupation with physical symptoms is higher than normal, whether there is a diagnosis or not.

Preoccupation with medical illness in hypochondriasis might focus on specific signs or symptoms, diseases or vaguely defined somatic phenomena. Typically, the individual attributes unwanted bodily sensations to the possible disease and is highly concerned with their cause and authenticity. Individuals with IAD may repeatedly contact doctors, seek additional tests, search the internet and medical texts, and seek reassurance from significant others about bodily sensations which have been appropriately evaluated and judged to be benign. Due to these emotional, cognitive and behavioral manifestations, hypochondriasis is often disruptive to social, occupational and family functioning and its associated medical costs can be substantial.

The risk factors associated with hypochondriasis are family history of hypochondriasis, a serious childhood illness, psychiatric disorders such as depression, anxiety or personality disorder, physical, sexual or emotional abuse in childhood, exposure to violence in childhood, stressful experience with your own or a loved one's illness and a history of personal trauma.

There are only a handful of studies in this area. According to the interpersonal model of hypochondriasis as proposed by Noyes et al.,[3] hypochondriasis is associated with insecure attachment that in adults gives rise to abnormal care-seeking behavior associated with interpersonal difficulties and strained patient/physician relationship. Sherry et al. state that anxious attachment and emotional instability predispose to health anxiety [4]. The prevalence of the disorder is unknown. However, hypochondriasis has a prevalence of 4 to 6% in general medical clinic population [2]. According to Barsky et al., the 6-month prevalence of DSM-III-R hypochondriasis was estimated to be between 4.2% and 6.3% of consecutive attendees who met the inclusion criterion of having visited the same physician before [5]. According to various studies, the prevalence of hypochondriasis ranges from 0.4 to 14% [6-11].

Hypochondriasis is more common in the third and fourth decades of life.[6,10-18] Taylor et al. state that hypochondriasis is common in people who have a family history of hypochondriasis, [19] and according to Noyes et al. hypochondriasis is more common in people with a family history of functional syndromes [20]. Somatization in general is more commonly seen among those of lower social position and those less educated, but it is not clear whether these generalizations are applicable to hypochondriasis [5,10,11,21,22]. Between 65 and 88% of patients with hypochondriasis have psychiatric comorbidities [3,20]. Available literature on primary care populations and ambulatory medical patients contains current (1–6 months) prevalence estimates for major depression at 5–8%, for phobias at 6–9%, for alcoholism at 5–8%, and for panic disorder at approximately 2%. [6–29] Abramowitz et al. [30] compared Short Health Anxiety Inventory (SHAI) scores across groups of patients with various anxiety disorders and found elevated levels of health anxiety among patients with hypochondriasis and panic disorder relative to those with other anxiety disor-

ders. Hypochondriasis is associated with higher levels of undiagnosed medical illness and medically unexplained symptoms [31].

Though recognized as common and important, studies on its prevalence and risk factors in the Indian population are scarce. Hence, the present investigation was carried out in patients attending medical outpatients departments.

AIMS

1. To study the prevalence of illness anxiety disorder (IAD) in medical patients.
2. To study the risk factors associated with IAD.
3. To study psychiatric comorbidities associated with IAD.

METHOD

This cross-sectional, observational study was conducted at Civil Hospital, Ahmedabad, India. Inclusion criteria: Patients with medical complaints attending medical outpatients department. Exclusion criteria: (1) no consent to participate in the study; (2) confused and critically ill patients; (3) psychotic illness. Ethical permission was obtained from an institutional ethics committee. Sample size: 400 consecutive patients attending the hospital's medical outpatients department.

Written informed consent was obtained from all caregivers who participated in the study. Patient sociodemographic data were collected by a semi-structured interview, and comprised information about demographic characteristics and risk factors associated with illness anxiety, such as a family history of hypochondriasis, a history of serious illness in childhood, a stressful experience with one's own or a loved one's illness.

Materials

The participants were given the Gujarati version of the SHAI to fill in. Psychiatric comorbidities were assessed using the Mini International Neuropsychiatric Interview (MINI). In people who scored 18 or above on SHAI, the diagnosis of illness anxiety disorder was confirmed based on the DSM-5 criteria for illness anxiety disorder.

The Short Health Anxiety Inventory/Health Anxiety Inventory-18 (SHAI/HAI-18) was developed and validated by Salkovskis et al.[32] It is an 18item scale that has two sections, the main section comprising 13 items that measure cognitive, affective and behavioral aspects of health anxiety, and a 5item 'negative consequences' section tapping in to the respondent's perception of how bad it would be to be ill. Scoring is based on severity, ranging from 0 (no symptoms) to 3 (severe). A score of 18 or more is considered as positive for illness anxiety disorder.

The MINI is a short structured diagnostic interview, developed and validated jointly by psychiatrists and clinicians in the United States and Europe.[33] It consists of modules for the diagnosis of psychiatric conditions such as major depressive disorder, mania, panic disorder, agoraphobia, social anxiety disorder, obsessive–compulsive disorder (OCD), post-traumatic stress disorder, alcohol use disorder, other substance use disorders, psychotic disorders, anorexia nervosa, bulimia nervosa, generalized anxiety disorder and antisocial personality disorder.

ANALYSIS

Analysis was performed by SPSS (Statistical Packages for Social Sciences) Version 17. Patients with and without illness anxiety disorder were compared regarding demographic characteristics, prevalence, risk factors and comorbidities. Chi-square and Student's *t*-test were used for a further analysis; $p<0.05$ was considered as statistically significant.

RESULTS

Prevalence

In total, 400 consecutive patients attending the hospital medical outpatients department were included in the study. They were given the sociodemographic data sheet and a Gujarati version of SHAI. Out of the 400 patients, 37 were screened positive in SHAI and 28 also fulfilled the DSM-5 criteria of illness anxiety disorder.

SOCIODEMOGRAPHIC CHARACTERISTICS

Table 1. Sociodemographic characteristics of the study sample

Variable		Present (n=28)	Absent (n=372)	Chi-squared test
Sex	Male Female	9 (32.1) 19 (67.9)	220 (59.1) 152 (40.9)	χ^2=7.755 df=1 p=0.005358
Marital status	Single Married Other	4 (14.3) 15 (53.6) 9 (32.1)	116 (31.2) 230 (61.8) 26 (7.0)	χ^2=21.6 df=2 p=0.00002043
Occupation	Professional/Semi-professional Skilled/Semi-skilled Unskilled/Unemployed	4 (14.3) 6 (21.4) 18 (64.3)	79 (21.2) 105 (28.2) 188 (50.6)	χ^2=1.996 df=2 p=0.3687
Education	Graduate/Postgraduate Middle school/High school Primary school/Illiterate	3 (10.7) 11 (39.3) 14 (50.0)	68 (18.3) 189 (50.8) 115 (30.9)	χ^2=4.472 df=2 p=0.1069
Family income	<4900 4900–9800 >9800	10 (35.7) 11 (39.3) 7 (25.0)	40 (10.8) 215 (57.8) 117 (31.4)	χ^2=14.91 df=2 p=0.0005789
Religion	Hindu Other	28 (100.0) 0	341 (91.7) 31 (8.3)	χ^2=2.529 df=1 p=0.118
Family type	Nuclear Joint	13 (46.4) 15 (53.6)	214 (57.5) 158 (42.5)	χ^2=1.307 df=1 p=0.2538
Locality	Rural Urban	9 (32.1) 19 (67.9)	87 (23.4) 285 (76.6)	χ^2=1.094 df=1 p=0.2971

Table 1 shows the sociodemographic factors related to illness anxiety disorder. The variable is comparable in both groups, patients with and patients without IAD. The mean age of patients with illness anxiety disorder was 35.9 years. Several demographic characteristics were comparable in both groups and the difference was statistically significant for sex, marital status and family income ($p<0.05$). IAD was more common in females, divorced or widowed individuals, and people on a lower income.

RISK FACTORS

Table 2. Risk factors in illness anxiety disorder

Risk factors		IAD Present (n=28)	IAD Absent (n=372)	Chi-squared test
Family history	Present Absent	5 (17.86) 23 (82.14)	1 (0.27) 371 (99.73)	χ^2=54.52 df=1 p=<0.0000001

Serious childhood illness	Present Absent	2 (7.14) 26 (92.86)	2 (0.54) 370 (99.46)	χ^2=11.48 df=1 p=0.0007051
Psychiatric disorders	Present Absent	20 (71.43) 8 (28.57)	28 (7.53) 344 (92.47)	χ^2=100.7 df=1 p<0.000001
Abuse in childhood	Present Absent	9 (32.14) 19 (67.86)	2 (0.54) 370 (99.46)	χ^2=97.26 df=1 p<0.0000001
Observing violence in childhood	Present Absent	1 (3.57) 27 (96.43)	6 (1.61) 366 (98.39)	χ^2=0.58 df=1 p=0.44
Stressful experience with illness	Present Absent	8 (28.57) 20 (71.43)	34 (9.14) 338 (90.86)	χ^2=10.46 df=1 p=0.001
History of personal traumatic experience	Present Absent	7 (25) 21 (75)	52 (13.98) 320 (86.02)	χ^2=2.51 df=1 p=0.11
Death of loved one	Present Absent	17 (60.71) 11 (39.29)	166 (44.62) 206 (55.38)	χ^2=2.71 df=1 p=0.099
Knowing people with serious illness	Present Absent	7 (25) 21 (75)	41 (11.02) 331 (88.98)	χ^2=4.81 df=1 p=0.028

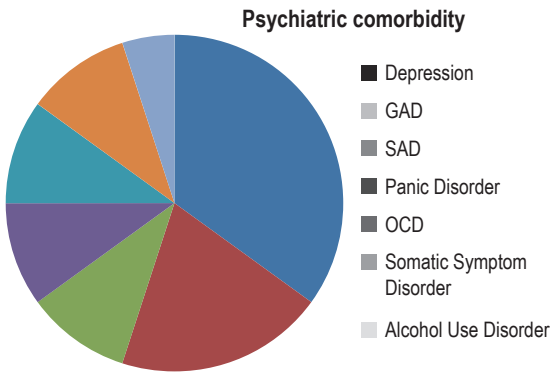
Table 2 shows the risk factors commonly associated with illness anxiety disorder. Family history of hypochondriasis, a serious childhood illness, psychiatric disorders, physical, sexual or emotional abuse in childhood, a stressful experience with one's own or loved one's illness, family members or others with serious disease were seen significantly more often in medical patients with illness anxiety disorder. The disorder was associated with a greater number of risk factors.

PSYCHIATRIC COMORBIDITIES

Table 3. Comparison of psychiatric comorbidities in patients with and without IAD

Psychiatric disorders		IAD present (n=28)	IAD absent (n=372)	Chi-squared test
Depression	Present Absent	07(25) 21(75)	018(4.8) 354(95.2)	χ^2=18.06 df=1 p=0.00002
Anxiety disorder	Present Absent	08(28.6) 20(71.4)	004(1.08) 368(98.92	χ^2=67.65 df=1 p=0.0000001
Obsessive – Compulsive disorder	Present Absent	02(7.1) 26(92.9)	000(0) 372(100)	χ^2=26.7 df=1 p=0.0000002

Somatic Symptom disorder	Present Absent	02(7.1) 26(12.9)	000(0) 372(100)	χ^2=97.26 df=1 p=0.0000002
Alcohol Use Disorder	Present Absent	01(3.6) 27(96.4)	005(1.3) 367(98.7)	χ^2=0.58 df=1 p=0.34
Overall psychiatric comorbidities	Present Absent	20(71.4) 08(28.6)	27(7.2) 345(92.8)	χ^2=103.4 df=1 p<0.0000001



Graph 1. Psychiatric comorbidities in illness anxiety disorder.

Nearly two-thirds (20/28; 71.4%) of patients with illness anxiety disorder had psychiatric comorbidity (Table 3, Figure 1). This is in contrast to only 7.2% of medical outpatients without illness anxiety disorder. The difference was statistically significant for depression, anxiety disorders, OCD, somatic symptom disorder and for psychiatric comorbidities overall. Alcohol use disorder was not found in excess in illness anxiety disorder compared with the control group. As shown in Figure 1, 7 (35%) patients with IAD had comorbid depression, 8 (40%) had anxiety spectrum disorder, 2 (10%) had OCD, 2 (10%) had somatic symptom disorder and 1 (5%) had alcohol use disorder.

ILLNESS ANXIETY DISORDER AND ILLNESS-RELATED FACTORS

Table 4. Factors related to medical illness and IAD

Variable		IAD present (n=28)	IAD absent (n=372)	Chi-squared test
Duration of illness	1.(<6m) 2. (6-12m) 3. (>12m)	01(3.57) 02(7.14) 25(89.29)	171(45.97) 062(16.67) 139(37.36)	χ^2=29.48 df=2 p=0.00000396
No. of physicians	1. 1-2 2. >=3	06(21.43) 22(78.57)	308(82.80) 064(17.20)	χ^2=58.1 df=1 p<0.0000001
Expenses	1. <3,000 2. 3,000-10,000 3. >10,000	07(25) 10(35.71) 11(39.29)	312(83.87) 048(12.90) 012(3.23)	χ^2=79.55 df=2 p<0.0000001
Diagnostic procedures	<=2 >2	13(46.4) 15(53.6)	355(95.4) 17(4.6)	χ^2=84.95 df=1 p<0.0000001
Diagnosed/ Undiagnosed	Diagnosed Undiagnosed	9(32.1) 19(67.9)	283(76.08) 89(23.92)	χ^2=25.5 df=1 p=0.0000004

We assessed various factors related to medical illness (Table 4). Factors such as duration of illness, number of physicians, expenses and number of diagnostic procedures are statistically significant. Illness anxiety disorder is more common in individuals with chronic and medically undiagnosed symptoms. Such patients undergo multiple diagnostic procedures, consult multiple physicians and spend greater amounts of money in the process of investigations and 'doctor shopping'.

DISCUSSION

Although hypochondriasis has been one of the most durable disease concepts in psychopathology, little is known about its epidemiology. Indian research in this field is very sparse. Several questions need to be addressed, such as the prevalence of hypochondriasis in India, the nature of symptomatology across various subcultures and the extent to which these are secondary to other major psychiatric illnesses [34].

At present, there are no conclusive data about specific risk factors for illness anxiety disorder, although patients with the disorder have higher rates of anxiety, depressive and other somatoform disorders than patients without the disorder. To date, there have been no conclusive studies documenting a genetic or familial predisposition for hypochondriasis or for somatoform disorders in general.

PREVALENCE

In this study, the prevalence of IAD was 7%. According to DSM-5, the prevalence of the disorder is unknown, aside from using data that relate to hypochondriasis, which give a prevalence of 4 to 6% in general medical clinic population, but can be as high as 15%. Various studies assess the prevalence of hypochondriasis at 0.4 to 14% [5-11]. Although somatization is very common in Indian patients, there are virtually no studies examining the relative proportion of illness anxiety disorder and somatic symptom disorder (SSD). As this study focuses on IAD, we are unable to comment on SSD.

DEMOGRAPHIC CHARACTERISTICS

The mean age of patients with IAD was 35.93 years and those without the illness 33.99 years; the difference was not statistically significant. According to DSM-IV, although the symptoms of hypochondriasis can occur at any age, they commonly appear in persons from 20 to 30 years of age. According to Noyes Jr et al., the mean age at onset of hypochondriasis is 36.9 years,[12] but other studies have assessed it as more common in the third and fourth decade.[6,10,11,13-18]

Various sociodemographic factors were comparable in both groups (the group with and without IAD), such as education, occupation, religion, family type and locality, but the difference was statistically significant only for sex, marital status and family income. Illness anxiety was more prevalent in separated, divorced and widowed (32%) as compared to those who were not (7%). A possible explanation for this could be that divorced and widowed people have a higher propensity for acquiring psychiatric illnesses and this acts as a poor prognostic factor. However, according to Barsky et al., marital status was not a significant factor in IAD.[5]

In our study, more people with IAD came from families on a lower income (75%), but in Barsky et al.'s study social class was not a significant risk factor for IAD [5].

Out of the 28 IAD-positive patients, 19 (68%) were female and 9 (32%) were male, yet both DSM-5 and a leading textbook of psychiatry consider hypochondriasis as equally prevalent in men and in women [1,2].

RISK FACTORS

There are various factors which can contribute to the risk of developing IAD. We compared nine such factors: family history of hypochondriasis, a serious childhood illness, existing psychiatric comorbidities (depression, anxiety etc.), physical, sexual or emotional abuse in childhood, witnessing violence in childhood, a stressful experience with own or a loved one's illness, a history of personal traumatic experience, death of a loved one, and family members or others with a serious illness. There was a significantly higher incidence of family history of hypochondriasis

in the IAD positive group (17.9%) as compared with the control group (0.27%). A similar result was found by Taylor et al.[19] This could be because partly the disease is heritable and partly because of environmental factors such as learning and parenting practices. Noyes et al. found hypochondriasis more commonly in people with a family history of functional syndromes [20].

In our study, the statistically significant risk factors in the IAD group were: a serious childhood illness, psychiatric comorbidities, childhood abuse, stressful illness experience, death of a loved one and knowing family members or others with a serious illness. A third (31.1%) of patients with hypochondriasis had a history of physical, emotional or sexual abuse in childhood as compared with only 0.54% of patients who did not have IAD. According to Salmon et al., physical and sexual abuse in childhood are risk factors, independent of their association with poor parenting, in the development of separate aspects of adult illness behavior.[35] Though there are theoretical considerations of hypochondriasis that give importance to childhood maltreatment, according to Bailer et al. childhood abuse and neglect do not appear to be necessary prerequisites for the development of hypochondriasis but they can increase the chances of having it [36].

A stressful experience with one's own or a loved one's illness and knowing family members or others with a serious illness also act as risk factors. This could be because if someone had a previous stressful experience with an illness, they could misinterpret ordinary symptoms as indicators of some serious disease which they or their loved one had. Similarly, knowing someone with a serious illness can lead the person to compare their symptoms with them and conclude that they must be having a serious illness too.

This study also shows that as the number of risk factors increases, the chances of having illness anxiety disorder increase too. While 22 patients (78.6%) had two or more risk factors, 6 patients (21.4 %) with IAD had fewer risk factors.

PSYCHIATRIC COMORBIDITIES

Psychiatric comorbidities such as depression and anxiety are commonly associated with IAD. In our study, 71.4% of patients with IAD had a psychiatric comorbidity: 7 (25%) had depression, 8 (28.6%) anxiety disorder (generalized anxiety disorder (4, 14.3%), social anxiety disorder (2, 7.1%), panic disorder (2, 7.1%)), 2 (7.1%) had OCD, 2 (7.1%) had somatic symptom disorder and 1 (3.6%) had alcohol use disorder. Except for alcohol use disorder, the difference was statistically significant for both IAD and no-IAD groups. There are various studies in the literature with similar results. According to Barsky et al., 88.1% of patients with hypochondriasis have psychiatric comorbidities [5]. According to Scarella et al., 65% of patients had at least one other DSM-IV diagnosis in addition to hypochondriasis.[23] The single most common comorbid diagnosis in their study was major depression (32.6%) and the prevalence of dysthymia was at 14.0%. Anxiety disorders as a group were remarkably common (generalized anxiety disorder 28.5%, panic disorder 14.4%, agoraphobia 16.1%, post-traumatic stress disorder and OCD each 12.9%), and despite major depression being the most common single comorbidity, anxiety disorders as a group were more common than depressive disorders as a group. Somatization disorder was found in 11.5% of patients [23].

According to Andisheh et al., there is a positive and significant correlation between major depression and hypochondriasis, where hypochondriasis was present in 17.9, 41.5 and 17.9% of patients with major depression to a medium, high and intense degree, respectively.[24] According to Noyes Jr et al., 62% of patients suffered from another DSM-III diagnosis apart from hypochondriasis and more hypochondriacal subjects had lifetime depressive and anxiety disorders, but not substance use disorders [12]. Similar result were obtained in our study. Sunderland et al. and Bach et al. also support the above [6,37]. According to Lee et al., high health anxiety significantly increased the incidence of 1-year major depressive episode, symptoms of generalized anxiety disorder, health service use and mistrust of doctors [38].

The high rate of comorbid psychiatric illness among patients with hypochondriasis has treatment implications. These patients have treatment-responsive syndromes, mostly depression and anxiety, both of which are responsive to

antidepressant medication, which might prove beneficial for such patients. Managing psychiatric comorbidities and early treatment of both will lead to a better prognosis. The quality of life of both patients and caregivers is much more likely to improve if illness duration is short. A high degree of awareness is needed among clinicians, physicians and psychiatrists alike regarding hypochondriasis and comorbid anxiety in patients with medically unexplained symptoms.

FACTORS RELATED TO MEDICAL ILLNESS

Various factors related to medical illness also predict the prevalence of IAD. These included duration of medical illness, number of physicians consulted, amount of money spent for health assessments and number of diagnostic procedures undergone. According to Sunderland et al., people with health anxiety utilize mental health services at a higher rate than those without health anxiety [6]. Such patients are not satisfied with their illness and even after reassurance by doctors feel something is seriously wrong with them, visit various physicians and request numerous investigations.

The prevalence of IAD was greater in undiagnosed medical illness as compared with a diagnosed medical illness. This is also supported by Escobar et al., who conclude that hypochondriasis had higher levels of undiagnosed medical illness and medically unexplained symptoms [31].

LIMITATIONS AND FURTHER RECOMMENDATIONS

1. Single center study, so results cannot be generalized to the whole medical population.
2. Study site was a tertiary care hospital, so people with more serious illness would gravitate towards it.
3. Average sample size.

In the future, a study should be conducted on a larger sample and multiple sites should be chosen to confirm the present findings. Primary, secondary and tertiary care should be included in the study in order to generalize the results to the whole medical population.

SUMMARY AND CONCLUSION

The anxiety of having a serious medical illness, although quite prevalent, has not been extensively studied in India. Our study, conducted in one of Asia's largest teaching hospitals, found that illness anxiety disorder was prevalent in 7% of patients attending medical outpatients department. About three-quarters of IAD patients had a comorbid psychiatric condition, mostly depression and anxiety disorders. Having a family history of hypochondriasis, a history of serious physical illness in childhood or a history of abuse in childhood as well as a history of serious physical illness in a close relative put the patient at a high risk for illness anxiety disorder.

Illness anxiety, although acknowledged, is not frequently addressed as a symptom to manage. Reassurance and group therapy and management of comorbid psychiatric disorders can go a long way towards giving patients a better quality of life.

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