Understanding and Managing Hypochondriasis

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Defining Hypochondriasis

Hypochondriasis is defined as the preoccupying fear or belief that one has a serious, undiagnosed disease. This fear or belief is based on a misinterpretation of normal or benign bodily sensations as indicative of a serious disease. The patient's concerns are chronic, disabling, and disproportionate to any demonstrable medical condition. Hypochondriacal patients are therefore distressed not only by bodily symptoms, but also by their beliefs and suspicions about the meaning and significance of these symptoms.

The hypochondriacal patient's bodily complaints have no demonstrable medical basis, or are out of proportion to any disease that is present. The patient's symptoms are often bodily sensations which are generally not thought of as symptoms of serious disease. They may be due to normal physiology (such as orthostatic dizziness or an ectopic beat), or are common, benign dysfunctions (e.g., a bad taste in one's mouth, yawning, or hiccupping), or are transient, infirmities of daily life (e.g., tinnitus or a cramp). Hypochondriacal patients, however, believe these symptoms indicate serious disease and become very concerned with the meaning and significance of the symptom, that is, with its cause and its prognostic implications. Hence, although they do seek symptom relief, they find it equally important, or even more important, to obtain a diagnosis from the doctor and an explanation for their symptoms. Headache relief, for example, may be less important to the hypochondriacal patient than a rigorous medical evaluation to determine the cause of the pain.

In addition to bodily symptoms, hypochondriasis is characterized by beliefs and/or fears about disease. Hypochondriacs are convinced they have a serious, occult disease which has not yet been diagnosed. This notion is remarkably resistant to reassurance, so that patients remain convinced they are sick despite an unrevealing medical evaluation and an appropriate explanation from the physician to the contrary. Hypochondriacal patients also have profound fears about disease. They are plagued with an ominous sense of doom that something terrible is about to happen. They fear that the suspected disease will worsen, that they will be incapacitated or even killed by it. And they are easily alarmed by the slightest hint of illness, for example becoming frightened when hearing that an acquaintance or co-worker has become ill, or learning about a disease for the first time on television or in a magazine.

Hypochondriacal patients are preoccupied with their health and their bodies. They are absorbed in their own symptoms and haunted by their health concerns. Nothing is as interesting to the hypochondriac as his own body, and he recognizes only his own needs. Illness becomes a way of life, an aspect

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of his self-identity, and a mode of responding to stressful events. Thus, for example, hypochondriacs respond to a marital argument or the failure to be promoted at work not with anger or shame, but instead with a headache and renewed fears of disease. Symptoms also function as a means of communicating with others, a topic of conversation, a non-verbal language used to communicate distress to acquaintances and family. Hypochondriacal patients therefore find themselves discussing their doctors, their medications, and their medical encounters with the people they meet.

The hypochondriac’s clinical presentation is familiar. They have massive, extensive and complicated medical histories, having visited many different physicians and undergone many diagnostic tests and procedures. They inevitably are given numerous, non-specific, medical diagnoses (such as “headache,” “irritable bowel,” and “anemia”). They come to their medical appointments armed with complete copies of their old medical records, and with extensive documentation of the course of their symptoms, their medication use, and all the adverse side-effects they have experienced. But although their medical care has been intensive and extensive, hypochondriacal patients have found it profoundly unsatisfactory and frustrating. They feel that their doctors have been unhelpful, have not tried hard enough to correctly diagnose and treat them, and have prescribed measures which have actually exacerbated their condition. Conversely, from the physician’s perspective, hypochondriacal patients seem impossible to help. Every therapeutic attempt seems only lead to intensified symptoms or to new symptoms which replace the old ones: Diagnostic interventions precipitate iatrogenic complications; Every suggestion or observation seems to be rejected out of hand; And attempts at reassurance and allaying the patient’s concerns provoke the patient’s irritation, hostility, and even outright derision. Indeed, an almost pathognomonic doctor–patient interaction develops, in which the more that physicians attempt to help, the worse the patients become. On the one hand, hypochondriacal patients cling, demand, and plead for more attention and information, additional consultations, and further medical evaluation. But at the very same time, they are particularly unresponsive to the doctor’s every effort and seem almost to be disparaging, dismissing, and rejecting their efforts.

Understanding Hypochondriasis

Hypochondriasis has been understood in a number of different ways. Three of these conceptual models are discussed below.

1. Cognitive/Perceptual model

This model posits that hypochondriasis is a self-validating and self-perpetuating disorder of symptom amplification. Hypochondriacal patients are unusually sensitive to visceral and somatic sensations, and are therefore bothered by normal physiological sensations and minor discomforts that non-hypochondriacs ignore, dismiss, or are completely unaware of. Because bodily sensation seems so intense, noxious, and disturbing, they readily misattribute it to disease. In other words, because bodily sensations are so intense and unpleasant, they conclude that they are sick. This misattribution is important because once an individual believes himself to be sick, it alters the way in which he subsequently perceives his body, and a process of symptom amplification begins. For example, a headache initially attributed to eye strain seems much worse when one begins to suspect that it is actually the first sign of a brain tumor. So as hypochondriacal patients begin to believe that they’re sick, they find their symptoms worsening. The belief that one is sick amplifies preexisting symptoms, making them more intense because they are now subject to closer scrutiny. This apparent worsening of their condition makes them even more firmly convinced they are sick. They pay increasing attention to their bodies, become hypervigilant for other symptoms which confirm their suspicions, and ignore contradictory information indicating that they are not in fact sick. For example, an individual may notice he is breathless after climbing a flight of stairs and wonder if this signifies the onset of asthma. With
this suspicion in mind, he now notices that his face
seems unusually pale in the mirror when he next
shaves. This too seems to provide further evidence
of disease progression. In addition, anxiety and
alarm mount, producing the autonomic symptoms of
anxiety. These symptoms too are then misinterpreted
as further evidence of disease. A vicious cycle
has been set into motion in which bodily perception
and cognitive interpretation fuel each other.

2. Interpersonal model
An alternative conceptual model of hypochondriasis emerges when we view it as a form of inter-
personal communication. It has been quipped that
"if you put a hypochondriac on a deserted island, his
symptoms will disappear." While facetious and
unfair, this adage does point out that complaining
about our distress is an interpersonal process—we
complain to someone. According to this model then,
hypochondriasis is a non-verbal way of saying
something to the important people in the patient's
life. The hypochondriacal patient is using a bodily
pantomime to tell others that he is facing a seeming-
ly insoluble life problem, or an insurmountable
dilemma which he cannot solve or cope with. He is
asking to take a "time-out," saying to others (in a
non-verbal language) "I am in a desperate situation
and so I need special care and attention, unusual
assistance and support at this time." Hypochondriacal patients have unwittingly learned that ill-
ness behaviors can be used to negotiate stressful
circumstances, secure support, and solicit care. It is
crucial to note that hypochondriacal patients do
have the symptoms they report; they are not malin-
gering or feigning disease. But they have learned
over the course of their lives that assuming the sick
role can help them to postpone or avoid a crisis or
challenge they face.

The sick role is a helpful construct in this context.
It is based on the observation that sick people have
a distinct and unique social role which carries with
it discrete responsibilities and privileges. If one is
sick, he is allowed to avoid many of his usual
obligations, duties, and responsibilities. Being sick
also confers special powers on the sufferer, particu-
larly within the family. But these dispensations are
accompanied by certain distinct obligations and
requirements: the sick person must be found to
have a medical disease, be in ongoing medical treat-
ment, and must be attempting to recover. In other
words, one can not claim the sick role himself but
must be admitted to it by a physician who confers
this status by providing a medical diagnosis and
accepting the individual in ongoing, medical treat-
ment. Thus it is necessary for the hypochondriacal
person to enter the medical care system, become a
patient, and enter an ongoing relationship with a
physician. And at this point his difficulties multiply,
since the physician with a biomedical model of
disease finds that the hypochondriacal patient is not
sick, has "nothing wrong" with him, and provides no
medical diagnosis. Effectively, the physician dismis-
ses the patient's petition for patienthood, either by
telling him he is not sick, or by treating him
symptomatically with the expectation that his
symptoms will soon resolve. This however is pre-
cisely contrary to the patient's unconscious object-
ive, since the patient seeks a diagnostic label and
an ongoing relationship with the physician. He may
therefore feel forced to press his request for
patienthood with more intense or urgent or ominous
symptoms, or by seeking out a new doctor and
repeating the entire scenario in hopes of finally
being admitted into sick role.

3. Psychological (Psychodynamic) model
The psychodynamic model of hypochondriasis is
based on the premise that pain and other distressing
symptoms can hold unconscious meanings and un-
conscious gratification for the sufferer. Psychoana-
lysts have pointed to dependency, hostility and in-
adequate self-esteem as prominent unconscious
themes in hypochondriasis. Thus hypochondriacs
may be viewed as people who are unconsciously
gratifying dependency needs and needs for love,
succorance and attention through somatic sym-
toms and physical suffering. The hypochondriac has
learned in childhood that pain brings love, and so
later in adult life when he feels in particular need of
care, somatic symptoms emerge in an attempt to
elicit the love and nurturance of those around him. Other psychodynamic observers have emphasized the importance of anger and hostility in hypochondriasis\textsuperscript{34}. They suggest that the hypochondriac is actually angry at those care-takers early in his life whom he feels let him down. He then deals with this unconscious conflict in adulthood by entering into putative care-taking relationships (e. g., with physicians) and then reproaching and belaboring the others with his complaints, soliciting their efforts to help him and then thwarting and rejecting their attempts. More recently, hypochondriasis has been studied in relationship to narcissism and the integrity of the self. According to this formulation, the hypochondriac finds it more tolerable to believe that something is wrong with his body than to believe that something is wrong with the self—with himself as a person. He thus displaces his deepest doubts and fears about his personal integrity onto the body, substituting physical suffering for psychological suffering. He distracts himself from concerns that he is defective and deficient as a person with concerns that his body is defective and deficient.

Managing Hypochondriacal Patients in the Medical Setting

Several strategies are useful for medical doctors and psychosomatic physicians caring for hypochondriacal patients. The first step is to identify a single, primary care doctor who will take overall responsibility for coordinating the patient’s medical care. The second step is to focus on care rather than cure, to begin to help the patient live with his/her symptoms rather than trying to cure them, remove them, or eliminate them. The third step, termed “therapeutic conservatism,” involves caution and restraint in diagnostic evaluation and therapy. The fourth step is to uncouple access to the doctor from the patient’s symptoms and clinical status. Finally, it is important to provide limited reassurance and to offer the patient an etiological explanation for his symptoms.

1. Identifying a single primary care physician

Hypochondriacal patients can’t be helped until all of their medical care is unified, coordinated, and integrated by a single primary care physician whom the patient feels he can trust and relate to. A durable, dependable, trusting relationship of this sort requires time to develop and can only result from the physician’s consistent, attentive, and respectful attention to the patient, sustained over a period of time. The hypochondriacal patient thereby gradually comes to trust his physician, to feel that he is understood and that his doctor truly has his best interests at heart. Only after such an alliance has been built can the medical management of the hypochondriacal patient be optimized. The primary care physician is now in a position to integrate and coordinate all of the patient’s specialty care and to regulate and control his diagnostic procedures and tests. This is crucial in curtailing the duplication of effort and redundant testing, and in protecting the patient from harmful interventions and iatrogenic complications which are so common and so problematic in the care of hypochondriacal patients.

2. Care rather than cure

Once a durable, long-term relationship has been forged, the objective of medical management is not to eliminate the patient’s symptoms, but rather to help him to cope more effectively with them—i. e., the goal is to care for the patient rather than to cure him.

The biomedically-oriented physician aims to detect a structural or physiological abnormality and then to institute a specific treatment. This strategy works well with a patient whose symptoms result from a demonstrable disease, but it is less successful with medically unexplained symptoms. When the symptoms have cognitive, interpersonal, circumstantial, and intrapsychic causes, it is unlikely that the physician will be able to extinguish them with medical or surgical treatments. It then follows that the physician’s task is to help the patient to cope better with his distress and his anxieties, to learn better ways of minimizing symptoms and of fun-
ctioning optimally in spite of them. This change is similar to that of caring for a patient with a chronic and refractory medical condition, where the physician helps his patient to cope with his condition, rather than definitively curing it. Allowing the patient to retain his symptoms and focusing instead on coping with them avoids the vicious circle in which the physician’s therapeutic attempts engender more symptoms and heightened demands. Much of the physician’s anger and frustration derive from the sense of being thwarted or foiled by the patient. Once the physician stops trying to cure the patient, then the patient no longer seems to be contravening and defeating his efforts. As a result, the physician feels less exasperated and angry.

3. Diagnostic and therapeutic conservatism

Hypochondriacal patients often respond negatively to medical interventions and treatments. Diagnostic tests, invasive procedures, and treatment regimens all too often result in complications, side-effects, iatrogenic illness, or new symptoms to replace the old ones. Thus it is best to make only those interventions which are medically necessary. Obviously, the physician must evaluate every complaint adequately, since hypochondriacal patients are as vulnerable to disease and as much at risk as other patients. The dilemma, however, is that in their frustration, exasperation, and helplessness, physicians sometimes subject hypochondriacal patients to unnecessary diagnostic procedures and excessively aggressive therapeutic interventions. The physician therefore needs to use caution in ordering invasive tests and major procedures. Before doing so, it is wise to question the patient carefully and check the record thoroughly to make sure the test has not already been performed. A rule of thumb in ordering laboratory studies is to do exactly what the physician would do for the same patient were he not a hypochondriac. If the patient requests a series of tests that are not indicated, the physician may obtain the first test if they can agree at the outset not to go on to further testing for that symptom if the results from the initial test are negative (e.g. “if your ambulatory electrocardiogram is normal, let’s agree not to go on to a stress test”).

The most powerful therapeutic tool is the physician himself: his attention, concern, interest, and careful listening. Hence the old adage, “don’t just do something, stand there.” Frequent physician visits, a laying on of hands, and careful physical examinations are beneficial. Simple and benign remedies like lotions, vitamins, slings, ace bandages, massage, and heating pads are helpful. They provide tangible evidence of the patient’s distress and an acknowledgement of the physician’s ongoing interest and concern.

4. Validating the patient’s distress

The interpersonal model suggests that hypochondriacal patients need to have their suffering recognized and to be accepted as patients, to be admitted to the sick role and to enter into an ongoing relationship with their doctor. Thus it is helpful for the physician to respond in ways which acknowledge the patient’s distress and legitimize the need for an ongoing relationship. This means uncoupling access to the doctor from the patient’s symptoms. Medical follow-up should not be made contingent on clinical status and continued symptoms. Visits should therefore be scheduled on a regular basis, rather than as needed: Physician and patient agree on a satisfactory frequency of appointments and then try not to stray from this when changes occur in the patient’s symptoms. This means that the frequency of visits should not be decreased if the patient’s symptoms improve, nor should it be increased in the face of escalating complaints. The latter of course may not be possible if the patient develops new or emergent symptoms. When practical, the physician can also volunteer a regular call-in time, since this too guarantees access to the physician without requiring that the patient first have an alarming change in clinical status to justify his contact. The net effect of divorcing medical attention from somatic complaints is to reduce the latter. A few patients may continue to make excessive and unreasonable demands on the doctor. Clear, firm, nonpunit
limit setting is then necessary in these cases.

The physician also assures the patient of the legitimacy of their relationship by getting to know him as a person. This is done by broadening the clinical agenda to include discussion of the patient's personal and social history, making it clear to the patient that his social life, work, family, and daily routine are all legitimate subjects to discuss with the doctor. The interpersonal model of hypochondriasis suggests that these patients are facing difficult life situations and stressful circumstances; discussing these keeps the patient's focus on these psychosocial difficulties and begins laying the groundwork for resolving them.

5. Reassurance and explanation

Hypochondriacal patients ask for reassurance frequently and urgently: “What is my diagnosis?” “What is wrong with me?” “Will it get worse?” “How can you be sure?” The difficulty is that attempts to reassure the patients by answering these questions only seem to intensify their fears and worries and to make them angrier at the doctor. It is characteristic of the hypochondriacal patient that he responds to reassurance with anger and resentment, reproaching the physician that he must have underestimated or ignored the intensity of his distress. Therefore reassurance should only be provided in a limited and qualified fashion. It is appropriate to explain to the patient that the medical evaluation indicates that he definitely does not have a very serious, grave, or fatal disease. The patient may be told that although no lethal disease is present however, his symptoms may nevertheless prove difficult to treat completely and that some degree of distress may persist. Beyond this, further reassurance may lead into a fruitless dispute in which the patient responds with the urgent insistence that the physician has underestimated the seriousness of his condition and failed to appreciate the severity of his distress.

The message that the patient does not have a lethal or progressive disease must be accompanied with the assurance that the symptoms are nonetheless “real,” that the physician is not suggesting that he is not sick, or that “nothing is wrong” and that he is making up his symptoms or feigning illness.

Because the hypochondriacal patient has symptoms and feels sick, he knows something is wrong. When no diagnosis is forthcoming, this tends to call his experience into question, to imply that his suffering is somehow less authentic or legitimate. Therefore it is insufficient to simply inform the patient that serious disease has been ruled out; an alternative explanation for the symptoms is necessary. Such an explanation should attempt to move the patient from a structural model of the problem (that of a localized, discrete, occult lesion) to a model of dysfunction. The cognitive and perceptual process of symptom amplification described above is a useful model to offer. An analogy can be made to a radio whose volume has been turned up so high that the background static has become disturbing and noxious. The physician is thereby suggesting that the problem lies in the central nervous system and its processing of bodily sensation, offering the possibility that the patient has an extraordinarily sensitive sensory nervous system that amplifies symptoms which others experience as less intense.

6. The psychiatric referral

Since hypochondriacal patients believe they are medically ill, psychological intervention and psychiatric referral seems profoundly misguided. At best it seems irrelevant, and at worst it indicates that others consider their symptoms “imaginary” and inauthentic. If the patient is resistant to a psychiatric referral, little is gained by forcing him since a reluctant patient will render the psychiatric encounter unproductive. It is better to wait and then gradually reintroduce the idea again in the future: the referral process need not be accomplished in a single visit. For the patient willing to see a psychiatrist, consultation can be helpful in: ① diagnosing psychiatric comorbidity, ② engaging patients in ongoing psychiatric treatment, and ③ assessing the indications for psychotropic medications.

Psychiatric comorbidity is prevalent in hypochondriasis. Major depression, dysthymia, panic disorder, obsessive compulsive disorder, generalized
anxiety disorder, and a variety of Axis II disorders commonly co-occur with it. It is especially difficult for primary care physicians to diagnose these conditions in hypochondriacal patients because they are hidden behind the veil of bodily complaints and concerns, obscured in the haze of doctor-patient disagreement, exasperation, and recrimination. Psychiatric consultation can be helpful in diagnosing these hidden conditions.

Some hypochondriacal patients are willing to accept psychiatric treatment for help with an emotional problem or a psychological difficulty which they can acknowledge. They may admit being distressed by anxiety or depression, for example, or having trouble with their marriages or their jobs. These patients often insist that their psychological difficulties are the result rather than the cause of their medical symptoms. This view need not be contested since it is not an obstacle to psychiatric treatment: it is not necessary for the patient to acknowledge a causal relationship between his emotional and somatic distress in order to benefit from psychiatric treatment.

Other patients, who resist a mental health referral may find treatment acceptable if it is narrowly focused on coping with somatic symptoms and learning techniques for symptom management. These patients may find a referral to a “stress management,” “stress reduction,” or “mind/body medicine” program acceptable.

**Psychiatric Treatment**

Promising cognitive and behavioral approaches to hypochondriasis have recently been developed. These programs are often conducted in a classroom format, meet for 6 to 16 sessions lasting 1 1/2 to 2 hours each, and are highly interactive. They contain a large educational component and treatment is supported with workbooks, reading materials, and audiotapes. The therapy combines experiential class exercises, didactic information, and group discussion. The aim is to identify and restructure dysfunctional beliefs and assumptions about health: modify maladaptive behaviors that sustain symptoms and disability, such as avoiding usual activities, seeking reassurance from others, and “doctor shopping”; initiate a program of progressive exercise and carefully graduated physical conditioning; and learn relaxation or meditation techniques. There is growing literature on the efficacy of this approach in treating hypochondriasis, somatization disorder, and medically unexplained syndromes such as atypical chest pain, irritable bowel syndrome, fibromyalgia, chronic fatigue syndrome, headache, and other forms of chronic idiopathic pain. Carefully conducted intervention trials with these therapies have been conducted and have included control groups, some receiving a nonspecific relaxation or education program. Follow-up has been conducted for up to four years, and attrition rates are modest. These cognitive and behavioral treatments have been shown to reduce somatic symptoms, generalized distress, and impairment of role function. Some interventions have also been shown to reduce the utilization and costs of medical care.

The role of psychotropic medication in treating hypochondriasis is a difficult issue since these patients tend to react negatively to medication and are prone to adverse side-effects. When a pharmacologically-responsive, Axis I disorder is present, a trial of an appropriate antidepressant, antianxiety or antiobsessional agent is definitely indicated. Frequently, the patient's hypochondriasis will improve significantly, if not remit completely, when the underlying anxiety or depressive disorder is adequately treated. The indications for psychotropic medications are less clear in patients with primary hypochondriasis who do not have another, major Axis I diagnosis. The similarities between hypochondriasis and obsessive-compulsive disorder, and the high prevalence of subdefinitional or subthreshold panic disorder, have led clinicians to suspect that serotonin reuptake inhibitors with anti-obsessional and anti-panic properties might be effective. The literature now contains several case reports and small, prospective and retrospective studies, suggesting that at least some, previously refractory cases of primary hypochondriasis do
respond\textsuperscript{13,14}, perhaps at doses higher than those used in depression and after a relatively long latent period before the therapeutic effect.

When prescribing these medications, a few specific techniques may improve the chances of the patient’s compliance and of completing an adequate trial. Since complete symptom elimination may not be totally welcome, and since they are prone to side-effects, it is wise to prescribe medication in a cautious and even pessimistic fashion. The patient may be told to have only limited expectations of pharmacotherapy, and cautioned that although some improvement may result, cure all symptoms is unlikely. Side-effects should be predicted in advance, and accompanied with the suggestion that they are actually to be welcomed because they indicate that the medication is in the patient’s bloodstream and working. Finally, initial dosage should be very low and increased gradually and slowly.

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Summary

Significant strides have recently been made in understanding and treating hypochondriasis. In particular, it has been conceptualized as a self-validating and self-perpetuating disorder of cognition and perception, and as a non-verbal form of interpersonal communication. Both of these conceptual models have important implications for medical management. They also serve as the basis for a focused, cognitive and behaviorally oriented treatment. This combination of improved medical management and cognitive/behavioral therapy gives us reason to be more hopeful about the course and outcome of this previously refractory and disabling condition.

References

編集委員会への手紙

「国際緊急医療援助活動における心身医療について」

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平成10年11月13日～12月10日の間、ホンジュラス国際緊急医療援助隊に参加し、現地で被災者のための医療活動に従事いたしました。その際、1日300人以上、2週間で4,031人の患者さんの診療を6名の医師を含む23名の医療隊で行いました。患者さんの80％近くは小児および女性であり、特に被災によるPTSDの症状と考えられる悪夢、不眠、フラッシュバック現象を訴える子どもたちを毎日10人以上診ることになりました。しかし、限られたマンパワー、殺到する患者さんたち、コミュニケーションの壁（現地はスペイン語圏で英語も通じない）などの悪条件が重なり、ゆっくり傾聴する時間もとれず、とても満足な心身医療のできる状況ではありませんでした。そのことは、帰国後も大きな心残りでした。「それでもどうすれば良かったのか」という疑問に対する答えは、まだ出ません。

特にTriage Officer（トリアージ・オフィサー：すべての患者さんを最初に診療して、重度度判定、治療の優先順位、診療科の選定を担当する医師）の役割をしていた私は、心療内科医としての診療はできず、primary care physicianとして勤務しかありませんでした。

帰国後、通訳として医療活動を支えていただいた外交官（20代、女性）に再会する機会があり、彼女自身もPTSDの症状（多くの現地人の患者さんに追いかけられるという悪夢や不眠など）に悩まされていたことを知りました。

被災者のストレス管理も重要ですが、医療スタッフを含む救援スタッフの精神健康管理の重要性を再認識しました。

岡本論文（心身医38：608–615,1998）に阪神・淡路大震災被災者におけるPTSDの疫学調査の結果が掲載されており、学術的にも意義のあることと考えます。

願わくば、今回のホンジュラスでの国際的な災害医療支援のように、「特に限られたマンパワーを時間、そして異文化圏の患者さんたちに対して、どのようにすれば効率的な心身医療が実施できるか」という問いに答えられるような提言や研究論文が、今後掲載されることを期待したいと思います。

もちろん、私自身もこのテーマについては、じっくり時間をかけて取り組みたいと考えております。