

Validity of Current Treatment Protocols to Overcome Hypochondriasis

SHRAYASH KHARE¹, MEHER NARAIN SRIVASTAVA²

ABSTRACT

Hypochondriasis has been difficult to define and its classification amongst diseases has been blurred since, time immemorial. Though decades have been passed since its discovery and known to the people that the disorder is of the mind itself, the treatment options are still limited for the disorder and therefore, in dire need of exploration and analysis. Hypochondriasis, also sometimes referred to as health anxiety, is much more common in general health ward than previously accounted for. Thus, an efficient way of its management needs to be formulated and this review article helps to shed out light on the current treatment protocol available for hypochondriasis and their efficacy for the same. The treatment modules for hypochondriasis are unfortunately few and limited. None of the review articles have evaluated the efficacy of the tried treatment interventions and through this review article we want to highlight the same. A Medline search of the relevant publications and the references of the studies were incorporated to obtain the data.

Keywords: Health anxiety, Psychiatric disorder, Mental disorder

INTRODUCTION

Mental disorder, though not recognized, is as old as mankind itself. The two are so entwined together, that, as man progresses and develops new methods of freeing himself from the thorns of infirmity, it continues to mutate into a more and more vicious pathology. This unceasing one-upping has led to an increased understanding of the biological functioning of the human body and henceforth branching of the field of medicine into hitherto unrecognized realms. One of the vestiges to be opened during the search for cure is the effect of brain and its neural circuits on the human mind, which has continued to baffle physicians. The 20th century finally saw theories of unconsciousness put forward by Sigmund Freud and his use of psycho-analysis for the cure of psychiatric ailments, increasing hope for future advancements [1].

One such psychiatric entity to be recognized was 'Hypochondriasis'. Referred to as "a step child" in the field of psychiatry by Macalpine and as a "strange child" in Psychiatric disorder dimension by Jelliffe, its definition and therefore, classification has been blurred since, time immemorial. The term Hypochondriasis takes its origin from two Greek words, 'Hypo' meaning below and 'Chondriac' meaning cartilage, since, one of the most common presentations of the patients was unexplained abdominal pain [2]. In his book, Anatomy of Melancholy, Robert Burton describes Hypochondriasis as a disorder ranging from "too much spittle" to "rumbling in the guts."

As time rolled on, the knowledge about the enigmatic human mind reached new levels, and soon enough, Hypochondriasis happened to transform into a psychiatric disorder implying that a disease, which was earlier associated with an abdominal organ, became an ailment concerning the brain and the nervous system. Psychiatrists then defined Hypochondriasis, as an unshaken belief of serious medical illness that persists despite being assured of its vagueness by appropriate medical evaluation. In hypochondriasis, as with somatization disorder, a history of poor relationship with physicians stemming from their sense that they have not been treated aptly or correctly is present. Hypochondriasis causes debilitation due to stress and its chronic course, and symptoms that may vary with time in their intensity [3]. Furthermore, Hypochondriasis has been labeled as a mental disorder instead of psychiatric disorder. Since, psychiatry is only one of the disciplines that deals with

hypochondriasis (besides, clinical psychology and psychosomatic medicine). Therefore, the recent Diagnostic and Statistical Manual of Mental Disorder (DSM 5) criterion has recommended using the more neutral term "mental disorder" for Hypochondriasis [4]. Further the new DSM 5 system no longer addresses the disorder as hypochondriasis, renaming it as 'illness anxiety disorder'.

Another disorder, often flummoxed with hypochondriasis, is Somatization. Both these terms though often used inter-changeably, in reality, represent two different facets of the same psychiatric ailment. Hypochondriasis is a situation in which a patient is too apprehensive of some malady afflicting his body despite continuous negative medical evaluations and assurances. In somatization, patients present with various physical complaints that no known medical condition can explain [5]. Though the relationship between the two is not well understood, it is better to conceptualize hypochondriasis as a distinct categorical designation rather than as an element of somatization. Another way of isolating the difference is to understand the concept in terms of cognitive and emotional symptoms, which is a characteristic feature of hypochondriasis, whereas, the description of somatization emphasizes upon symptoms, which are mainly somatic [6]. It is imperative for the primary care physician to recognize and understand somatization and hypochondriasis as two different psychiatric conditions since they are more liable to be found among patients paying a visit to general medical care.

The prevalence of hypochondriasis has not been surveyed in a substantial way in the field of psychiatry. In a study conducted in Department of Psychiatry, Harvard Medical School, Boston, USA, between 4.2% and 6.3% of the patients visiting the outpatient ward in a period of 6 months were estimated to be suffering from hypochondriasis [7]. In a similar study the prevalence of hypochondriasis was found to be in between 1%-5% in the general population and between 2% - 7% in the medical population. A study conducted by Martin and Yutzky estimated hypochondriacs to be between 3 to 13% in the medical population. Further, the gender specificity for the disorder has also been not evaluated upon with clarity. An article by Suzanne Feinstein, PhD, and Brian Fallon, MD, MPH, reported that in psychiatric or medical clinics, women were found to have hypochondriasis three to four times more often than men. However, DSM-IV-TR, reports equal incidence of hypochondriasis in both genders [7].

Search Strategy

A Medline search of the relevant publications and the references of the studies were incorporated to obtain the data. The search strategy used keywords as Hypochondriasis crossed with terms, definitions, epidemiology, incidence, prevalence, etiology and various treatment modules. The search was limited from 1970 to 2014. Few very old studies were also referenced so as to highlight upon the history of hypochondriasis needed for the review.

Current Treatment Modules

Hypochondriasis was defined by Barsky and Klerman as to comprise four main characteristics: a) physical symptoms disproportionate to demonstrable organic disease; b) fear of disease and the conviction that one is sick; c) a pre-occupation with one's body; d) the persistent and unsatisfactory pursuit of medical care [8]. This disorder is usually heterogeneous and mostly chronic [9,10]. Kaplan (1991) reported that a hypochondriacal person complains of many symptoms, focusing mainly on bodily sensations. This results in misinterpretation and henceforth-undue alarm to the patient [11]. Though the treatment provides significant relief, some degree of discomfort is likely to persist [12]. Floru suggests that behavioural intervention is especially helpful in neurotic cases [13]. Health anxiety, apart from having detrimental effects on the patient, causes inconvenience and worry to the family members in terms of costs incurred to avail higher medical care utilization [14]. The occupational disability is an added setback [15]. Hence, development of effective treatments should be prioritized, for the sake of both patients and health care service providers.

1. Reassurance

The first step towards ensuring proper treatment is reassurance which must be credible, educative specific, and directed at both, expressed and concealed fears [16]. Certain theories suggest that childhood experiences [17] and social reward [18] might encourage somatic complaints under stress, thereby, causing such individuals to misinterpret normal sensations [19] or feel them more sharply [20]. Hence, explanation of psycho-somatic symptoms to the patients, coupled with careful examination and reassurance can prove to be very effective [21]. Detailed reassurance has been documented to become increasingly effective over time, and to reduce worries, which might arise by fresh symptoms in the future. The therapeutic effect of reassurance is further bolstered by family counseling on reinforcement [22]. Reassurance therapy aims at reducing pre-occupation with one's assumed ill health by pointing to reproducible evidences that nothing is wrong. Although the patient is temporarily relieved, a long-term positive outcome has not yet been documented and the patients' fears relapse [23].

2. Pharmacotherapy

Reassurance can be coupled with pharmacotherapy. Drugs most commonly used are Imipramine (Tofranil) [24], Clomipramine (Anafranil) [25,26], Fluoxetine (Prozac) [27,28] and Amitriptyline (Elavil, Etrafon) [29]. Apart from anti-depressants, various Monoamine Oxidase (MAO) inhibitors, like Pimozide (Orap) (for monosymptomatic hypochondriacal obsession) have been used. Nevertheless, anti-depressants seem to be more effective and are therefore considered the treatment of choice. Systematic double-blind studies, demonstrating the efficacy of pharmacotherapy, are still lacking. This is exemplified by a case report in which a patient with monosymptomatic hypochondriasis exhibiting koro-like symptoms not responding to pimozide, improved with a tricyclic anti-depressant and remained symptom-free for 1.5 years [30] as opposed to another patient responding better to MAO inhibitors treatment of which lasted several months [31].

If there is paucity of knowledge on the long-term outcome of hypochondriasis, it is nothing compared to that of the effect of

treatment with anti-depressants such as Selective Serotonin Reuptake Inhibitor (SSRI). A Long-term follow-up of hypochondriasis after SSRI treatment in 46 patient was carried out [32] which revealed that a substantial proportion of patients who received treatment with SSRIs achieved remission over long term, concluding that interim SSRI use may contribute to better prognosis. Similarly, a randomised control study conducted to evaluate the efficacy of Fluoxetine (SSRI) in patients suffering from hypochondriasis, proved that Fluoxetine was moderately effective and well-tolerated [33]. Amitriptyline has also been useful in relieving hypochondriac symptoms in nonpsychotic inpatients with DSM-III diagnosis of melancholia [34].

The past two decades have seen the emergence of Pimozide as the drug of choice for hypochondriasis. Although a few studies with controls have been done to support the efficacy of pimozide, the treatment recommendation is largely based on case reports [35]. Pimozide has significant adverse effects, including cardiac and extrapyramidal defects (Drug induced Parkinsonism) [36], which assume significance and are a matter of concern for the elderly. Although pimozide is effective in some cases of somatic delusional disorders, newer anti-psychotics such as risperidone, are gaining precedence for the treatment of this perplexing cluster of disorders. Risperidone is considered safer than pimozide and hence roped in as first-line therapy for monosymptomatic hypochondriacal psychoses [37].

3. Cognitive behavioural therapy (CBT)

Although previously considered a disorder extremely difficult to treat CBT, in the past 15 years, has emerged as an effective, empirically supported treatment for severe health anxiety [38]. Patients with health anxiety are more inclined towards psychological treatments than to drug treatments [39]. However, till date, the effects of psychological treatments on health anxiety disorders have been woefully limited [40]. Cochrane review concluded that the most effective psychological therapy for hypochondriasis was CBT, having many positive outcomes [41]. However, several limitation of the existing trial data on the psychological treatment of health anxiety were noted. First, the possibility that, improvements may be due to non-specific factors frequently involved in regular therapist contact could not be ruled out, emphasizing the need for mediational analyses. Second, there was no possible way to determine what proportion of patients was "cured" by the treatments, highlighting the need to define diagnosis. And third, data on long-term outcome from psychological treatments for health anxiety are minimal, highlighting the need for elaborate follow-up periods. This lack of follow-up data is especially detrimental given the low natural recovery rate of health anxiety [42]. Furthermore, in some studies of psychological treatments for health anxiety, only 30% of eligible participants agreed to participate [43], with dropout rates of 25%–30% [44,45], advocating that prevailing psychological interventions are either not acceptable to patients with health anxiety or not efficacious enough to meet the general expectations of the patients and hence offer scope for improvement. Forster, Southern and Caprara [46,47] have reported on the effectiveness of behavioural counseling. A case report by Revar also demonstrates the effectiveness of a behavioural strategy in the treatment of hypochondriasis [48].

Yet another facet of CBT is 'Group CBT' which is an improvised methodology of psychodynamic models of pathology and developed even before the practice of CBT was first described by Aaron Beck and his colleagues [49]. As the name suggests, group psychotherapy provides communication and interface between the group members as a vehicle of change. Group models offer some for positive peer modelling opportunities, reinforcement, and most importantly, social support, in addition to being an approachable option with regard to the limited availability of focused CBT therapists [50]. One of the largest studies conducted in the field of hypochondriasis to compare the usefulness of group CBT over individual CBT has shown CBT group therapy to be more appropriate and cost-effective [51].

4. Internet-delivered exposure-based Cognitive Behaviour Therapy (ICBT)

Yet another technique for the effective treatment of severe health anxiety has been developed by a research group is the 'Internet-delivered exposure-based CBT (ICBT)', which has shown positive results in two randomised controlled trials [52,53]. ICBT is an internet-based bibliotherapy with a support from an online psychiatrist through a classified asynchronous online system of messaging [54]. ICBT offers a multitude of advantages, one of the most essential being that it can upsurge the number of patients who could receive the psychological treatment for severe health anxiety as each psychiatrist can have up to 80 patients in ongoing treatment. The only health economic evaluation of ICBT, which was conducted, concluded that the treatment was highly economical when compared to a basic attention control condition that did not receive active treatment [55]. No study has, however, tried to find out if ICBT is economically effective in comparison to an active and inclusive psychological treatment. In the latest trial of ICBT, it was compared with Internet-delivered Behavioural Stress Management (IBSM), which is based on taking control over symptoms directly through management of stress and applied relaxation. Though both displayed impressive improvements in health anxiety, it was seen to be more efficacious in participants receiving ICBT.

5. Exposure Therapy

Exposure therapy uses techniques to resolve mistaken beliefs. In case of hypochondriasis, it involves gradual confrontation of the situations and bodily sensations that person avoids because of the fear of illness. During exposure, patients also learn to tolerate the uncertainty regarding a sensation being a real symptom or not. Initially, people tend to become anxious during exposure practice; however, the distress is temporary as it subsides by a process called habituation. It is this habituation which causes the person to realize that their distress is transient, which in turn, helps them overcome their fear of situations and sensations. They are then able to resist the urge that they have to seek constant information or reassurance about their health and perceived illness. Various randomized control studies have been conducted to prove the efficacy of exposure therapy on patients of hypochondriasis and they have proven it to be as effective as CBT [56].

CONCLUSION

This review above helps to bring forth the issue that, somatoform disorders are till date, one of the most controversial and mind boggling areas of modern psychiatry. These disorders are particularly demanding for psychiatrists exposed only to patients who have become extensively disabled by chronic disorder. Under these circumstances psychiatrists often insist that early intervention should be able to prevent numerous secondary problems. Effective early intervention will not be achieved unless general psychiatrists working in primary or secondary general medical care encourage medical and nursing staff to work towards quick and appropriate management of all patients who present with bodily symptoms or any illness relating to distress and worry.

As highlighted in this review, clinical and research efforts are lacking a lot in various treatment areas of hypochondriasis and they need to be greatly enhanced. It will be unfortunate if these disorders received attention only because of the high health costs incurred, as it will undermine the suffering of the patients. It reflects the sorry state of affairs that, despite being one of the biggest areas of health dollar expenditure, there are no clear guidelines for its treatment and referral. Therefore, a massive research undertaking is needed to fully understand and help these patients.

REFERENCES

[1] De Sousa A. Freudian theory and consciousness: A conceptual analysis. *Mens Sana Monogr.* 2011;9(1):210–17.

- [2] Hare E. The history of 'nervous disorders' from 1600 to 1840, and a comparison with modern views. *Br J Psychiatry.* 1991;159:37–45.
- [3] Diagnostic and Statistical Manual of Mental Disorders. American Psychiatric Association, American Psychiatric Press, Inc; 2004.
- [4] Bailer J, Kerstner T, Wittthöft M, Diener C, Mier D, Rist F. Health anxiety and hypochondriasis in the light of DSM-5. *Anxiety Stress Coping.* 2016;29(2):219–39.
- [5] Holder-Perkin V, Wise TN, Williams D. Hypochondriacal concerns: Management through understanding. *Prim Care Companion J Clin Psychiatry.* 2000;2(4):117–21.
- [6] Lipowski ZJ. Somatization: the experience and communications of psychological distress as somatic symptoms. *Psychother Psychosom.* 1987;47:160–67.
- [7] Barsky AJ, Wyshak G, Klerman GL, Latham KS. The prevalence of hypochondriasis in medical outpatients. *Social Psychiatry and Psychiatric Epidemiology.* 1990;25(2):89–94.
- [8] Barsky AJ, Klerman GL. Overview: Hypochondriasis, bodily complaints and somatic styles. *Am J Psychiatry.* 1983;140:273.
- [9] American Psychiatric Association. Diagnostic and statistical manual of mental disorders, Text Revision. 4th ed. Washington DC: American Psychiatry Association; 2010.
- [10] Janca A, Ustün TB, Early TS, Sartorius N. The ICD-10 symptom checklist: A companion to the ICD-10 classification of mental and behavioural disorders. *Soc Psychiatry Psychiatr Epidemiol.* 1993;28:239–42.
- [11] Kaplan HI, Sadock BJ. *Synopsis of Psychiatry, 6th Edition-Revised*, (1991) Baltimore: Williams & Wilkins. 422–424.
- [12] Barsky AJ. Somatoform Disorders. In *Comprehensive Text Book of Psychiatry*, (eds. H.I. Kaplan and B.J. Sadock), 4th Edn, pp.1020. Williams and Wilkins.
- [13] Flora L. Attempts at Behaviour Therapy by Systematic Desensitisation. *Psychiatria Clinica.* 1973;6:300–18.
- [14] Barsky AJ, Ettner S, Horsky J, Bates D. Resource utilization of patients with hypochondriacal health anxiety and somatization. *Medical Care.* 2001;705–715.
- [15] Mykletun A, Heradstveit O, Eriksen K, Glozier N, Overland S, Maeland JG, et al. Health anxiety and disability pension award: The HUSK Study. *Psychosomatic Medicine.* 2009;71:353–60.
- [16] Kesse N. Reassurance. *Lancet.* 1979;1128–33.
- [17] Parker G, Lipscombe P. The relevance of early parental experiences to adult dependency, hypochondriasis and utilization of primary physicians. *Br J Med Psych.* 1980;53:355–63.
- [18] Wooley S, Epps B, Blackwell B. Pain tolerance in chronic illness behaviour. *Psychosom Med* 1975;37:98.
- [19] Mechanic D. Social psychologic factors affecting the presentation of bodily complaints. *N Engl J. Med.* 1972;286:1132–39.
- [20] Penne baker JW, Skelton JA. Psychological parameters of physical symptoms. *Personality and Social Psychology Bulletin.* 1978;4:524–30.
- [21] Kellner R. Psychotherapeutic strategies in hypochondriasis: a clinical study. *Am J Psychotherapy.* 1982;146–57.
- [22] Barsky AJ, Klerman GL. Overview: hypochondriasis, bodily complaints and somatic styles. *Amn Psychiatty.* 1983;140:273–83.
- [23] Neziroglu F. Hypochondriasis: A fresh outlook on treatment. *Psychiatric Times.* July 01, 1998.
- [24] Wesner RB, Noyes R Jr. Imipramine: an effective treatment for illness phobia. *J Affect Disord.* 1991;22(1–2):43–8.
- [25] Kamlana SH, Gray P. Fear of AIDS. *Br J Psychiatry.* 1988;153:129.
- [26] Stone AB. Treatment of hypochondriasis with clomipramine. *J Clin Psychiatry.* 1993;54(5):200–01.
- [27] Fallon BA, Liebowitz MR, Schneier F. An open trial of fluoxetine for hypochondriasis. Paper presented at the American Psychiatric Association Meeting New Orleans. 1991 May.
- [28] Viswanathan R, Paradis C. Treatment of cancer phobia with fluoxetine. *Am J Psychiatry.* 1991;148(8):1090.
- [29] Kellner R, Fava GA, Lisansky J, Perini GI, Zielezny M. Hypochondriacal fears and beliefs in DSM-III melancholia: Changes with amitriptyline. *J Affect Disord.* 1986;10(1):21–6.
- [30] Fernando N. Monosymptomatic hypochondriasis treated with a tricyclic antidepressant. *Br J Psychiatry.* 1988;152:851–52.
- [31] Tyrer P. Towards rational therapy with monoamine oxidase inhibitors. *Br J Psychiatry.* 1976;128:354–60.
- [32] Schweitzer PJ, Zafar U, Pavlicova M, Fallon BA. Long-term follow-up of hypochondriasis after selective serotonin reuptake inhibitor treatment. *J Clin Psychopharmacol.* 2011;31(3):365–68.
- [33] Fallon BA, Petkova E, Skritskaya N, Sanchez-Lacay A, Schneier F, Vermes D, et al. A double-masked, placebo-controlled study of fluoxetine for hypochondriasis. *J Clin Psychopharmacol.* 2008;28(6):638–45.
- [34] Kellner R, Fava GA, Lisansky J, Perini GI, Zielezny M. Hypochondriacal fears and beliefs in DSM-III melancholia. Changes with amitriptyline. *J Affect Disord.* 1986;10(1):21–6.
- [35] Riding J, Munro A. Pimozide in the treatment of monosymptomatic hypochondriacal psychosis. *Acta Psychiatr Scand.* 1975;52(1):23–30.
- [36] Bohlega SA, Al-Foghom NB. Drug-induced Parkinson's disease. A clinical review. *Neurosciences.* 2013;18 (3).
- [37] Elmer KB, George RM, Peterson K. Therapeutic update: use of risperidone for the treatment of monosymptomatic hypochondriacal psychosis. *J Am Acad Dermatol.* 2000;43(4):683–86.
- [38] Olatunji BO, Kauffman BY, Meltzer S, Davis ML, Smits JA, Powers MB. Cognitive-behavioural therapy for hypochondriasis/health anxiety: A meta-analysis of treatment outcome and moderators. *Behav Res Ther.* 2014;58:65–74.

- [39] Walker J, Vincent N, Furere P, Cox B, Kjernisted K. Treatment preference in hypochondriasis. *Journal of Behaviour Therapy and Experimental Psychiatry*. 1999;30:251-58.
- [40] Thomson AB, Page LA. Psychotherapies for hypochondriasis. *Cochrane Database of Systematic Reviews*. 1999;4:1-43.
- [41] Clark DM, Salkovskis PM, Hackmann A, Wells A, Fennell M, Ludgate J, et al. Two psychological treatments for hypochondriasis. A randomised controlled trial. *British Journal of Psychiatry*. 1998;173:218-25.
- [42] Olde Hartman TC, Borghuis MS, Lucassen PLBJ, van de Laar FA, Speckens AE, van Weel CV. Medically unexplained symptoms, somatisation disorder, and hypochondriasis: Course and prognosis. A systematic review. *Journal of Psychosomatic Research*. 2009;66:363-77.
- [43] Barsky AJ, Ahern DK. Cognitive behaviour therapy for hypochondriasis. A randomized trial. *Journal of the American Medical Association*. 2004;291:1464-70.
- [44] Greeven A, van Balkom AJ, Visser S, Merkelbach JW, van Rood YR, van Dyck R, et al. Cognitive behaviour therapy and paroxetine in the treatment of hypochondriasis: A randomized controlled trial. *The American Journal of Psychiatry*. 2007;164:91-9.
- [45] Visser S, Bouman TK. The treatment of hypochondriasis: Exposure plus response prevention vs. cognitive therapy. *Behaviour Research and Therapy*. 2001;39:423-42.
- [46] Forster J. Counselor credentialing revisited. *Personnel and Guidance Journal*. 1978;57:593-98.
- [47] Southern S, Caprara R. Behavioural Counselling. In *Progress in Behaviour Modification* (eds. M. Hersen, R. Eisler & P. Miller), Vol. 17. 1984 New York: Academic Press.
- [48] Revar JM. Behavioural management of hypochondriasis. *Indian J Psychiat*. 1993;35(4):232-33.
- [49] Beck AT, Rush AJ, Shaw BF, et al. *Cognitive Therapy of Depression*. Guilford Press. 1979.
- [50] Liber JM, Van Widenfelt BM, Utens EMWJ, Ferdinand RF, Van der Leeden AJM, Van Gastel W, et al. No differences between group versus individual treatment of childhood anxiety disorders in a randomised clinical trial. *J Child Psychol Psychiatry*. 2008;49(8):886-93.
- [51] Wolgensinger L. Cognitive behavioural group therapy for anxiety: recent developments. *Dialogues Clin Neurosci*. 2015;17(3):347-51.
- [52] Hedman E, Andersson G, Andersson E, Ljótsson B, Rück C, Asmundson GJ, et al. Internet-based cognitive-behavioural therapy for severe health anxiety: randomised controlled trial. *Br J Psychiatry*. 2011;198:230-36.
- [53] Hedman E, Axelsson E, Görling A, Ritzman C, Ronnheden M, Alaoui SE, et al. Internet-delivered exposure-based cognitive-behavioural therapy and behavioural stress management for severe health anxiety: randomised controlled trial. *Br J Psychiatry*. 2014;205:307-14.
- [54] Hedman E, Ljótsson B, Lindefors N. Cognitive behaviour therapy via the internet. A systematic review of applications, clinical efficacy and cost-effectiveness. *Expert Rev Pharmacoecon Outcomes Res*. 2012;12:745-64.
- [55] Hedman E, Andersson E, Lindefors N, Andersson G, Rück C, Ljótsson B. Cost-effectiveness and long-term effectiveness of internet-based cognitive behaviour therapy for severe health anxiety. *Psychol Med*. 2013;43:363-74.
- [56] Weck F, Neng JM, Schwind J, Höfling V. Exposure therapy changes dysfunctional evaluations of somatic symptoms in patients with hypochondriasis (health anxiety). A randomized controlled trial. *J Anxiety Disord*. 2015;34:1-7.

PARTICULARS OF CONTRIBUTORS:

1. Faculty, Department of Psychiatry, Sarojini Naidu Medical College, Lucknow, Uttar Pradesh, India.
2. Faculty, Department of Psychiatry, Sarojini Naidu Medical College, Lucknow, Uttar Pradesh, India.

NAME, ADDRESS, E-MAIL ID OF THE CORRESPONDING AUTHOR:

Dr. Shrayash Khare,
Shrayash Khare, 1/270, Virat Khand, Gomti Nagar, Lucknow-226010, Uttar Pradesh, India.
E-mail: dr.shrayash@gmail.com

FINANCIAL OR OTHER COMPETING INTERESTS: None.

Date of Submission: **Jul 02, 2016**
Date of Peer Review: **Oct 12, 2016**
Date of Acceptance: **Oct 14, 2016**
Date of Publishing: **Jan 01, 2017**