

Hypochondriasis and Illness Phobia in Panic-Agoraphobic Patients

Alessandra Benedetti, Giulio Perugi, Cristina Toni, Beatrice Simonetti, Belen Mata,
and Giovanni B. Cassano

In a sample of 131 patients with panic disorder, we explored both the presence of DSM-III-R criteria for hypochondriasis and the occurrence of illness phobia before the onset of panic disorder. To explore further the possible relationship between hypochondriacal features and panic-agoraphobic syndrome, we compared patients both with and without current hypochondriasis and then patients both with and without illness phobia before the onset of panic disorder. Finally, we investigated the relationship between premorbid phobic-anxious traits and hypochondriasis during panic disorder. No differences were found between patients with and without hypochondriasis, either in terms of clinical features or in the course of panic disorder. Patients with illness phobia before the onset of panic disorder reported higher levels of

anticipatory anxiety in nonagoraphobic situations and more depersonalization and derealization during panic attacks, and they met our definition of phobic-anxious temperament more frequently than the rest of the sample. This would suggest that illness phobia before the onset of panic disorder may be viewed either as a separate disorder, a prodrome, or a mild, early-onset form of panic disorder without full-blown attacks. Although patients with premorbid illness phobia are more likely to develop hypochondriasis after the onset of panic disorder, approximately 40% of them do not; therefore, illness phobia should not be considered the only factor that influences the development of hypochondriasis during panic disorder.

Copyright © 1997 by W.B. Saunders Company

THE TERM HYPOCHONDRIASIS was introduced by Aretaeus of Cappadocia during the first century B.C. At that time, it referred to an accessory symptom of melancholia, but during the last century it has come to mean either believing that there is a disease when none exists or having an exaggerated fear of acquiring an illness.¹

The DSM-III² and DSM-IV³ definition of hypochondriasis includes only what is probably the most severe end of a spectrum of various types of fears and beliefs. Various observations of undue concern about bodily functions that do not fulfill the criteria for the diagnosis of hypochondriasis have suggested several distinctions in this field.⁴ According to Marks,⁵ for example, illness phobia constitutes a focal form of hypochondriasis, focused on a single symptom or illness. Patients with illness phobia have a pathological fear of getting a specific disease, whereas patients with hypochondriasis are overwhelmingly afraid that they may already be suffering from one or more diseases.⁶ This definition overlaps partially with the proposed diagnostic criteria for use in psychosomatic research for disease phobia.⁷ In the current classifications,³ illness phobia is listed within the broad heading of hypochondriasis. However, there is some evidence

that the disorder has a relatively independent status.⁸

The relationship between panic disorder, illness phobia, and hypochondriasis has recently been the focus of attention of investigators and clinicians.⁸⁻¹⁹ Fear and/or the conviction of being affected by a somatic disease has been observed in 25% to 60% of patients with panic disorder or related syndromes.^{10,13-16,20} The wide variation in reported rates is presumably accounted for by differences in diagnostic and sample-selection procedures. On the other hand, Warwick and Salkovskis¹² reported that 59% of hypochondriacal subjects met the criteria for panic disorder. Therefore, although the nature of the relationship between the two diagnostic categories has not been sufficiently investigated, both disorders would seem to be epidemiologically and clinically related.¹⁵

According to DSM-IV criteria,³ a diagnosis of hypochondriasis should not be made if hypochondriacal symptoms (such as bodily concerns, fear of illness, or conviction of being affected by a somatic disease) are "better accounted for by Panic Disorder." For the Manual, a complete hypochondriacal syndrome, or some aspects of it, that first appears during the course of panic disorder but then disappears after successful treatment for panic disorder must be considered secondary. However, recent studies^{9,21-22} have reported cases in which hypochondriacal fears or beliefs are present before the onset and persist after the remission of panic disorder. In

From the Psychiatric Clinic, University of Pisa, Pisa, Italy.
Address reprint requests to Giulio Perugi, M.D., Via Roma
67, 56100, Pisa, Italy.

Copyright © 1997 by W.B. Saunders Company
0010-440X/97/3802-0003\$03.00/0

such patients, panic attacks would appear to be qualitatively different from those found in panic disorder and should be considered secondary phenomena of hypochondriasis. Confirming this hypothesis, it has been reported also that these patients rarely develop agoraphobia and that successful treatment decreases the frequency of panic attacks but does not relieve hypochondriacal fears.²¹ On the contrary, Starcevic et al.¹⁶ found higher rates of agoraphobia in patients with both panic disorder and hypochondriasis, and they reported that hypochondriasis improves with adequate treatment for panic disorder. Noyes et al.¹⁰ confirmed this observation in a sample of 60 panic patients, reporting that in a large percentage of patients, most hypochondriacal fears and beliefs disappeared after a 6-week treatment for panic disorder. However, it is unclear whether these last two studies included patients who had suffered from illness phobia or hypochondriasis before the onset of panic disorder.

In the present study conducted in a large sample of patients with panic disorder, we explored both the presence of DSM-III-R²³ criteria for hypochondriasis and the occurrence of illness phobia before the onset of panic disorder. Furthermore, to explore the possible relationship between hypochondriacal features and panic-agoraphobic syndrome, we compared patients both with and without current hypochondriasis and then patients both with and without illness phobia before the onset of panic disorder. Finally, we investigated the relationship between premorbid phobic-anxious traits and hypochondriasis during panic disorder.

METHOD

The sample consisted of 131 outpatients at the Psychiatric Institute of the University of Pisa. The subjects came from a variety of sources, almost equally divided between self-referrals, referrals from general practitioners, various medical specialists, and psychiatrists, and referrals from former patients. Admission criteria for the study were (1) a diagnosis of panic disorder with or without agoraphobia according to DSM-III-R criteria,²³ (2) an absence of severe physical and laboratory abnormalities, and (3) an absence of any current psychotic disorders. Comorbidity with other anxiety and mood disorders was not an exclusion criterion. All patients were screened by the two senior psychiatrists (G.P. and C.T.) in face-to-face interviews to ensure that admission criteria were met. The patients were enrolled in a follow-up study for panic disorder and agoraphobia conducted at the Psychiatric Institute of the University of Pisa. Patients provided informed consent for participation in this research. At the time they were first examined, the mean age was 35.6 years (SD, 11.1; range, 12 to 69) and 73% were women.

An intensive face-to-face interview that consisted of structured and semistructured components was the means of collecting data. The interview lasted approximately 1 hour at baseline and 30 minutes during subsequent visits. The interviews were conducted by residents with experience in the diagnosis and treatment of anxiety disorders. Each interviewer underwent a training program in the use of the interview instruments that included direct observation of experienced interviewers, direct supervision of interviews, and interrater trials. The most experienced interviewers provided direct supervision of the other clinicians.

Because data collection was largely dependent on patient recall of historical information, the diagnostic determinations in the study had to be considered estimates and therefore subject to inaccuracies. However, to take into account this limitation of retrospective descriptive studies, all data collected were reviewed by the interviewer team for the purpose of consensual agreement. When questions arose, patients were reapproached for further clarification. In some cases, patients' medical records were reviewed and information was obtained from family members and previous physicians.

The diagnostic instrument was the Structured Clinical Interview for DSM-III-R (SCID-II) by Spitzer and Williams.²⁴ According to this instrument, 80.1% of the sample suffered from panic disorder with agoraphobia; the remaining patients had uncomplicated panic disorder. The mean age at onset was 28.7 years (SD, 9.7; range, 9 to 54) for panic disorder and 29.6 years (SD, 10.3; range, 3 to 55) for agoraphobia; the mean duration of illness was 75.6 months (SD, 92.0; range, 0 to 440).

Demographic and illness characteristics were obtained with the Questionario Panico-Agorafobia (QPA).²⁵ This semistructured interview permitted the use of the first panic attack as the primary anchoring point. The majority of patients recalled this attack with clarity and precision. Once the period of the first panic attack had been described, years preceding and following this event were reviewed. The instrument is subdivided into different sections exploring (1) demographic characteristics, based on the Adult Personal Inventory Data²⁶; (2) first-degree psychiatric loading according to the Winokur approach as incorporated into the family history version of the Research Diagnostic Criteria²⁷; (3) symptomatological and longitudinal characteristics of panic disorder, with particular focus on the course of the illness and on the relationship between panic attacks and agoraphobic behavior, separation anxiety disorder during childhood according to DSM-III-R criteria, psychosocial life events in childhood and preceding the onset of panic disorder, and the presence of hypochondriasis according to DSM-III-R criteria. Contrary to DSM-III-R criteria, a diagnosis of hypochondriasis was made even when the hypochondriacal concerns involved mostly somatic symptoms of panic attacks. Furthermore, we questioned patients with regard to the illnesses feared most of all.

The final section, administered during the remission phase, explored avoidant and dependent personality disorders according to DSM-III-R criteria and the SCID-II,²⁸ affective temperaments diagnosed according to Akiskal and Mallya criteria,²⁹ and premorbid symptoms that had emerged during the period preceding the onset of the first panic attack.

Premorbid phobic-anxious traits, in our definition, are long-lasting features found in the premorbid history of patients, such as fear or distress in situations from which escape is difficult,

متن کامل مقاله

دریافت فوری ←

ISIArticles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات