



## Disease phobia and disease conviction are separate dimensions underlying hypochondriasis<sup>☆</sup>

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### ABSTRACT

The current study uses data from a large nonclinical college student sample ( $N = 503$ ) to examine a structural model of hypochondriasis (HC). This model predicts the distinctiveness of two dimensions (disease phobia and disease conviction) purported to underlie the disorder, and that these two dimensions are differentially related to variables important to health anxiety and somatoform disorders, respectively. Results were generally consistent with the hypothesized model. Specifically, (a) body perception variables (somatosensory amplification and anxiety sensitivity – physical) emerged as significant predictors of disease phobia, but not disease conviction; (b) emotion dysregulation variables (cognitive avoidance and cognitive reappraisal) emerged as significant predictors of disease conviction, but not disease phobia; and (c) both disease phobia and disease conviction independently predicted medical utilization. Further, collapsing disease phobia and disease conviction onto a single latent factor provided an inadequate fit to the data. Conceptual and therapeutic implications of these results are discussed.

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The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association [APA], 2000) places hypochondriasis (HC) with the somatoform disorders, but contemporary conceptualizations of HC suggest it is better represented as an extreme form of health anxiety (Abramowitz, Schwartz, & Whiteside, 2002) and belongs to the anxiety disorders domain (Olatunji, Deacon, & Abramowitz, 2009). Consistent with this position, some cognitive variables hypothesized to underlie anxiety conditions are relevant to HC as well (e.g., anxiety sensitivity, body vigilance; Deacon & Abramowitz, 2008).

However, the ability for the reconceptualization of HC as health anxiety to capture the full HC domain was recently put into some doubt. In particular, Fergus and Valentiner (2009) found that the disease phobia (i.e., fear of having a serious disease) dimension of HC shared significantly stronger relations with health anxiety than did the disease conviction (i.e., the idea that one has a serious disease) dimension. Further, whereas the disease conviction dimension predicted unique variance over an index of health anxiety in medical utilization scores, the disease phobia dimension did not. Based on these results, Fergus and Valentiner postulated that the view of HC as health anxiety may be more consistent with

disease phobia and the view of HC as a somatoform disorder may be more consistent with disease conviction.

Whereas dimensions other than disease phobia and disease conviction underlie HC, researchers have pointed to the specific importance of these two dimensions. For example, Barsky (1992) suggested that disease phobia and disease conviction subgroups characterize HC. The diagnostic definition of HC (APA, 2000) defines the disorder as consisting of two beliefs that correspond to disease phobia and disease conviction (i.e., “fears of having, or the idea that one has, a serious disease;” p. 507); however, HC is still conceptualized as a unidimensional construct within the DSM-IV-TR. Although the issue surrounding the suitability of subgroups is not directly examined in the present study, finding disease phobia and disease conviction to be distinct dimensions would give further credence to Barsky’s notion that utility can be gained in defining HC as a multidimensional construct. Further, if disease phobia and disease conviction are distinct, these dimensions may be associated with different mechanisms (Olatunji, 2008). With the above issues in mind, the present study sought to explicate whether disease phobia and disease conviction represent meaningfully distinct dimensions of HC.

### 1. Body perception

Like with many anxiety disorders, the attention one pays to body sensations is believed to be central to the development and

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maintenance of HC. That is, individuals with HC are believed to feel they need to pay close attention to ambiguous body sensations in an attempt to prevent the sensations from leading to perceived negative consequences (Abramowitz et al., 2002). In an attempt to better understand the misinterpretation of body sensations seen within HC, researchers have turned towards understanding the relevance of at least three body perception variables (body vigilance, somatosensory amplification, and anxiety sensitivity) to HC.

Body vigilance is a perceptual bias in which individuals pay excessive attention to body sensations (Olatunji, Deacon, Abramowitz, & Valentiner, 2007), somatosensory amplification characterizes the tendency to view ambiguous sensations as more threatening than they truly are (Barsky, Wyshak, & Klerman, 1990), and anxiety sensitivity represents the fear of arousal-related sensations due to physical, social, and cognitive consequences (Taylor et al., 2007). Research indicates that all three of these body perception variables are relevant to HC, particularly the disease phobia dimension (Barsky et al., 1990; Fergus & Valentiner, 2009; Wheaton, Berman, Franklin, & Abramowitz in, in press). If disease phobia is more consistent with the view of HC as an anxiety disorder, then body perception variables should appear especially relevant to this dimension. Currently, an explicit test of the specificity of these variables to disease phobia versus generality to both disease phobia and disease conviction is lacking in the extant HC literature.

## 2. Emotion dysregulation

Dysfunctions in emotion regulation are believed to be instrumental in the phenomenology of somatoform disorders (e.g., HC), as these disorders purportedly represent the communication of somatic instead of psychological distress (Waller & Scheidt, 2006). Waller and Scheidt noted that the trait of alexithymia characterizes the emotion regulation deficits of individuals suffering from somatoform disorders. Alexithymia is a deficit in an individual's ability to understand and regulate emotions. It is marked by difficulties in identifying and describing feelings, as well as problems differentiating between body sensations and feelings, and predicts long-term somatization (Taylor, Bagby, & Parker, 1997).

Other variables important to understanding emotion regulation include antecedent- and response-focused strategies (Gross & John, 2003). Antecedent-focused strategies refer to actions taken prior to emotional activation and response-focused strategies refer to actions initiated after emotional activation. Cognitive reappraisal is considered a core adaptive antecedent-focused strategy, and reflects an individual's attempt to alter the emotional impact of an event by changing the way it is viewed. Emotion suppression is considered a core maladaptive response-focused strategy, and represents an individual's tendency to inhibit the outward expression of emotions and feelings (Gross & John, 2003).

An additional response-focused strategy is cognitive avoidance. Cognitive avoidance is a broad term used to represent a number of emotion regulation strategies (e.g., thought suppression; Sexton & Dugas, 2008). A consequence of using maladaptive emotion regulation strategies, particularly cognitive avoidance, is that it impedes emotional processing (Foa & Kozak, 1986). This failure of emotional processing leads to consistently heightened physiological arousal (Pennebaker, 1989). The continual presence of physiological arousal, coupled with alexithymic tendencies, may render an individual unable to correctly ascribe somatic complaints to mental events, and these emotions are misinterpreted as the presence of an actual disease. If disease conviction is truly more consistent with the view of HC as a somatoform disorder, then emotion regulation variables should emerge as especially relevant to this HC dimension. A direct test of this possibility is needed.

## 3. Present study

A structural model was developed to test the distinctiveness of disease phobia and disease conviction (Fig. 1). The structural model tested whether body perception variables were specific predictors of disease phobia (i.e., controlling for disease conviction and the effects of emotion dysregulation variables) and emotion dysregulation variables were specific predictors of disease conviction (i.e., controlling for disease phobia and the body perception variables). The structural model also tested the incremental validity (controlling for the exogenous variables and the other belief dimension) of disease phobia and disease conviction in predicting medical utilization. Because medical utilization represents the HC behavior that researchers often try to predict (Abramowitz, Deacon, & Valentiner, 2007; Fergus & Valentiner, 2009; Olatunji et al., 2007), the utility in conceptualizing disease phobia and disease conviction as distinct constructs can be based, in part, on the ability of both dimensions to independently predict this construct. Finally, the structural model allowed for an examination of the adequacy of a one-factor model of disease phobia and disease conviction predicting medical utilization. If a one-factor model does not provide a significant decrement in model fit, the tenability of the disease phobia-disease conviction distinction would be placed in doubt.

Although studying carefully diagnosed patients with HC remains important, the relations outlined above were investigated using a medically healthy, nonclinical sample. Studying HC-related phenomena in this population reduces the extent to which (a) HC is confounded with actual physical health problems (Abramowitz et al., 2007) and (b) co-occurring disorders and the overrepresentation of disease conviction obscure relationships (Noyes, Carney, & Langbehn, 2004). It is also consistent with Ferguson (2009), who found support for the dimensionality (i.e., non-taxonomic nature) of HC and concluded HC should be examined using unselected samples.

## 4. Method

### 4.1. Participants and procedure

The sample consisted of 503 undergraduate college students enrolled in an introductory psychology class at a Midwestern university. The sample had a mean age of 19.1 ( $SD = 2.3$ ) years, and was predominantly female (67.7%) and Caucasian (69.2%).

Participants completed the fixed-order questionnaire packets in small group sessions in a university classroom. Data were collected anonymously and participants were informed that they were free to withdraw from the study at any time.

### 4.2. Measures

#### 4.2.1. Disease phobia and disease conviction

Disease phobia and disease conviction were assessed via the Illness Attitudes Scale (IAS; Kellner, 1986) and Whiteley Index (WI; Pilowsky, 1967). Given its replicability, the IAS factor structure outlined by Hadjistavropoulos, Frombach, and Asmundson (1999) was used. The WI factor structure outlined by Rief, Hiller, Geissner, and Fichter (1994), and later replicated by Hiller, Rief, and Fichter (2002), was used, as this solution is the only known replicable multidimensional model of the measure that clearly articulates separate factors for disease phobia and disease conviction. The disease phobia and disease conviction scales consisted of items that had primary loadings on the respective IAS and WI scales. Following the recommendations of Barsky et al. (1992), respondents rated the WI items using a 5-point scale instead of the traditional true/false rating of items. Both sets of scales have

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