

## Correlates of illness worry in chronic fatigue syndrome

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Received 12 June 2000; accepted 7 January 2002

### Abstract

**Background:** Anxiety about illness leading to restriction of activity and physical deconditioning has been hypothesized to contribute to the chronicity of fatigue. Pathological symptom attributions, personality traits, and depression have all been hypothesized to contribute to illness worry. **Methods:** We compared 45 chronic fatigue syndrome (CFS) and 40 multiple sclerosis (MS) outpatients using a battery of psychometric instruments comprising the 12-item Illness Worry scale, the Symptom Interpretation Questionnaire (SIQ), the NEO Five-Factor Inventory (NEO-FFI), and a modified version of the SCL-90R Depression scale. **Results:** There was no difference between the two diagnostic groups on neuroticism, depressive symptoms, as well as the three scales of

the SIQ. On the illness worry index, the CFS group had significantly higher scores than the MS group. This difference was due to items tapping vulnerability to illness and the perception that others are not taking their illness seriously. Somatic attributional style, neuroticism, depressive symptoms, and age were all significant predictors of illness worry in both CFS and MS patients. **Conclusions:** Somatic attributions, neuroticism, and depression all contribute to illness worry in chronic illness. However, these factors do not account for the higher levels of illness worry in CFS as opposed to MS, which may be due to other specific cognitive and social interactional processes. © 2003 Elsevier Science Inc. All rights reserved.

*Keywords:* Chronic fatigue syndrome; Illness worry; Physical functioning; Attributions; Personality; Depression

### Introduction

Chronic fatigue syndrome (CFS) is a poorly understood condition, characterized by persistent debilitating fatigue lasting 6 months or more and unexplained by any other clinical condition [1]. Although the etiology of CFS is unknown, attempts to identify an infectious or immune condition have generally failed and many authorities have turned to cognitive and psychological models to account for distress and impairment in CFS [2–4]. The cognitive model hypothesizes a vicious circle in which patient's beliefs and fears concerning symptoms and activity lead to unhelpful ways of managing symptoms, including avoidance behaviors, activity restriction, and depression that, in turn, lead to physical deconditioning with greater symptoms and disability [4].

The present study was designed to test aspects of a more general cognitive model of impairment in CFS that suggests that illness worry associated with this condition is a function of symptom attributions, personality, and depressive symptoms that contribute to symptom amplification, help-seeking, avoidance of activity, and disability [5,6].

It is quite legitimate for patients with chronic conditions to worry about their health but some people do worry more than others. However, how much worry is too much? Norms for the acceptable level of worry for a given condition are still inexistent. However, in medical patients, greater levels of illness worry have been associated with increased health care utilization [6], increased doctor shopping [7], and negative reactions from practitioners [8]. In the case of medically unexplained physical symptoms, illness worry has been associated with greater levels of impairment [9]. It is therefore crucial to identify the factors that contribute to higher levels of illness worry in order to improve healthcare of patients as well as their quality of life. This is even more pertinent in the

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case of a functional somatic syndrome where the absence of a medical explanation combined with significant social stigma may contribute to greater preoccupation with the condition.

Illness worry has been shown to be greater in primary care patients with fatigue lasting 6 months or longer by comparison with patients with more recent fatigue [10]. Ill patients with exaggerated illness fears, preoccupation, or worries with symptoms are known to suffer from hypochondriasis. Schweitzer et al. [11] examined the illness behavior of CFS patients. They found that, compared to general practice patients, CFS scored higher on the general hypochondriasis subscale of Pilowsky's Illness Behavior Questionnaire (IBQ) [12], had comparable scores to that of psychiatric patients, and had similar scores to hypochondriasis patients on the Whiteley Index of Hypochondriasis, which is derived from 14 items of the IBQ. Although it might be held that illness worry is a direct consequence of the severity of medical illness or symptoms, in a 12-month prospective study of hypochondriacal worry in 546 primary care patients, Robbins and Kirmayer [13] showed that level of illness worry was not related to severity of coexisting medical illness. Other factors, such as personality traits and past illness experiences, may therefore explain differential levels of illness worry among patients.

Symptom attribution and labeling may play an important role in perpetuating CFS in patients who believe that minor symptoms associated with activity are evidence of serious illness [14]. Most CFS patients consulting medical specialists believe their illness is due to an external agent, usually an infectious one [4]. In previous work, somatic symptoms attributions were shown to be associated with more somatic symptoms and more symptoms that received no immediate medical diagnosis among family medicine patients [6]. A recent population-based study found that attributing fatigue to a physical illness, such as myalgic encephalomyelitis, seemed to protect against psychological distress but not against disability [15]. A prospective study of 618 subjects attending a general practitioner's clinic in London, diagnosed with a viral illness, showed that persistent fatigue at 6-month follow-up was predicted by the tendency to attribute symptoms to disease, being given a less definite diagnosis and receiving a sick certificate [16]. However, a subsequent study of a subset of 64 cases with chronic severe fatigue (of whom 23 fulfilled CFS criteria) found that "psychologizing attributional style" was a risk factor for CFS [17]. Uncertainty thus remains over which attributional styles, if any, contribute to psychological distress, chronicity, and disability in CFS.

Personality factors can influence reporting of symptoms and illness [18] and may predispose an individual to CFS or impede recovery following a viral illness by amplifying symptom perception and reducing level of activity. The personality trait of neuroticism (also known as negative affectivity) is characterized by a tendency to experience a

wide variety of somatic or emotional dysphoric states. CFS patients have been shown to have significantly higher levels of neuroticism than healthy controls [19] but similar levels to multiple sclerosis (MS) patients [20]. Neuroticism has been shown to be related to hypochondriasis [21]. Because of their generally pessimistic view of the world, individuals with high neuroticism are also more likely to worry about the implications of their perceived symptoms and tend to expect the worst when they get sick.

Recent reviews indicate that 50–80% of CFS patients suffer from concurrent depression [22,23]. Depression may be seen as a consequence of CFS [24] or as a contributor to its development [25]. In either case, depression may perpetuate CFS [4]. Persistent illness worry has been associated with elevated levels of depressive symptoms in primary care patients [13] and depressed fatigued patients were reported to experience more medically unexplained somatic symptoms and to score higher on the Illness Worry scale than a group of fatigued but nondepressed patients and a group of nonfatigued patients [10]. Depression is also associated with neuroticism [26]. Johnson et al. [20] found that only the subgroup of CFS patients who had a simultaneous diagnosis of depression had higher scores on the Neuroticism scale of the NEO Five-Factor Inventory (NEO-FFI) as opposed to the healthy population.

## Hypotheses

Based on these theoretical considerations and observations, the present study examined the contribution of personality, symptom attributions, and depressive symptoms to illness worry, by comparing a group of patients with CFS to a group of patients suffering from MS. According to Schweitzer et al. [11], an appropriate comparison group to examine hypochondriacal worries in CFS may be "patients with an identifiable organic disease and a level of physical dysfunction similar to patients with CFS." Because MS is a central nervous system (CNS) disorder characterized by significant complaints of fatigue as well as sensory impairment, loss of vision, incontinence, and weakness, and CNS mechanisms for fatigue in CFS have been postulated [27], MS appeared to be a good comparison group and has been used as such in numerous studies of CFS [20,28–33]. We compared levels of illness worry, somatic symptom attributions, neuroticism, and depressive symptoms between patients with CFS and MS. Consistent with earlier findings that health concerns are often proportional to the ambiguity of the symptoms [13], we hypothesized that CFS patients would report higher levels of illness worry compared to MS patients. We also hypothesized that greater levels of somatic attributions, neuroticism, and depression would account for higher levels of illness worry in CFS.

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