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LONG-TERM OUTCOME OF HYPOCHONDRIACAL PERSONALITY DISORDER

PETER TYRER,* NICHOLAS SEIVEWRIGHT† and HELEN SEIVEWRIGHT*

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Abstract—Hypochondriacal personality disorder diagnosed according to the Personality Assessment Schedule, a structured clinical interview, was related to outcome after 2 years and 5 years in a randomized, controlled trial of treatment of generalized anxiety, panic, and dysthymic disorders. Seventeen individuals (9%) from a population of 181 patients had hypochondriacal personality disorder and they experienced a significantly worse outcome than other patients, including those with other personality disorders, in terms of symptomatic change and health service utilization. This lack of improvement was associated with persistent somatization in hypochondriacal personality disorder. The results give further support to the belief that hypochondriacal personality disorder is a valid clinical diagnosis that has important clinical correlates, but further work is needed to establish the extent of its overlap with hypochondriasis as a mental state disorder. © 1999 Elsevier Science Inc.

Keywords: Personality disorder; Hypochondriasis; Outcome; Somatization.

INTRODUCTION

Although personality characteristics have been recognized as important in the evaluation of hypochondriacal personality disorders for over 400 years [1], they are not currently acknowledged in either of the main classification systems (DSM and ICD) in psychiatry. The possibility that at least some forms hypochondriasis primarily encompass personality rather than mental state was not mentioned in authoritative reviews [2] until recently [3, 4]. We feel this is an error, and in defining a better classification of hypochondriacal disorders it is essential to take into account personality factors. In previous work, we have described the main characteristics of hypochondriacal personality disorder, a condition developing early in adult life and associated with persistent preoccupation with health and avoidance of disease, the magnification of minor ailments into major disease in personal perception, repeated medical consultations for this imagined disease, and adoption of self-help and alternative treatment strategies [5]. This work suggests that hypochondriacal personality disorder is a condition within the anxious–fearful cluster of personality disorders with associations with both anankastic and anxious personality features [6]. However, this

* Imperial College School of Medicine, St. Mary's Campus, Paterson Centre, London, UK.
† Substance Misuse Service, Community Health Sheffield NHS Trust, Sheffield, UK.
Address correspondence to: Dr. Peter Tyrer, Imperial College School of Medicine, St. Mary's Campus, Paterson Centre, London W2 1PD, UK. Phone: 0171-886-1655; Fax: 0171-886-1995; E-mail: p.tyrer@ic.ac.uk

work has only identified the disorder in cross-sectional form and its relevance in longitudinal studies is the subject of this article.

The main distinctions between hypochondriacal personality disorder and hypochondriasis as a mental state disorder within the somatoform group are the persistent features of the personality disorder, the constant preoccupation with health seeking behavior as a desirable goal, and a lifestyle designed to perpetuate these ends that is defended strongly at all times. Hypochondriasis as a mental disorder is different, with recognition that it is not habitual behavior (i.e., is ego-dystonic), is associated with the "persistent belief of the presence of a maximum of two serious specific diseases" [7] and which, because of the degree of personal distress created by the symptoms, is associated with more determined attempts to find the alleged disease, including frequent changes of doctor and direct consultations with a large number of professionals. The condition is also commonly associated with high levels of anxiety. In hypochondriasis as a somatoform disorder, improvement in anxiety and associated symptoms also leads to improvement in hypochondriasis *pari passu* [8, 9]. Nevertheless, there is a certain amount of overlap between these conditions and health anxiety is common to both.

Our previous work has suggested that hypochondriacal personality disorder seldom exists in pure form and is usually associated with other psychiatric disorders, particularly affective and neurotic disorders. We therefore examined the outcome of hypochondriacal disorder in a population of patients with defined neurotic disorders who also had hypochondriacal personality disorder. A comparison of those with and without the disorder in terms of outcome was therefore possible.

METHOD

The outcome of hypochondriacal personality characteristics was part of a separate study of response to treatment and long-term outcome in patients with three defined neurotic disorders (i.e., the Nottingham study of neurotic disorder [10]). A total of 210 patients with generalized anxiety and dysthymic, and panic disorder who were referred to general practice psychiatric clinics in Nottingham, England, between 1983 and 1987, were randomly assigned to drug therapy, cognitive behavior, and self-help and treated for 10 weeks under double-blind conditions. After 10 weeks, patients continued to be treated in the same mode as that originally allocated, as much as possible (with all those allocated to drug therapy originally being asked to continue taking antidepressants in the first instance) and patients were followed-up for 5 years. Assessments of clinical symptomatology were made before treatment and at regular intervals for 2 years using the Comprehensive Psychopathological Rating Scale (CPRS) [11] and associated scales for depression, Montgomery and Åsberg Depression Rating Scale (MADRS) [12], and the Brief Anxiety Scale (BAS) [13]. Self-ratings of anxiety and depression were also made with the Hospital Anxiety and Depression Scale (HADS) [14]. Each patient had their somatization status assessed at the end of the interview using a specially developed somatic–psychic ten-point scale (Fig. 1). Diagnostic status using the Structured Clinical Interview for DSM-III (SCID) [15] was initially used to define the diagnostic status of each patient and also to record serially on four occasions throughout the 4 years. The null hypothesis being tested was that there was no difference in clinical outcome, as measured by global outcome (using the CPRS scale) and changes in symptoms (at 2 years) or global outcome (using a five-point outcome scale) in patients with and without hypochondriacal personality disorder.

Of the original 210 patients, 198 had their personality status determined using the Personality Assessment Schedule [16], and 72 (36%) had a personality disorder [17]. The Personality Assessment Schedule derives personality categories from 24 traits rated on nine-point scales based on degree of social dysfunction for each trait. The diagnosis of hypochondriacal personality disorder is made using a computer algorithm based on cluster analysis of original data [18] and cannot be identified at the time of assessment.

Assessments at 2 years were made by independent psychiatric investigators who had no knowledge of initial diagnosis and personality status and, at 5 years, all assessments were made by H.S., who also had no knowledge of patients' initial diagnostic status. At 5 years, although patients were not inter-