



Assessing Bodily Preoccupations is sufficient: Clinically effective screening for hypochondriasis



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ABSTRACT

Objective: Hypochondriasis is a persistent psychiatric disorder and is associated with increased utilisation of health care services. However, effective psychiatric consultation interventions and CBT treatments are available. In the present study, we provide evidence of clinically effective screening for hypochondriasis. We describe the clinically effective identification of patients with a high probability of suffering from hypochondriasis. This identification is achieved by means of two brief standardised screening instruments, namely the Bodily Preoccupation (BP) Scale with 3 items and the Whiteley-7 (WI-7) with 7 items.

Methods: Both the BP scale and the WI-7 were examined in a sample of 228 participants (72 with hypochondriasis, 80 with anxiety disorders and 76 healthy controls) in a large psychotherapy outpatients' unit, applying the DSM-IV criteria. Cut-off values for the BP scale and the WI-7 were computed to identify patients with a high probability of suffering from hypochondriasis. Additionally, other self-report symptom severity scales were completed in order to examine discriminant and convergent validity. Data was collected from June 2010 to March 2013.

Results: The BP scale and the WI-7 discriminated significantly between patients with hypochondriasis and those with an anxiety disorder ($d = 2.42$ and $d = 2.34$). Cut-off values for these two screening scales could be provided, thus identifying patients with a high probability of suffering from hypochondriasis.

Conclusions: In order to reduce costs, the BP scale or the WI-7 should be applied in medical or primary care settings, to screen for patients with a high probability of hypochondriasis and to transfer them to further assessment and effective treatment.

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Introduction

Severe health anxiety is the core feature of hypochondriasis, which affects a significant proportion of the population and leads to substantial medical costs [1–3]. However, there is evidence that the early identification of patients with hypochondriasis, and treatment at an early stage can save costs [4–6]. Therefore, effective and quick screening measures for hypochondriasis are needed, but should meet some specific criteria [7]. Firstly, they should be short and easy to apply in medical or psychiatric settings. Secondly, they should be reliable and valid. Thirdly, they should be able to correctly classify patients with health-related anxiety, within a group of patients with other *relevant* disorders.

Several disorders can be considered as relevant disorders with regard to hypochondriasis. In the 1960s and 1970s, close relationships were observed between patients with depressive disorders and those with hypochondriasis, and there was discussion on whether hypochondriasis is a secondary phenomenon of depressive disorder. However, the link between hypochondriasis and depression is not as strong as once

believed, because many studies found a closer relationship between hypochondriasis and anxiety disorders, than between hypochondriasis and somatoform disorders [8]. Recently, the classification of hypochondriasis as an anxiety disorder was suggested because of conceptual [9] and phenomenological [10] similarities between anxiety disorders and hypochondriasis. Moreover, empirical research has demonstrated that hypochondriasis seems to be more closely connected to anxiety than to somatoform disorders [11]. Therefore, anxiety disorders should be considered as the relevant comparison group for identifying patients with hypochondriasis using a screening measure.

Pilowsky [12] presented the Whiteley Index (WI) as an initial approach for the assessment of hypochondriasis. The WI reflects three dimensions of hypochondriasis, namely *Bodily Preoccupation*, *Disease Phobia* and *Conviction of the Presence of Disease with Non-Response to Reassurance*. The short version of the WI, the Whiteley-7 (WI-7) [13], was developed for the screening of hypochondriasis and demonstrated good classification results (sensitivity and specificity) for hypochondriasis in large primary care samples [14].

Another screening instrument is the Bodily Preoccupation (BP) Scale, which is a subscale of the Illness Attitude Scales (IAS) [15]. The BP scale demonstrated good classification results for hypochondriasis in a large general population sample [16]. However, to date, no study has been conducted of clinically diagnosed patients with hypochondriasis on the

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one hand, and patients with a primary anxiety disorder and non-patient participants with no psychological disorder (healthy controls) on the other hand. One important outcome of such a study would be valid cut-off values for identifying patients with a high probability of hypochondriasis.

Thus, the aim of the current study was to demonstrate the quality of the two brief hypochondriasis measures. Firstly, we hypothesised that, despite their brevity, the BP scale and the WI-7 would not be inferior to other instruments for hypochondriasis, regarding the ability to discriminate between patients with hypochondriasis and those with a primary anxiety disorder (Hypothesis 1). Secondly, we assumed that the BP scale and the WI-7 measure the same underlying construct (Hypothesis 2). Thirdly, diagnostically accurate prediction is possible, with the BP scale and the WI-7, through providing cut-off values to separate patients with hypochondriasis and those with an anxiety disorder, and to separate patients with hypochondriasis and healthy controls (Hypothesis 3). Finally, both instruments yield comparable relationships with other relevant measures for assessing hypochondriasis (Hypothesis 4).

Method

Participants

The study was conducted at the outpatient unit of the Department of Clinical Psychology and Psychotherapy at the University of Frankfurt, Germany (about 50 therapists and 1200 patients). In the outpatient unit, a randomised controlled trial was conducted (registered under NCT0119469) comparing the efficacy of cognitive therapy with exposure therapy. Patients with a diagnosis of hypochondriasis and those with a primary anxiety disorder were recruited in the outpatient unit for the current study. Diagnoses were determined by the Structured Clinical Interview for DSM-IV Disorders (SCID) [17] by experienced

clinicians who were specially trained in a two-day workshop on how to apply the SCID. In addition to the existence of a primary anxiety disorder or hypochondriasis, inclusion criteria were fluency and literacy in German, and informed consent. Exclusion criteria were a major medical illness (e.g. cancer), acute suicidality or suicidal tendencies, and a clinical diagnosis of substance addiction, schizophrenia or schizoaffective disorder, and bipolar disorders. Patients with primary anxiety disorders with comorbid hypochondriasis were also excluded. Fig. 1 provides an overview of the participation recruitment process. The entire sample of 228 participants consisted of three subsamples, with 72 participants having a primary diagnosis of hypochondriasis (hypochondriasis group), 80 with a primary diagnosis of an anxiety disorder (anxiety group) and 76 with no diagnosis (healthy control group). The healthy control group was recruited by four students from their circle of acquaintances as part of their master programme. The entire sample (56.1% female) and the subsamples were balanced with regard to gender, and the mean age was 37.5 ($SD = 13.7$; range = 18–75). Additionally, 37.7% of the participants with a diagnosis of hypochondriasis and 28.6% with an anxiety disorder also had another comorbid anxiety disorder, and 21.7% of the participants with hypochondriasis and 33.8% with an anxiety disorder also had another comorbid affective disorder. Institutional Board Approval was obtained for this study.

Measures

Whiteley-7 (WI-7)

The Whiteley-7 (WI-7) [13] is a short, 7-item-version of the original Whiteley Index [12]. Previous research demonstrated acceptable sensitivity (.82) and specificity (.81) coefficients of the WI-7 [14]. The German version of the WI-7 had acceptable internal consistency ($\alpha = .80$) and correlated highly with the original 14-item-version ($r = .94$). The seven items of the WI-7 (e.g. “Do you worry a lot about your health?”) have a dichotomous response format [18,19].

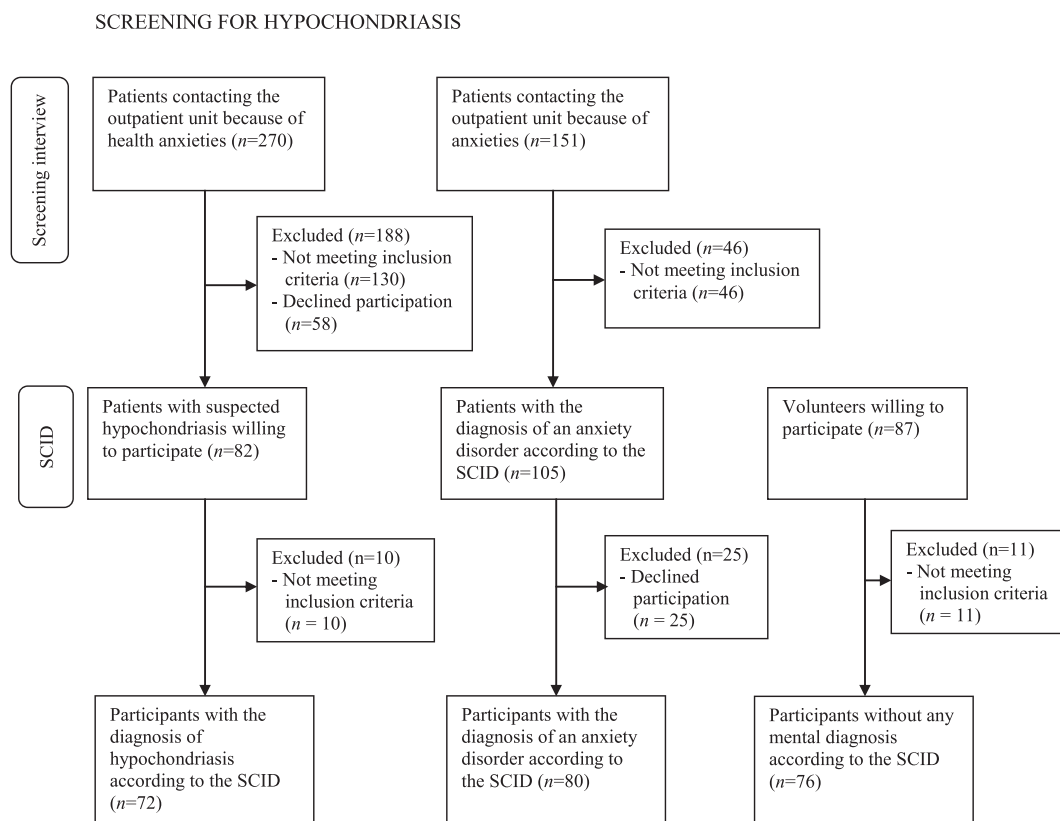


Fig. 1. Participant flowchart.

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