



The restrictive concept of good health in patients with hypochondriasis

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ABSTRACT

The restrictive concept of good health and the misinterpretation of bodily symptoms as a sign of illness are considered in the DSM and in well-established cognitive models as central characteristics of hypochondriasis. However, until now it has not been satisfactorily resolved whether this tendency is unique for hypochondriasis. In the current study a modified card sorting technique was used to investigate the extent to which bodily complaints were seen as compatible with a state of good health. We found that patients with hypochondriasis ($n=45$) showed a more restrictive concept of good health than anxiety patients ($n=45$) and healthy controls ($n=45$). Those differences were only observable when a concrete evaluation of own bodily symptoms was carried out in comparison to a more general evaluation of symptoms. The misinterpretation of bodily symptoms demonstrates to be a highly specific characteristic of hypochondriasis.

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1. Introduction

According to DSM-IV, hypochondriasis is characterized by anxieties based on the person's misinterpretation of bodily symptoms as a serious disease (APA, 2000). Furthermore, the work group for DSM-5 suggests that "a low threshold for considering [themselves] to be sick" and "a low threshold for becoming alarmed about their health" are criteria of *Illness Anxiety Disorder*, the former hypochondriasis (APA, 2011). This means that the misinterpretation of bodily symptoms as indicators for a severe physical illness as well as a definition of health as a widely symptom-free state are central characteristics of hypochondriasis. The importance of the misinterpretation of bodily symptoms for the development and maintenance of health anxieties is also emphasized in the well-established cognitive model for hypochondriasis and health anxiety (Warwick & Salkovskis, 1990). However, the empirical evidence for those theoretical assumptions is insufficient as the specificity of the theory for patients with hypochondriasis has not yet been adequately resolved (see Marcus, Gurley, Marchi, & Bauer, 2007).

Several studies have found dysfunctional beliefs about bodily symptoms and illnesses in patients with hypochondriasis and persons with elevated health anxieties, but most studies investigated patients who do not fulfill the diagnostic criteria of hypochondriasis (e.g., Hadjistavropoulos, Craig, & Hadjistavropoulos, 1998;

Hitchcock & Mathews, 1992; MacLeod, Haynes, & Sensky, 1998; Marcus, 1999; Marcus & Church, 2003; Sensky, MacLeod, & Rigby, 1996) or used only healthy participants or patients from medical settings as control groups (e.g., Barsky et al., 2001; Barsky, Coeytaux, Sarnie, & Cleary, 1993; Haenen, de Jong, Schmidt, Stevens, & Visser, 2000; Haenen, Schmidt, Schoenmakers, & Van den Hout, 1998). Investigations on dysfunctional illness-related beliefs in patients who fulfilled the diagnostic criteria of hypochondriasis and which consider patients with mental disorders as control groups are rare, but they are necessary in order to demonstrate specificity of the misinterpretation of symptoms and the narrow health concept in patients with hypochondriasis.

One study which compared patients with the diagnosis of hypochondriasis to a control group of patients with a mental disorder other than hypochondriasis (mainly patients with major depression and dysthymia) is the study of Rief, Hiller, & Margraf (1998). They found that patients with hypochondriasis showed catastrophizing interpretations of bodily complaints (e.g. "Bodily complaints are always a sign of disease.") more often than the clinical controls by using the *Cognitions About Body and Health Questionnaire* (CABH; Hiller et al., 1997). Therefore, the study demonstrated that dysfunctional interpretations of bodily symptoms are specific for hypochondriasis and not a characteristic of other mental disorders as well.

Many studies have demonstrated large phenomenological similarities between hypochondriasis and anxiety disorders. Both disorders show a high level of anxiety, an enhanced bodily vigilance, and excessive safety and avoidance behavior (e.g., Abramowitz, Olatunji, & Deacon, 2007; Deacon & Abramowitz, 2008; Hiller, Leibbrand, Rief, & Fichter, 2005; Noyes, Reich, Clancy,

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& O’Gorman, 1986; Van den Heuvel et al., 2005; Weck, Bleichhardt, Witthöft, & Hiller, 2011). Therefore, it is also important to find differences between patients with hypochondriasis and those with anxiety disorders regarding symptom- and illness-related beliefs. Recently, it was found that patients with hypochondriasis estimated bodily symptoms to be more likely an indicator for a catastrophic illness in comparison to patients with an anxiety disorder. However, patients with an anxiety disorder showed an increased likelihood to estimate bodily symptoms as an indicator for a catastrophic illness in comparison to healthy controls and took a middle position between patients with hypochondriasis and healthy controls (Weck, Neng, Richtberg, & Stangier, 2012). Those results demonstrated that illness-related beliefs are especially pronounced in patients with hypochondriasis, but that comparisons with patients suffering from anxiety disorders are important as well, in order to demonstrate the specificity of illness-related beliefs.

Barsky et al. (1993) stated that the narrow concept of good health and the misinterpretation of bodily symptoms is an enduring tendency in patients with hypochondriasis which is not only limited to the interpretation of own symptoms but for the interpretation of symptoms in general, and therefore, in the case of others as well. Many empirical investigations explicitly evaluate the misinterpretation of someone else’s bodily symptoms and found this tendency to be more pronounced in patients with hypochondriasis than in the control groups (e.g., Barsky et al., 1993; Marcus, 1999; Marcus & Church, 2003; Weck et al., 2012). As an example, the study of Barsky et al. can be referred. The authors used the *health norms sorting task* (HNST) in which the participants have to decide whether a ‘completely healthy person’ can be considered to be “still healthy” or “no longer healthy” if he or she develops one of 24 common and ambiguous somatic complaints (e.g. headache, dizziness, dry mouth). Patients with hypochondriasis categorized significantly more somatic complaints as “no longer healthy” in comparison to non-hypochondriacal controls from the same general medical clinic.

The given instruction of the HNST in the study of Barsky et al. (1993) leads to a more general appraisal of bodily symptoms, rather focusing on someone else’s state of health. In contrast to the view of Barsky, our experience gained in cognitive therapy shows that patients with hypochondriasis are often able to correctly evaluate the relevance of bodily symptoms in general, but they clearly misinterpret own bodily symptoms which have existed for a while (e.g., stomachache since one month). Therefore, it can be expected that the tendency to misinterpret bodily symptoms as a sign of illness is even more pronounced when patients are instructed to evaluate bodily symptoms presented for a defined period of time as their own symptoms. To our knowledge, no study has directly compared the impact of such a concrete instruction in comparison to a more general instruction (as phrased by Barsky) for the appraisal of bodily symptoms in patients with hypochondriasis.

We hypothesized that patients with hypochondriasis have a more restrictive concept of good health and therefore categorize more bodily symptoms as incompatible with a state of good health in comparison to healthy controls and patients with an anxiety disorder (Hypothesis 1). A specific instruction which emphasizes the evaluation of own bodily symptoms existing for a defined period of time (in comparison to an instruction which emphasizes a more general appraisal of symptoms) will lead to the fact that more symptoms will be categorized as incompatible with a state of good health (Hypothesis 2). We expect that patients with hypochondriasis show a stronger increase in the classification of bodily symptoms as incompatible with a state of good health than the control groups when participants are instructed to evaluate own bodily symptoms presenting for a defined period of time (Hypothesis 3).

2. Method

2.1. Participants

The study took part at the outpatient unit of the Department of Clinical Psychology and Psychotherapy at the University of Frankfurt, Germany. The outpatient unit is a large institute (about 50 therapists and 1200 patients) which offers ambulatory psychotherapy for patients with mental disorders. Moreover, in the outpatient unit an ongoing randomized controlled trial which compares the efficacy of cognitive therapy with exposure therapy for hypochondriasis is being conducted. Information in the local newspapers and radio were given about the randomized trial for the recruitment of patients with hypochondriasis.

Patients with a primary diagnosis of an anxiety disorder and patients with a primary diagnosis of hypochondriasis of the outpatient unit were recruited from June 2010 till November 2011 for the current study. Inclusion criteria were the existence of an anxiety disorder/hypochondriasis according to the SCID, fluency and literacy in German, and informed consent. Exclusion criteria were a major medical illness (e.g. cancer), acute suicidal tendencies, and the clinical diagnosis of substance addiction, schizophrenia or schizoaffective disorder, and bipolar disorders according to the SCID. Patients with primary anxiety disorders with comorbid hypochondriasis were excluded as well.

Patients with the diagnosis of an anxiety disorder were asked whether they were willing to participate in the current study after being diagnosed and 45 (78%) patients were willing to participate. Every person who was interested in participating in the randomized controlled trial for hypochondriasis received a personal and diagnostic interview. Forty-five (61%) of the interested persons fulfilled inclusion criteria and were willing to participate in the current study.

All patients were diagnosed according to DSM-IV criteria using the structured clinical interview for DSM-IV (SCID; First, Spitzer, Gibbon, & Williams, 1997). Diagnosticians were experienced clinicians who were trained in a two-day workshop on how to apply the SCID. An inquiry was made about minor medical conditions in the interview as well (Do you have medical illnesses diagnosed by a physician?). Moreover, 45 participants without mental disorders (according to the SCID) were recruited by four students in their circle of acquaintances as part of their qualification for diploma.

2.2. Questionnaires

2.2.1. Brief Symptom Inventory

The Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983; Franke, 2000) is a widely used self-report instrument to assess aspects of the general psychopathology and consists of 53 items. Items of the BSI are assessed using a five-point scale ranging from ‘not at all’ (0) to ‘extremely’ (4). The instrument consists of nine subscales (somatization, obsessive–compulsiveness, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism). In addition to these subscales, the inventory comprises three general distress measures, the most important of which is the *General Severity Index* (GSI), which is the mean item score. The BSI demonstrated good reliability and validity (Derogatis, 1993; Boulet & Boss, 1991; Broday & Mason, 1991). Comparable psychometric properties were found for the German version (Franke, 2000). The internal consistency (Cronbach’s alpha) in the current study for the 53 items of the BSI was $\alpha = 0.96$.

2.2.2. Illness Attitude Scales

The Illness Attitude Scales (IAS; Hiller & Rief, 2004; Kellner, 1986) is a questionnaire consisting of 27 items which are to be

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