



# Overlapping and Distinctive Features of Hypochondriasis and Obsessive–Compulsive Disorder

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**Abstract**—The spectrum of obsessive–compulsive disorders has received a great deal of theoretical attention, but there has been relatively little associated empirical research. The purpose of this study was to compare three groups of patients; those diagnosed with hypochondriasis (HC, a proposed spectrum condition), obsessive–compulsive disorder (OCD) and those with both OCD and HC (OCD/HC). The results show that patients with HC scored highest on a measure of overvalued ideas, and that the HC and HC/OCD groups scored significantly higher on measures of panic and agoraphobic cognitions. The groups also differed significantly for symptoms associated with compulsions. The patient groups were not different for measures of obsessions, depression, and anxiety. The results provide partial support for inclusion of HC in the spectrum of obsessive–compulsive disorders, but also provide indirect support for the association between HC and panic disorder. These results are interpreted in light of distinguishing characteristics among obsessive–compulsive spectrum conditions. © 2000 Elsevier Science Ltd. All rights reserved.

*Keywords:* Obsessive–compulsive disorder; Hypochondriasis; Overvalued ideas; Obsessive–compulsive spectrum disorder

The obsessive–compulsive spectrum of disorders includes a wide range of conditions, many of which have not been empirically tied to obsessive–compulsive disorder (OCD). Among the conditions that have been proposed as part of this spectrum include body dysmorphic disorder, bulimia nervosa, anorexia nervosa, trichotillomania, and even some substance abuse disorders (Hollander, 1993). Whereas there has been considerable postulation about

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Portions of these data were presented at the 29<sup>th</sup> annual meeting of the Association for Advancement of Behavior Therapy, Washington, DC.

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these relations, the supporting data have primarily stemmed from similarity of treatment response to interventions used for OCD (i.e., Zohar, Kaplan, & Benjamin, 1994) and apparent overlap in phenomenology, family history, and patterns of comorbidity (Goldsmith, Shapira, Phillips, & McElroy, 1998). The persuasiveness of an argument linking these conditions to a broader spectrum of obsessive-compulsive disorders would rest upon other population similarities. For example, it has recently been shown that body dysmorphic disorder does share common features with OCD (McKay, Neziroglu, & Yaryura-Tobias, 1997). Rubinstein, Altemus, Pigott, Hess, & Murphy (1995) have found similar levels of obsessionality in a sample of bulimics. Support for inclusion in the spectrum for other conditions has been less convincing, such as in the case of trichotillomania (Himle, Bordnick, & Thyer, 1995).

Hypochondriasis (HC) has also been considered a member of the spectrum of obsessive-compulsive disorders. The shared relation has been documented at phenomenological and symptom levels (Barsky, 1992). It has also been suggested that HC and OCD may be treated by using similar methods (Fallon, Klein, & Liebowitz, 1993a; Fallon, Rasmussen, & Liebowitz, 1993b; Yaryura-Tobias & Neziroglu, 1997a, 1997b). A recent study showed that OCD patients have high levels of illness-related concerns, suggesting that the base rate of hypochondriacal concerns even in patients without HC, but with OCD, is considerable (Savron et al., 1996). However, other trait similarities have not been explored, and no direct comparisons have yet been made with HC patients. It is also possible that some attributes present in more severe cases of OCD are more normative in HC. For example, one fundamental characteristic identified in HC is a strong disease conviction (Kellner, Hernandez, & Pathak, 1992). A description of disease conviction would appear similar to elevated overvalued ideation, a prognostic indicator in OCD (Kozak & Foa, 1994). In the case of HC, the essential belief is that a disease is present, and compulsions revolve around the identified illness. This is fundamentally different from OCD where compulsions are directed toward preventing an obsessional idea from becoming reality. Further, most frequently OCD patients state that both the obsessions and compulsions are senseless. Barsky (1992) details several important differences that theoretically distinguish these groups. HC patients see their fears as realistic, that a disease/illness is actually present, possess pervasive ideas of illness as part of their personality, are public about their concerns, and experience genuine somatic discomfort. These are all contrary to the typical experience and cognitive manifestations of OCD, where obsessions and fears are held secretly and are seen as unrealistic and separate from their personality. Indeed, the description of HC along these dimensions is similar to the higher-order personality disturbance that Eysenck (1982) suggested was part of secondary anxiety disorders (such as HC). It should be noted that the prognostic significance of overvalued ideas have been mixed, due in part to the

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