

## Are dysfunctional beliefs about illness unique to hypochondriasis?

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### Abstract

**Objective:** There is evidence that individuals high in hypochondriasis overestimate the likelihood of ambiguous symptoms being indicative of serious illness. However, it is not known whether this tendency is unique to hypochondriasis or whether it can be attributed to high negative affectivity or other anxiety symptoms often found to be comorbid with hypochondriasis. **Method:** College students ( $N=133$ ) completed measures of hypochondriasis, depression, anxiety, worry, avoidance and estimated the likelihood of various symptoms indicating catastrophic and minor illnesses. **Results:** Even after entering the

other self-report variables, hypochondriasis was the only variable to predict estimates of the likelihood of serious illness. Conversely, being female, high levels of negative affect, agoraphobic avoidance when accompanied by others and higher estimates about the likelihood of symptoms leading to catastrophic illnesses best predicted hypochondriasis scores. **Conclusion:** Dysfunctional beliefs about illness appear to be unique to hypochondriasis and to uniquely contribute to the prediction of hypochondriasis.

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### Introduction

Central to the cognitive-behavioral model of hypochondriasis [1–3] is the premise that hypochondriacal individuals hold dysfunctional beliefs about illnesses. Especially important may be beliefs about the likelihood of contracting a serious illness: Believing that serious illnesses are especially common serves as a risk factor for hypochondriasis. Thus, individuals who hold the assumption that serious illnesses are common may be more likely to misinterpret any bodily variation [2] as a source of concern.

This aspect of the model has received substantial empirical support. Hypochondriacal patients sorted more common somatic complaints into a stack indicating that a person with these complaints would no longer be healthy than did a group of medical patients [4]. Similarly, when reading about situations that could pose health-related dangers, hypochondriacal patients gave higher estimates of negative outcomes than did healthy controls [5]. Compared to college students low in hypochondriasis, those high in hypochondriasis were more likely to report that

ambiguous body sensations (e.g., tightness in the chest) would lead them to think that they had a catastrophic illness (e.g., heart attack) [6]. Also compared to college students low in hypochondriasis, those high in hypochondriasis estimated that hypothetical individuals with ambiguous symptoms were more likely to have a catastrophic illness [7].

Thus, both patients diagnosed with hypochondriasis [4,5] as well as individuals drawn from a nonclinical population who score high on measures of hypochondriasis [6,7] are more likely to interpret ambiguous symptoms or situations as indicative of serious illness. However, none of these studies has examined whether this tendency to overestimate the likelihood of catastrophic illnesses is specific to hypochondriasis. Haenen et al. [5] found that compared to controls, hypochondriacal individuals overestimated negative outcomes when it came to health-related issues, but did not differ from controls when estimating negative outcomes for nonhealth-related scenarios. However, because the hypochondriacal participants also scored higher than the controls on measures of negative affect and anxiety, they could not “rule out the possibility that the inflated estimates of negative outcomes with respect to health issues are not specifically due to

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high levels of health anxiety but to high levels of anxiety per se” (p. 829).

In fact, hypochondriasis as a personality trait correlates with neuroticism and negative affectivity [8–10]. As a clinical diagnosis, hypochondriasis is comorbid with a variety of mood and anxiety disorders, especially, panic disorder (PD), generalized anxiety disorder (GAD) and major depression [11–15]. It may be that this tendency for individuals high in hypochondriasis to overestimate the probability of negative health outcomes is simply a function of their high levels of negative affect. Alternatively, and more interestingly, it may be that dysfunctional assumptions about illness are unique to hypochondriasis and contribute to differentiating hypochondriasis from related conditions, such as GAD and PD. This possibility is consistent with Salkovskis and Clark’s [16] formulation that, whereas PD patients are primarily concerned with the immediate consequences of anxiety, hypochondriasis is specifically linked to concerns about the significance of physical symptoms.

The aim of the present study was to examine whether dysfunctional illness assumptions are unique to hypochondriasis, or whether they can be explained by higher-level constructs such as negative affect or by other symptoms, such as worry (GAD) or agoraphobic avoidance. The present study tested whether Marcus’ [7] finding that individuals high in hypochondriasis were more likely to believe that ambiguous symptoms were indicative of catastrophic illnesses could be replicated even when controlling for various mood and anxiety symptoms. As in Marcus [7], the participants were drawn from a non-clinical population and hypochondriasis was treated as a personality dimension. This approach seems justified considering that (a) clinical hypochondriasis and subclinical health concerns exist on a continuum [17,18], (b) studies using nonclinical samples to examine dysfunctional assumptions about illness have yielded results that are highly consistent with studies of patients with hypochondriasis [6,7], and (c) the cognitive-behavioral model encompasses both subclinical health anxiety and hypochondriasis [1–3].

## Method

### Participants

The participants were drawn from introductory-level psychology courses, where they volunteered to participate in return for extra credit. All students volunteering were selected for the study, but because the majority of the participants were traditional-age college students and because somatic complaints may increase with age as a result of actual disease [8], data from students over the age of 35 were excluded from the analyses. The remaining participants were 133 students (39 men and 93 women, 1

did not indicate). They ranged in age from 18 to 35 ( $M = 19.84$ ,  $S.D. = 2.57$ ).

### Materials and procedure

After providing their informed consent, the students completed a set of five questionnaires assessing (a) hypochondriasis, (b) depression and anxiety, (c) agoraphobic avoidance, (d) worry and (e) dysfunctional beliefs about the meaning of physical symptoms. To control for order effects, these instruments were organized in one of four different orders.

The Illness Attitudes Scale (IAS) [19] is a reliable instrument for assessing hypochondriacal symptoms that has good convergent and divergent validity [20]. The IAS consists of nine three-item subscales and items are answered using a five-point Likert-type scale. Following Marcus [7], the IAS was scored by averaging the items from the five subscales that Kellner et al. identified as most relevant to the diagnosis of hypochondriasis (i.e., worry about illness, concern about pain, hypochondriacal beliefs, disease phobia and bodily preoccupation). This composite IAS score was internally consistent, with  $\alpha = .86$ . Factor analyses of the IAS have generally yielded four or five factors [21]. Our method of scoring the IAS is highly similar to the “General Hypochondriacal Fears and Beliefs” factor yielded by Ferguson and Daniel’s [22] factor analysis of college students’ IAS scores, with 11 of the 15 items in our scoring of the IAS loading on this factor. In fact, if the 12 items that comprise this factor are substituted for the 15 items that we used, the results of the subsequent analyses remained essentially unchanged.

The Mood and Anxiety Symptom Questionnaire (MASQ) [23] is a 90-item self-report scale that provides measures of depressive and anxious symptoms. Items are answered using a five-point Likert-type scale. The five scales of the MASQ are derived from the tripartite model of depression and anxiety [24]. They are General Distress: Mixed (GDM, 15 items), General Distress: Anxiety (GDA, 11 items), General Distress: Depressed (GDD, 12 items), Anxious Arousal (AA, 17 items) and Anhedonic Depression (AD, 22 items). The three General Distress (GD) scales assess negative affect, which is common to both anxiety and depression. The AD scale measures the absence of positive affect, which is unique to depression. The AA scale assesses hyperarousal, which is unique to anxiety. All five scales of the MASQ have excellent internal consistency, and they are highly correlated with other measures of depression and anxiety [25]. In the present sample, the coefficient  $\alpha$ ’s were .88 for GDM, .85 for GDA, .90 for GDD, .85 for AA and .93 for AD. Because the three GD scales were all highly intercorrelated (mean  $r = .79$ ) and all assess negative affect, they were combined to create a 38-item GD scale ( $\alpha = .95$ ).

The Mobility Inventory (MI) [26] is a 27-item self-report inventory that measures agoraphobic avoidance. Participants use a five-point Likert-type scale to indicate

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