



Health anxiety in obsessive compulsive disorder and obsessive compulsive symptoms in severe health anxiety: An investigation of symptom profiles



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ABSTRACT

Severe health anxiety (SHA) shares features with obsessive-compulsive disorder (OCD) and in recent years there has been a debate as to whether the two disorders may represent two facets of the same condition. Few studies have however investigated the overlap and differences in symptom profiles between the disorders. The primary aim of the present study was to investigate these aspects using one sample of participants with a principal diagnosis of SHA and one sample of participants with a principal OCD diagnosis. The second aim was to examine differences in improvement trajectories on measures of health anxiety and OCD symptoms in patients with SHA receiving treatment with exposure and response prevention.

We compared persons participating in clinical trials with a principal diagnosis of SHA ($N=290$) to persons with a principal diagnosis of OCD ($n=95$) on measures of health anxiety, OCD symptoms, and depressive symptoms. A subsample of SHA participants ($n=99$) received exposure and response prevention (ERP) for SHA over 12 weeks and was assessed at baseline and post-treatment. The results showed large and significant differences between SHA and OCD patients on measures of health anxiety ($d_s = 2.99-3.09$) and OCD symptoms ($d_s = 1.64-2.14$), while they had equivalent levels of depressive symptoms ($d = 0.19$, 95% CI $[-0.04, 0.43]$). In the SHA sample 7.6% had comorbid OCD, and in the OCD sample 9.5% had SHA. For participants with a principal diagnosis of SHA, ERP led to large reductions of health anxiety, but effects on OCD symptoms were small to moderate. Among participants with comorbid OCD, effect sizes were large on measures of health anxiety and moderate to large on OCD measures. We conclude that SHA and OCD are separate psychiatric disorders with limited overlap in symptom profiles.

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1. Introduction

Severe health anxiety (SHA) can be described as a debilitating and persistent fear of having or acquiring a serious somatic disease. In diagnostic terms, this disorder was labeled as hypochondriasis in the DSM-IV (American Psychiatric Association, 2000) but now falls under somatic symptom or illness anxiety disorder in the DSM-5 (American Psychiatric Association, 2013). Obsessive-compulsive disorder (OCD) is characterized by intrusive thoughts and

behavioral rituals aimed at reducing the frequency or intensity of those thoughts (American Psychiatric Association, 2013). Although classified as different psychiatric disorders, SHA and OCD share several features. As pointed out by Abramowitz and Braddock (2006), there are clear similarities between the two disorders both in terms of cognitions (intrusive thoughts) and behaviors (e.g. repetitive checking). These behaviors also seem to have similar functional properties. That is, in both SHA and OCD the individual overestimates the likelihood of threat, which is associated with increased anxiety, which in turns serves as a cue for checking behaviors that lead to a short-term increased sense of safety and reduction of anxiety (Abramowitz & Braddock, 2006). Both SHA and OCD are associated with difficulties in dealing with ambiguities and uncertainty (Deacon & Abramowitz, 2008) and it has been shown that

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psychological treatment based on exposure and response prevention is effective for SHA as well as OCD (Franklin & Foa, 2011; Hedman et al., 2011; Olatunji et al., 2014).

There are however also differences between the disorders. Individuals with SHA more often believe that their fears are realistic, i.e., that they really are sick, while persons with OCD view their intrusions as unrealistic (but rituals are nonetheless hard to resist) (Barsky, 1992), although recent research has shown that a subgroup of persons with OCD have poor insight (e.g. Eisen et al., 2001; Kozak & Foa, 1994; Phillips et al., 2012). It has also been suggested that presence of somatic symptoms is more prominent in SHA than in OCD and some data indicate that there is a stronger influence of heritability in OCD compared to SHA (Fallon, Qureshi, Laje, & Klein, 2000; Lopez-Sola et al., 2014; Mataix-Cols et al., 2013; Taylor, Thordarson, Jang, & Asmundson, 2006). One important distinction between the disorders is also that while distressing thoughts about disease is a key feature of SHA, individuals with OCD most often present with intrusions unrelated to health, such as intrusions about symmetry or fear of harming others (American Psychiatric Association, 2013). A minority of persons (10–15%) with OCD do however experience health concerns (Abramowitz, Brigidi, & Foa, 1999; Savron et al., 1996), but a recent study by Fergus (2014) showed that after controlling for OCD-related beliefs and anxiety sensitivity, health-related dysfunctional beliefs were clearly related to health anxiety but not significantly associated with OCD symptoms. This thus suggests that health-related dysfunctional beliefs are specific to health anxiety.

As for co-morbidity, there are relatively few studies conducted, but available data suggest that the overlap is limited. There seems to be an increased risk of SHA when OCD is present, and vice versa, but that comorbidity rates are not higher between these two disorders compared to other anxiety disorders (Barsky, 1992; Deacon & Abramowitz, 2008; Sunderland, Newby, & Andrews, 2013). As described in a review by Fallon et al. (2000), investigations of health anxiety symptoms in persons with OCD using dimensional measures have generally shown that health anxiety is not more elevated in OCD than in other common psychiatric disorders. The same pattern was also shown in a study by Abramowitz, Olatunji, and Deacon (2007). Major limitations of those studies are however that they mostly have used small samples sizes and data on both health anxiety and OCD symptoms are seldom reported. An exception to the latter is a study by Greeven, van Balkom, van Rood, van Oppen, and Spinhoven (2006) which showed that there were large differences between persons with SHA and OCD on disorder specific symptom measures. That study was however conducted on small samples (severe health anxiety sample, $n=31$; OCD sample, $n=45$) rendering limited statistical power, which the authors acknowledged as a limitation (Greeven et al., 2006). Considering the recent debate about problems in replicating findings in psychological research (Open Science Collaboration, 2015) and the uncertainty of estimates derived from small sample sizes (Biau, Kerneis, & Porcher, 2008) it is therefore highly important to investigate potential similarities and differences between in persons with SHA and OCD using clinical samples of adequate size.

Given the substantial covariation between depressive and anxiety symptoms, and that comorbid depression is related to a more severe course of illness, increased impairment and worse treatment outcomes (Hanel et al., 2009; Hedman, Lindefors et al. 2013; Keeley, Storch, Merlo, & Geffken, 2008) we also viewed it as important to include depressive symptoms in our investigation of symptom profiles of SHA and OCD. Comorbid depression is also of interest to investigate in this context because it has been suggested that health anxiety is a “masked” form of, or defense against, depression. As described by Taylor and Asmundson (2004) in a review of the topic this would imply that persons with SHA should have less depressive symptoms than other psychiatric populations (e.g.,

persons with OCD). However, these claims are yet without empirical support, if anything available data are inconsistent with this hypothesis (Taylor & Asmundson, 2004). Demonstrating evidence of equivalence between SHA and OCD in terms of depressive symptoms would add to the data refuting this hypothesis. A previously conducted study did not find a significant difference between SHA and OCD in this regard (Neziroglu, McKay, & Yaryura-Tobias, 2000).

In summary, on the one hand there seems to be similarities between SHA and OCD in terms of presence of intrusive thoughts, increased anxiety and behavioral rituals. On the other hand, SHA and OCD seem to differ in terms of frequency of somatic symptoms, how realistic persons view their intrusions and the diagnostic and symptom overlap between the disorders may be limited. The emerging picture regarding the boundaries between SHA and OCD is thus rather complex and different researchers have come to different conclusions. Some experts have suggested that SHA may represent a special case of OCD (Abramowitz & Braddock, 2006; Neziroglu et al., 2000), while others have concluded that empirical data does not support the hypothesis that SHA and OCD represent the same disorder (Fallon et al., 2000; Greeven et al., 2006; Solem et al., 2015).

Against this background we regarded it as important to further investigate potential differences in symptom profiles in persons with SHA and OCD using sufficiently large samples to yield adequate statistical power. Gaining more knowledge in this regard can be highly useful in establishing diagnostic and conceptual validity, and may have implications for treatment. That is, it is important for the clinician to know whether a given individual with SHA is likely to have elevated symptoms of OCD, and vice versa, and whether a treatment aimed at reducing symptoms in one domain also has an effect in the other.

The aim of this study was to investigate symptom profiles in persons with SHA and OCD by assessing health anxiety, OCD-symptoms and depressive symptoms. We expected that SHA participants would display significantly more health anxiety and significantly less OCD-symptoms compared to the OCD participants. In terms of depressive symptoms, we expected the groups to be equivalent. A second aim was to investigate if OCD-symptoms are affected by exposure and response prevention (ERP) aimed specifically at reducing SHA when delivered to persons with a principal diagnosis of SHA and to compare that effect to improvement in health anxiety. ERP for SHA is a highly structured treatment where the patient is systematically exposed to health anxiety relevant stimuli (e.g., pounding heart) while refraining from using safety behaviors (e.g., checking the pulse). Several putative mechanisms of ERP have been suggested, such as extinction of conditioned responses, inhibitory safety learning, and restructuring of fear relevant cognitions (e.g. Craske et al., 2008). Recently, a study by Solem et al. (2015) showed that ERP for persons with OCD can yield moderate reductions in comorbid health anxiety and the authors suggested that ERP may affect cognitions common to both disorders. To our knowledge no prior study has however conducted an analogous study on ERP for SHA. We hypothesized that improvements would be larger on measures of health anxiety than on measures of OCD symptoms. In addition, we exploratively analyzed the improvement trajectories for participants with both SHA and OCD.

2. Methods

2.1. Design

A sample of participants with a principal diagnosis of SHA ($n=290$), defined as DSM-IV hypochondriasis or DSM-5 somatic symptom disorder or illness anxiety disorder, was compared to a

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