Predictors of illness anxiety symptoms in patients with obsessive compulsive disorder

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ABSTRACT

Illness anxiety and OCD symptoms appear to overlap in their presentation as well as in other conceptually important ways (e.g., dysfunctional cognitions). Little research, however, has directly examined these putative relationships. The present study examined the extent to which illness anxiety symptoms were associated with OCD symptom dimensions and relevant cognitive factors in a large treatment-seeking sample of patients with OCD. Patients completed a battery of self-report measures of OCD and health anxiety symptoms and related cognitive biases. Results from regression analyses indicated that illness anxiety symptoms were associated with harm obsessions and checking rituals, as well as with the tendency to overestimate threat and responsibility for harm. Illness anxiety was not associated with perfectionism. Conceptual and clinical implications of these findings are discussed.

1. Introduction

Illness anxiety entails a preoccupation with the unsubstantiated belief that one has, or is imminently developing, a serious medical condition (Taylor and Asmundson, 2004). The belief may be based on a catastrophic misinterpretation of harmless bodily sensations (e.g., headache or pulled muscle), the presence of a benign physical condition (e.g., hives), or a previous health issue that is no longer active (e.g., a treated heart condition). To manage illness worry, the person engages in unnecessary behaviors designed to provide reassurance of good health, such as excessively checking one’s body (including its waste products), repeatedly seeking reassurance (e.g., on the internet), and obtaining multiple unnecessary medical evaluations. Although most people in the general population occasionally entertain illness concerns, in its severe form illness anxiety results in substantial personal distress and interference with work/school, relationship, and social functioning, which indicates the presence of illness anxiety disorder (IAD; formerly known as hypochondriasis [HC]). Prevalence rates of severe illness anxiety range from 0.2% to 4.5% (e.g., Bleichhardt and Hiller, 2007) with similar overall rates for men and women.

Illness anxiety symptoms are commonly observed in individuals with obsessive-compulsive disorder (OCD; e.g., Abramowitz et al., 2007) and research suggests a significant rate of comorbidity between HC/IAD and OCD (e.g., 15% in Bienvenu et al., 2000). OCD is heterogeneous, with the themes of obsessions and compulsions varying from patient to patient; research (e.g., Foa and Kozak, 1995) and clinical observations suggest that obsessional fears of illness, disease (e.g., HIV resulting from contamination), and other somatic concerns (e.g., serious medical problems) are among the most common thematic presentations. Among patients with OCD, the prevalence of obsessions focused on bodily symptoms (i.e., somatic obsessions) is as high as 34% (e.g., Rasmussen and Tsuang, 1986). Such obsessions are ordinarily accompanied by washing, checking, and reassurance-seeking rituals that serve to reduce anxiety and provide reassurance of safety or good health. Although authors have recognized overlaps between the signs and symptoms of illness anxiety and obsessions and compulsions in OCD (e.g., Deacon and Abramowitz, 2008; Hollander et al., 2005), IAD was not included among the Obsessive-Compulsive and Related Disorders in DSM-5 (APA, 2013). Yet, the preoccupation with fears of illness in IAD is comparable in form and function to obsessional thoughts in OCD in that both have intrusive, repetitive, anxiety-provoking qualities and are subjectively resisted (APA, 2013). Similarly, checking and reassurance-seeking behaviors in IAD are similar to compulsive checking rituals in OCD: both are performed in response to unrealistic perceptions of threat and reinforced by the reduction in anxiety (albeit temporary).
they frequently engender. They also prevent the natural extinction of anxiety and thereby complete a vicious cycle that characterizes both OCD and IAD (Abramowitz and Braddock, 2008; Deacon and Abramowitz, 2008).

In addition to these phenomenological overlaps, illness anxiety and OCD symptoms appear to share cognitive factors that figure prominently in empirically supported conceptual approaches to understanding and treating these conditions (e.g., Abramowitz and Braddock, 2008; Abramowitz et al., 2009). Several studies show that certain cognitive distortions characteristic of OCD (i.e., “obsessive beliefs”) are also present in illness anxiety, including the tendency to overestimate threat and responsibility, the need for certainty, and the need for perfectionism (e.g., Wheaton et al., 2010a; Wheaton et al., 2010b; Deacon and Abramowitz, 2008; Melli et al., 2014). Patients with OCD, for example, overestimate the probability of becoming sick from germs (e.g., Wheaton et al., 2010a). Similarly, those with illness anxiety overestimate the probability of serious illnesses and view their prognosis as overly catastrophic (e.g., Weck et al., 2012). The need for certainty and the intolerance for mistakes are also observed to be a motivator of compulsive checking and reassurance-seeking in both illness anxiety and OCD (e.g., Abramowitz and Braddock, 2008; Tolin et al., 2003; Wheaton et al., 2010a).

Another cognitive bias that is present in both OCD and illness anxiety is anxiety sensitivity (AS)—the tendency to fear anxiety-related body sensations based on mistaken beliefs about their presence and meaning (Otto et al., 1998; Raines et al., 2014; Wheaton et al., 2012). Such mistaken beliefs fall into three domains: (a) physical concerns (e.g., When my heart races I think I am having a heart attack), (b) cognitive concerns (e.g., When my thoughts race, I worry I am going crazy), and (c) concerns about the social consequences of anxiety (e.g., If I tremble in front of others, they will think I am incompetent; Taylor, 1999). Wheaton and colleagues (2012) found an association between the physical concerns domain of AS and certain OCD symptoms; namely contamination and harm obsessions and checking rituals. They posited that individuals with these OCD symptoms misappraise physical symptoms of anxiety as indicating contamination, sickness, and harm. Similarly, numerous studies show that illness anxiety is associated with misinterpretations of arousal-related body sensations as signs of medical illness (e.g., Deacon and Abramowitz, 2006; Taylor and Asmundson, 2004).

Despite the overlaps in symptom presentation and cognitive factors, as well as the presence of illness anxiety in many patients with OCD, there is a dearth of research directly examining the relationships among illness anxiety and OCD symptoms. Abramowitz and colleagues (1999) compared OCD patients with and without health concerns and found that whereas the presence of illness anxiety symptoms was not associated with the severity of OCD symptoms overall, OCD patients with health concerns reported more somatic and harm obsessions and checking rituals relative to non-health concerned OCD patients. Surprisingly, fears of illness related to contamination were not elevated among the health-concerned patients. This study, however, was hindered by limitations in the assessment procedures. In another study, Abramowitz, Olatunji, and Deacon (2007) found that patients with OCD had greater illness anxiety than did those with social phobia, specific phobias, and generalized anxiety disorder. However, patients with OCD scored similarly to those with HC on measures regarding the feared likelihood of becoming ill. This study, however, used a combined sample of individuals with anxiety disorders of which only a fraction (n = 18; 11%) had OCD.

The seeming overlaps between illness anxiety and OCD are of conceptual and clinical consequence. Abramowitz et al. (1999), for example, found that among individuals with OCD, health concerns were associated with poorer insight into the senselessness of obsessions and compulsions; and poor insight is known to predict attenuated response to both psychological and pharmacological treatment for OCD (e.g., Eisen et al., 2001). These overlaps are also of interest given continued uncertainty regarding how to best classify illness anxiety (IAD) and OCD (e.g., Abramowitz and Jacoby, 2015; Cosci and Fava, 2015). Despite appearing as a somatoform disorder in DSM-5, some have argued that IAD is more closely related to OCD than to the other somatoform conditions (e.g., Deacon and Abramowitz, 2008). When the phenomenological and conceptual overlaps between OCD and illness anxiety/IAD are considered along with the scarcity of empirical research on this topic (and limitations of the existing studies), one recognizes the need to more carefully elucidate the relationship between illness anxiety and OCD symptoms.

Recently, Solem et al. (2015) examined associations between illness anxiety and obsessive-compulsive symptoms among a large sample of patients with OCD and found that nearly one third of the patients scored above the established cutoff for clinically significant health anxiety symptoms. Hedman et al. (2017) also examined associations between obsessive-compulsive symptoms and illness anxiety among participants with OCD. Importantly, Hedman and colleagues also examined these associations among patients with severe illness anxiety (SHA) and found differences between OCD and SHA patients on various symptom measures (e.g., illness behaviors). A strength of Hedman and colleagues’ study is the inclusion of both patients with OCD and patients with SHA; however, both of these aforementioned studies offered a sub-optimal assessment of OC symptoms, as neither study included a dimensional assessment tool of OCD.

Although one study to date (Fergus and Russell, 2016) has adopted a dimensional approach by examining associations between a measure of illness anxiety and the obsessive-compulsive symptom dimensions, the researchers used a community sample to test their hypotheses. Fergus (2014) had previously examined associations between obsessive beliefs and AS in relation to both illness anxiety and obsessive-compulsive symptoms. Results revealed that AS appeared to be a shared set of beliefs between illness anxiety and obsessive-compulsive symptoms, whereas obsessive beliefs seemed to be more relevant to obsessive-compulsive symptoms than to illness anxiety. Limitations of these studies (2014, 2016), however, included use of a community sample and combining belief domains. Thus, further additional examination of these constructs in a clinical sample is necessary.

Accordingly, the aim of the current study was to examine the extent to which illness anxiety symptoms were associated with OCD symptoms and relevant cognitive factors in a large sample of treatment-seeking patients with OCD. To improve upon previous work, we used a dimensional measure of OCD symptom severity that allowed us to determine associations between illness anxiety symptoms and empirically established thematic OCD symptom dimensions (e.g., contamination, harm). On the basis of previous conceptual and empirical work, we predicted that illness anxiety symptoms would be associated with harm and contamination obsessions and checking rituals. We also hypothesized that beliefs relating to the overestimation of threat, the need for certainty and intolerance of mistakes, as well as the tendency to fear the physical consequences of anxiety-related body sensations would be associated with illness anxiety symptoms.

2. Methods

2.1. Participants

Participants were 132 consecutively referred treatment-seeking patients (52.3% female; n = 69) with a primary diagnosis of OCD who presented for treatment at the Obsessive-Compulsive Disorders Center at Rogers Memorial Hospital in Oconomowoc, Wisconsin. Of the 132 participants, 112 were enrolled in residential treatment and 20 in the partial hospitalization program. On average, participants were 31.29 years old (SD = 12.05; range = 18 – 64). The sample was 89.4% White, 2.3% African American, 3.0% Asian, 3.6% Latino/Hispanic, and 0.7% Indian. One individual did not report their racial/ethnic background.
2.2. Measures

2.2.1. Yale-Brown obsessive compulsive scale - self-report version (Y-BOCS-SR; Goodman et al., 1989a, 1989b)

A measure of global OCD symptom severity, the Y-BOCS assesses obsessions (items 1–5) and compulsions (items 6–10) on the following five parameters: (a) time spent, (b) interference, (c) distress, (d) resistance, and (e) control. Scores on the Y-BOCS range from 0 to 40; higher scores indicate greater symptom severity. The self-report version (Y-BOCS-SR) has good reliability and validity (Steketee et al., 1996).

2.2.2. Dimensional obsessive-compulsive scale (DOCS; Abramowitz et al., 2010)

The DOCS is a 20-item self-report instrument that measures the severity of the four most consistently identified theme-based OCD symptom dimensions: (a) contamination obsessions and decontamination rituals, (b) harm obsessions and checking rituals, (c) symmetry/ordering obsessions and compulsions, and (d) unacceptable (taboo) thoughts and neutralizing rituals. Within each symptom dimension, five items (rated 0–4) assess the following parameters: (a) time occupied by obsessions and rituals, (b) avoidance behavior, (c) associated distress, (d) functional interference, and (e) difficulty refraining from compulsions. The DOCS subscales exhibit excellent congeneric validity and reliability in clinical samples (α = 0.94–0.96; Abramowitz et al., 2010). Reliability of the DOCS subscales in the present sample was excellent (α = 0.92–0.96).

2.2.3. Obsessive beliefs questionnaire (OBQ; Obsessive Compulsive Cognitions Working Group, 2001)

The OBQ is a 44-item self-report tool that assesses cognitive factors (i.e., obsessive beliefs) relevant to OCD. It contains three subscales: (a) threat overestimation and responsibility (OBQ-RT), (b) importance and control of thoughts (OBQ-ICT), and (c) need for certainty and perfection (OBQ-PC). The instrument has good validity, internal consistency, and test-retest reliability (Obsessive Compulsive Cognitions Working Group, 2001). Reliability of the OBQ subscales in the present sample was excellent (α ranged from 0.93 to 0.95).

2.2.4. Beck depression inventory-II (BDI-II; Beck et al., 1996)

The BDI-II is a 21-item self-report measure that assesses the severity of various components of depression. Scores of 10 or less are considered normal; scores of 20 or greater suggest the presence of clinical depression. The BDI-II has excellent reliability and validity and is widely used in clinical research (Beck et al., 1996).

2.2.5. Beck anxiety inventory (BAI; Beck et al., 1988)

The BAI assesses 21 common symptoms of clinical anxiety (e.g., indigestion, nervous) as experienced over the past month. Respondents indicate the degree to which they have recently been bothered by each symptom during the past month ranging on a scale from 0 “Not at all” to 3 “Severely.” The BAI assesses anxiety symptoms independently from depression symptoms. The measure exhibits good reliability and validity (Beck et al., 1988).

2.2.6. Whiteley index (WI; Pilowsky, 1967)

The WI is a 14-item self-report measure that assesses hallmark features of illness anxiety (e.g., “Do you think there is something seriously wrong with your body?”). Respondents answer a series of Yes/No questions and receive one point for each affirmative answer. Total scores range from 0 to 14, and higher scores indicate higher levels of health anxiety. The WI is the most widely used measure of illness anxiety and showed good reliability in the present sample (α = 0.85).

2.2.7. Anxiety sensitivity index (ASI; Reiss et al., 1986)

The ASI is a 16-item self-report measure of beliefs about the dangerousness of arousal-related body sensations (e.g., “It scares me when my heart beats rapidly”). Participants rate their agreement with each statement on a 0 (very little) to 4 (very much) scale; higher scores indicate greater AS. This widely used measure has three factors/subscales (calculated according to Taylor et al., 2007): fears of physical sensations (e.g., racing heart), fears of cognitive symptoms of anxiety (e.g., dizziness, racing thoughts), and concerns about the social consequences of displaying the symptoms of anxiety (e.g., embarrassment). Reliability of the ASI subscales in the present sample ranged from 0.77 to 0.80.

2.3. Procedure

Prior to admission to an OCD treatment program, all patients completed a telephone assessment with a trained intake staff member. The clinical director of the Obsessive-Compulsive Disorder Center (BCR) reviewed the results of this assessment and determined if the patient was appropriate for admission. Upon admission, each patient completed an initial in-person diagnostic evaluation with an experienced psychiatrist. The severity rating from the self-report version of the Yale-Brown Obsessive-Compulsive Scale (YBOCS; Goodman et al., 1989a, 1989b) was used to determine the presence of DSM-IV OCD (APA, 2000). Each participant then completed a packet of self-report questionnaires, including the measures described above. As part of the admissions process, patients provided consent (either in person or online) to allow their responses to the study measures to be used for both clinical and research purposes. The Human Subjects Committee and the Rogers Center for Research and Training approved the consent procedures and study measures.

2.4. Statistical analyses

We used the following statistical approach to test our hypotheses. First, we examined descriptive statistics and measures of central tendency for the study variables, and conducted independent samples t-tests to examine possible gender differences on the WI. Second, we computed Pearson correlation coefficients between the WI and other study variables to examine patterns of zero-order associations between illness anxiety and demographic variables, OCD symptom dimensions, cognitive factors, and the symptoms of depression and anxiety. Third, we computed two linear regression analyses. The first regression examined symptomatic predictors of illness anxiety (WI): OCD symptom dimensions (DOCS subscales) and associated distress (BAI, BDI). The second regression examined cognitive predictors of the WI: obsessive beliefs (OBQ subscales) and AS (ASI).

3. Results

3.1. Descriptive statistics and preliminary analyses

Means and standard deviations on all study measures appear in Table 1. The sample’s mean Y-BOCS-SR score indicated severe OCD symptoms. The sample’s mean WI score indicated mild to moderate health anxiety (e.g., Conradt et al., 2006), and 43.2% (n = 57) exceeded the cutoff for SHA (i.e., scored > 5 on the WI; Hedman et al., 2015). The mean DOCS total score was comparable to a similar sample of treatment-seeking patients with OCD (Abramowitz et al., 2010). There were no gender differences on the WI, r (130) = −0.02, p = 0.99. There was also no association between age and health anxiety (WI), r = −0.09, p = 0.33.

We computed a correlation between the BDI and BAI, which often overlap, to determine whether to use both measures in the analyses that follow. Scores were moderately correlated (r = 0.55), indicating related but distinct constructs. Accordingly, in the analyses that follow, both measures were considered separately.
3.2. Zero-order Pearson correlations

Table 2 presents the results of our zero-order correlational analyses. Given the multiple comparisons, we applied a Bonferroni correction of \( p < 0.005 \) (0.05 / 12). As can be seen, the Whiteley Index (WI) was weakly to moderately associated with the other study variables (rs ranging from 0.12 to 0.43). Among the OCD symptom dimensions, only the DOCS harm obsessions and checking rituals subscale was significantly correlated with the WI. Among the obsessive belief domains, both the responsibility/threat estimation and importance/control of thoughts OBQ subscales were significantly correlated with the WI. The ASI physical concerns and social concerns subscales, but not the cognitive concerns subscale, were significantly correlated with the WI (rs ranging 0.25-0.43). Finally, the BAI, but not the BDI, was significantly correlated with the WI.

<table>
<thead>
<tr>
<th>Measure</th>
<th>( M ) (SD)</th>
<th>( N = 132 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y-BOCS-SR (total)</td>
<td>26.67 (6.64)</td>
<td></td>
</tr>
<tr>
<td>DOCS Contamination</td>
<td>7.70 (6.97)</td>
<td></td>
</tr>
<tr>
<td>Responsibility for harm</td>
<td>6.72 (5.96)</td>
<td></td>
</tr>
<tr>
<td>Unacceptable thoughts</td>
<td>11.02 (6.15)</td>
<td></td>
</tr>
<tr>
<td>Symmetry</td>
<td>6.05 (5.74)</td>
<td></td>
</tr>
<tr>
<td>OBQ-44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsibility/Threat</td>
<td>63.46 (24.97)</td>
<td></td>
</tr>
<tr>
<td>Perfectionism/ Certainty</td>
<td>68.64 (25.23)</td>
<td></td>
</tr>
<tr>
<td>Importance/Control of Thoughts</td>
<td>40.63 (19.36)</td>
<td></td>
</tr>
<tr>
<td>BDI-II</td>
<td>26.72 (13.28)</td>
<td></td>
</tr>
<tr>
<td>BAI</td>
<td>21.12 (10.92)</td>
<td></td>
</tr>
<tr>
<td>WI</td>
<td>4.80 (3.32)</td>
<td></td>
</tr>
<tr>
<td>ASI Physical concerns</td>
<td>7.20 (4.92)</td>
<td></td>
</tr>
<tr>
<td>Cognitive concerns</td>
<td>4.32 (3.47)</td>
<td></td>
</tr>
<tr>
<td>Social concerns</td>
<td>13.42 (5.88)</td>
<td></td>
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</tbody>
</table>

Note. Y-BOCS-SR = Yale-Brown Obsessive Compulsive Scale-Self report; DOCS = Dimensional Obsessive Compulsive Scale; OBQ-44 = Obsessive Beliefs Questionnaire-44; BDI-II = Beck Depression Inventory-II; BAI = Beck Anxiety Inventory; WI = Whiteley Index; ASI = Anxiety Sensitivity Index.

3.3. Regression analyses

Summary statistics for the two regression models predicting WI scores appear in Table 3. In the first model, the BAI, BDI, and DOCS subscales collectively accounted for 24.7% of the variance in WI scores, which was significant, \( F(6,86) = 4.70, p < 0.001 \). As can be seen in Table 3, the BAI and the DOCS harm obsessions and checking compulsions subscale emerged as unique significant predictors (\( p < 0.003 \)).

In the second model, when the cognitions (i.e., OBQ-44 and ASI subscales) were entered as predictors, they collectively accounted for 22.6% of the variance in WI scores, which was significant, \( F(6,97) = 4.43, p = 0.001 \). As can be seen in the table, the ASI Physical concerns subscale and the OBQ Responsibility/threat estimation subscale emerged as significant individual predictors (\( p \) < 0.01 – 0.03).

4. Discussion

Illness anxiety symptoms are widely observed in patients with OCD and there are phenomenological and cognitive overlaps. Some authors (e.g., Deacon and Abramowitz, 2008) have proposed that illness anxiety (and IAD) is a “variant” of OCD, yet this has not been adequately studied. Our first hypothesis that illness anxiety would be associated with harm obsessions and checking rituals was supported. In fact, a robust association remained even after controlling for general distress and other OCD symptoms. This corroborates clinical observations that preoccupation with illness in IAD is characterized by unwanted obsession-like thoughts of harm befalling oneself (e.g., due to cancer) and frequent checking in the form of reassurance-seeking behaviors (e.g., unneeded diagnostic tests) that mirror compulsive rituals in OCD. Illness anxiety was not associated with other OCD symptoms, including contamination and washing symptoms. As previous investigations have found (Abramowitz et al., 1999), illness anxiety appears to concern diseases that are not communicable (e.g., cancer, heart disease) and thus might be distinct from obsessions with germs and washing rituals.

In partial alignment with our second hypothesis, illness anxiety symptoms were associated with the tendency to overestimate threat and responsibility for harm, but not with the need for certainty and intolerance of mistakes (i.e., perfectionism). As has been mentioned, the presence of health concerns among individuals with OCD is associated with poorer insight into the senselessness of obsessions and compulsions. Thus, individuals with such concerns may be more preoccupied with certainty of health-related harm (i.e., overestimates of threat of having or developing a serious medical illness), as opposed to the uncertainty of whether or not they are ill. Beliefs about the
importance and need to control thoughts had a significant zero-order association with illness anxiety, which is consistent with the previous finding that health-related intrusive thoughts are appraised as indicating responsibility for preventing harm (Freeston et al., 1994). This relationship disappeared, however, once the other predictors were accounted for (as discussed further below).

Our zero-order correlations also indicated that illness anxiety symptoms were associated with both the physical and social dimensions of AS. The former association is in line with previous research and clinical observations that illness anxiety is associated with the catastrophic misinterpretation of bodily sensations (e.g., thinking a tension headache might be a sign of brain cancer). In addition, among people with OCD, illness anxiety symptoms also were associated with the fear that others will notice and negatively evaluate the presence of anxiety-related body sensations (e.g., sweating). Perhaps health anxious individuals also harbor concerns about being perceived as ill by others. In our regression model using cognitive factors to predict health anxiety, the physical concerns domain of AS and the responsibility/threat overestimation domain of obsessive beliefs were the only variables that emerged as significant unique predictors. There are various reasons as to why the cognitive dimension of AS was not a significant predictor of illness anxiety. For example, it may be that individuals with illness anxiety are preoccupied with somatic experiences and/or observable related body sensations (e.g., sweating). Perhaps health anxious individuals also harbor concerns about being perceived as ill by others.

Our findings wield implications for understanding how illness anxiety is related to OCD, at least from a cognitive perspective. In particular, they suggest that illness anxiety may be conceptualized in the context of certain OCD symptom dimensions characterized by obsessions about harm from serious illnesses that are appraised as indicating a physical threat and that give rise to compensatory checking and reassurance-seeking compulsions. Given that individuals with IAD usually present to physicians for what they perceive to be medical problems, practitioners should be aware of the extent to which symptoms of illness anxiety may present within the context of OCD, specifically the responsibility for harm dimension. Accordingly, these findings support the need for nuanced assessment of illness anxiety in primary care settings.

The current study has limitations that should be considered, including its cross-sectional design and exclusive reliance on self-report methodology. The former drawback prevents us from being able to draw causal inferences, and the latter raises the possibility of inflated associations between study measures due to method invariance. Further, standardized diagnostic interviews were not used to assess for illness anxiety or other comorbidities. Updated measures of health anxiety (e.g., the Short Health Anxiety Inventory; SHAI; Salkovskis et al., 2002) and AS (i.e., ASI-3; Taylor et al., 2007) are also available, but were not used in the present study. Future investigations might include multiple assessment methods and updated measures as there have been some reports that the WI demonstrates only adequate reliability (Speckens et al., 1996). Further examination of insight into the seeming illogic of illness fears is also warranted (e.g., using measures like the Brown Assessment of Beliefs Scale; Eisen et al., 1998), as heightened illness anxiety in combination with poor insight may interfere with OCD treatment outcome. Additionally, the sample consisted exclusively of patients with primary OCD; accordingly, the current sample does not afford conclusions as to whether health anxiety is more strongly associated with OCD than to other anxiety-related conditions (e.g., generalized anxiety disorder). Furthermore, the dimension of obsessive beliefs that predicted health anxiety symptoms may not be specific to OCD (e.g., Tolin et al., 2006).

References


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