EDITORIAL

HYPOCHONDRIASIS AND ILLNESS BEHAVIOR

The definition and exact nosological status of hypochondriasis have for long been a subject of debate. Jelliffe (1931) referred to it as "a strange child in the psycho-pathological family" and Macalpine (1953) used the phrase "a step child in psychiatry proper". It has been described in terms of the disturbed attitudes to doctors as well as health as a concept and also in terms of the symptoms presented.

The word hypochondriasis itself has multiple connotations and has often been used by both clinicians and the lay public with different meanings. Three common usages are:

a) It can mean a morbid concern with health and with protecting one's healthy status. Such persons may be preoccupied with health foods and patent medicines to delay aging etc. Many of them do not complain at all of ill health, and in fact, may protest their healthiness, linking it to the measures they have taken to protect it.

b) It can be used to describe a group of individuals who seem to pursue ill health as a way of life. These appear to enjoy bad health and collect new symptoms and shed old ones as they progress through life.

c) It can describe a conviction of the actual disease or a fear of developing serious disease.

A normal individual, as one can often discover by introspection, is subject at all times to somatic sensations slightly below the level required to claim the attention of consciousness. These sensations, as a rule, pass unheeded and do not form the subject of complaint. However, in hypochondriacal states these sensations seek conscious appreciation and are felt to be the cause of discomfort or malaise. These may go on to interfere with normal activity, and hence become the symptoms of illness. Though there is the usual amount of normal variation in the liability to hypochondriasis, the tendency is sufficiently universal to provoke exploitation by manufacturers of laxatives, backache pills, patent medicines and remedies which are usually sold across the counter. This commercial exploitation itself increases the diffusion of this tendency through the population, and has, for instance, led to what has been termed 'a national hypochondriacal neurosis centered on constipation' (Slater & Roth, 1977).

Current concepts of hypochondriasis rest on usage (c) mentioned above, i.e., the preoccupation with or the conviction that one has a disease. DSM III-R (APA, 1987) requires that, apart from the preoccupation with the disease which persists despite of medical reassurance, and absence of physical findings, there should be a minimum duration of six months. However, ICD-10 (WHO, 1992) specifies no such duration; both systems are clear about the non-delusional nature of the belief.

The notion of illness behavior was introduced by Mechanic (1962), and it refers to the ways in which symptoms may be differentially perceived, evaluated and acted upon by different kinds of persons. Pilowsky further refined the concept of "abnormal illness behavior" in 1969 and proposed that number of psychiatric syndromes (such as hypochondriasis, conversion reaction, malingering etc.) may be viewed as varying dimensions along the same spectrum of illness behavior.

Kenyon (1976) recommended that the term hypochondriasis be dropped and that "hypochondriacal" be retained only as a descriptive term. The large majority of hypochondriacal symptoms appear to be secondary to other disorders especially depressive illness, paranoid psychosis, schizophrenia and anxiety states. However two large studies (Kenyon, 1964; Lader & Sartorius, 1968) could not isolate a clear cut primary state of hypochondriasis. In both studies, the heterogenous group of hypochondriacal states could be allocated to other psychiatric syndrome of which hypochondriasis was only a symptom. However, Pilowsky (1967) described 60 patients with primary and 88 with secondary hypochondriasis. This distinction was important, for at follow up, 50% of the primary group described their symptoms as unremitting or continuous compared with only 17% of the secondary group. The latter were nearly always secondary to an affective disorder.

Attempts to study hypochondriasis have been varied. The Hypochondriasis scale of the Minnesota Multiphasic Personality Inventory (MMPI) has been used by Conrey (1957) and O'Connor and Stelc (1959). Factors extracted in these studies related mainly to clusters of physical symptoms. This was due to the fact that the MMPI Hypochondriasis scale is mainly a symptom inventory and there are no items which tapped the individual's attitudes to diseases or the reactions of those in his environment. To overcome this, a questionnaire called the 'Whiteley Index' was devised and validated by Pilowsky (1967). Seventeen questions were found to have discriminatory value between hypochondriacal and non-hypochondriacal patients. Further work in this area led to the development of the 'Illness Behavior Questionnaire' (IBQ) (Pilowsky & Spence, 1983), a self reported inventory. This was translated and adapted to the Indian situation by Varma et al (1986).

Indian research in this field is scanty. Several questions need to be addressed such as the prevalence of hypochondriasis in India, nature of symptomatology across various sub-cultures and the extent to which these are secondary to other major psychiatric illnesses, such as depression. This issue of the Journal contains an invited article by Prof. J. Pilowsky, an authority in the field. It is hoped that this overview of illness behavior will prompt...
further work in this area and throw light on illness behavior and hypochondriasis across cultures.

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