

Hypochondriasis and Depression as functions of Aging

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ABSTRACT

The scientific study of aging and aged is comparatively of recent origin. The interest in the field of Gerontology is growing very rapidly not only in the developed countries of the world but also in the developing countries, particularly in India, where the aging population is in the frontline. The first pre-requisite for a happy and productive old age is good health. An attempt was made in the present investigation to study the impact of age and sex on hypochondriasis and depression. One hundred aged men and women in the age group of 40 to 60 years and 60+, living in rural areas of A.P. were selected at random on their willingness to participate in the study. Hypochondriasis and depression were assessed by using MMPI. 't' test was employed to analyze the data. The findings of the study revealed that hypochondriasis and depression were significantly influenced by their backgrounds.

Keywords: Hypochondriasis, Depression

The twenty-first century can be called as the 'age of the aging' because one of the greatest challenges of the present century is increase in numbers and proportions of elder persons in the world. The scientific study of aging and aged is comparatively of recent origin. The interest in the field of Gerontology is growing very rapidly not only in the developed countries of the world but also in the developing countries, particularly in India, where the aging population is in the frontline. The first pre-requisite for a happy and productive old age is good health.

Many people tend to regard old age as being just one step away from the grave. Indeed, some would rather die than grow old in view of depleting physical and psychological resources and increasing dependencies on others. In general, old age is characterized by disabilities, diseases and dependencies. Therefore, the fear of growing old is probably one of the most common fears in our society. In order to help old people cope with problems associated with aging the family, the community and the state have to undertake necessary welfare measures to make life in old age livelier.

All human beings age and become old if they live long enough. Old age beset with various kinds of problems-health, psychological and economic, in a social-familial setting. These

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problems are interdependent and interactive in nature (Raihamurti, 1970). As one ages, the physiological systems become increasingly less efficient and less resistant to diseases. Consequently, the individual undergoes sufferings, disease and disability with accompanying helplessness and frustration produce depression and stress. Added to the problems of a physically wearing out systems are social and psychological consequences of aging. Retirement and reduced income, the social stigma associated with old age, abundant leisure without suitable avenues for occupation of time and social interaction are only some of the more important factors that add to the experience of stress and depression in old age (Kumar, 1988).

It has been documented that the elderly are prone to psychological problems, among which depression and hypochondriasis are the commonest. In fact, the elderly in India face a multitude of psychological, social and physical health problems. As the age advances, there is increased morbidity and functional loss, the presence of a variety of depressive factors and the occurrence of varying life events like the death of the spouse, retirement and interpersonal difficulties with family members, poverty and loneliness. These situations greatly impact the psychological statuses of the elderly, making them prone to depression and hypochondriasis. Under these unfavorable circumstances even well integrated personality may break down and may pose serious threats. Thus, at this turn of the century, man facing two hazardous mental health problems—the problem of hypochondriasis and the problem of depression.

Hypochondriasis is a disorder that has been well known for centuries but not well studied. In fact, although both clinicians and laypersons immediately have an image of someone who exaggerates the significance of their physical symptoms, many physicians don't know what to do for such a patient. Family members and friends often reassure the person that there is nothing wrong with them, and physicians, armed with medical test results, often do the same. Unfortunately, the patient never seems satisfied and continues to be preoccupied with his or her symptoms.

Hypochondriacs feel that they suffer from every new disease they read or hear about and that they cannot recover. They are on the alert about the latest medical treatment and are prone to the indiscriminate use of a wide range of medication (Coleman, 1976).

Hypochondriasis is a somatoform disorder marked by excessive fear of or preoccupation with having a serious illness that persists in spite of medical testing and reassurance. It was formerly called hypochondriacal neurosis.

Hypochondriasis also known as hypochondria, health phobia, health anxiety or illness anxiety disorder, refers to worry about having a serious illness. This debilitating condition is the result of an inaccurate perception of the condition of body or mind despite the absence of an actual medical condition. An individual suffering from hypochondriasis is known as a hypochondriac. Hypochondriacs become unduly alarmed about any physical or psychological symptoms they detect, no matter how minor the symptom may be, and are convinced that they have, or are about to be diagnosed with, a serious illness.

The DSM-IV describes the core symptom present in hypochondriasis (HC) as the perception of having a serious disease based upon the misinterpretation of one or more bodily signs and symptoms (American Psychiatric Association, 1994). The term "hypochondrium" can be traced back to Hippocrates, who used it in 400 B.C. to describe the superolateral region in the abdomen. In ancient times it was believed that hypochondriasis was due to disturbed function

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of organs in this region. Over the years the term has taken on a negative connotation and therefore it has at times been replaced by the terms "health anxiety," "illness phobia" and "somatic preoccupation."

In order to receive a DSM-IV-TR diagnosis of hypochondriasis, a person must meet all six of the following criteria:

- The person must be preoccupied with the notion or fear of having a serious disease. This preoccupation is based on misinterpretation of physical symptoms or sensations.
- Appropriate medical evaluation and reassurance that there is no illness present do not eliminate the preoccupation.
- The belief or fear of illness must not be of delusional intensity. Delusional health fears are more likely to be bizarre in nature—for instance, the belief that one's skin emits a foul odor or that food is rotting in one's intestines. The preoccupations must not be limited to a concern about appearance; excessive concerns that focus solely on defects in appearance would receive a diagnosis of body dysmorphic disorder.
- The preoccupation must have lasted for at least six months.
- The person's preoccupation with illness must not simply be part of the presentation of another disorder, including **generalized anxiety disorder**, obsessive-compulsive disorder, panic disorder, separation anxiety, major depressive episode, or another somatoform disorder.

The primary feature of hypochondriasis is excessive fear of having a serious disease. These fears are not relieved when a medical examination finds no evidence of disease. People with hypochondriasis are often able to acknowledge that their fears are unrealistic, but this intellectual realization is not enough to reduce their anxiety. In order to qualify for a **diagnosis** of hypochondriasis, preoccupation with fear of disease must cause a great deal of distress or interfere with a person's ability to perform important activities, such as work, school activities, or family and social responsibilities. Hypochondriasis is included in the category of somatoform disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), which is the reference handbook that clinicians use to guide the diagnosis of mental disorders. Some experts, however, have argued that hypochondriasis shares many features with *obsessive-compulsive disorder* or *panic disorder* and would be more appropriately classified with the anxiety disorders.

The fears of a person with hypochondriasis may be focused on the possibility of a single illness, but more often they include a number of possible conditions. The focus of the fears may shift over time as a person notices a new symptom or learns about an unfamiliar disease. The fears appear to develop in response to minor physical abnormalities, like *fatigue*, aching muscles, a mild cough or a small sore. People with hypochondriasis may also interpret normal sensations as signs of disease. For instance, an occasional change in heart rate or a feeling of dizziness upon standing up will lead a person with hypochondriasis to fears of heart disease or **stroke**. Sometimes hypochondriacal fears develop after the death of a friend or family member, or in response to reading an article or seeing a television program about a disease. Fear of illness can also increase in response to **stress**. Individuals with hypochondriasis visit physicians frequently; and when told there is nothing physically wrong, they are likely to seek a second opinion since their fears are not soothed. Their apparent distrust of their physicians' opinions can cause tensions in doctor-patient relationships, leading to the patient's further dissatisfaction with health care providers. Physicians who regularly see a patient with hypochondriasis may become skeptical about any reported

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symptom, increasing the danger that a real illness may be overlooked. People with hypochondriasis also run the risk of undergoing unnecessary medical tests or receiving unneeded medications. Although they are usually not physically disabled, they may take frequent sick days from work, or annoy friends and family with constant conversation or complaints about illness, reducing their ability to function effectively in some aspects of life. Depression, on the other hand, is chronic sadness characterized by negative emotions and reduced physical activity. In spite of tremendous technological advances, we have not been able to ensure ourselves to solve many problems of mental health. However, numerous attempts have been made to relate hypochondriasis and depression to social, cultural, and individual variables. Out of all the variables aging and sex seem to play a significant role in this casual-model-concept of these mental states.

The depression in the elderly should never be considered as a natural consequence of ageing. It usually has an atypical presentation. It can manifest as a symptom eg: as a reaction to stress: as a syndrome ex: secondary to hypertension or Parkinson's disease; and as an illness e.g. endogenous depression. Depression as a major risk factor for suicide among the elderly also has been reported.

In India, most of the elderly live in the rural areas and the access to the health care facilities is meagre. The depressive symptoms are likely to be dismissed as "normal" by the older persons, their family members and even by health care providers. Given the relative ease with which the depressive illness can be diagnosed and treated, there is enormous potential for alleviating this largely neglected public health burden among the elderly. Community studies from India on the depression among the elderly are sparse.

There has been little systematic and comprehensive effort to study the pattern of hypochondriasis and depression across cultures (Holingshead and Redlich, 1958, Srivastava, 1983). In a study on aborigines of Australia western desert, classical neurotic patterns could not be found but it was noted that as these groups were increasingly exposed to contemporary civilization, hypochondriac concerns and other somatic complaints occurred (Kidson and Jones, 1968).The findings of these studies are quite contradictory and far from helping in arriving at any conclusion.

Sex roles with regard to hypochondriasis and depression may vary among different social classes and cultures. It has largely been explored by investigators and found that hypochondriac complaints were unrelated to sex differences (Aikows and Yoshibumi, 1978). Similarly, no sex difference was obtained on measures employed in MMPI (Dobson, 1958). In a study, age and sex were not found to be significant predictors of depression (Aneshensel and Yokopenic, 1985). Thus sex role has largely been explored but the results are not uniform.

Many people tend to regard old age as being just one step away from the grave. Indeed, some would rather die than grow old in view of depleting physical and psychological resources and increasing dependencies on others. In general, old age is characterized by disabilities, diseases and dependencies. Therefore, the fear of growing old is probably one of the most common fears in our society which leads to hypochondriasis and depression.

In a third world country like India the lives of many persons are mostly hand to mouth which only adds fuel to fire in the accentuation of the normal problems of the elderly. Also, Indian culture being different from that of the western world, several cultural factors may influence

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hypochondriasis and depression. However, there are any investigation on the impact of age and sex on hypochondriasis and depression among the Indian elderly.

Against this background, the present investigation was designed to explore the effect of aging and gender on hypochondriasis and depression.

Hypotheses

Keeping in view the objective of the study the following hypotheses were formulated for empirical verification:

1. Depression and hypochondriasis would be different at different age levels
2. Male and female aged would differ significantly in terms of Depression and hypochondriasis.

METHODOLOGY

Sample

One hundred subjects in two age groups (between 40 - 60 and above 60) were selected at random on the basis of their willingness to participate in the study. Out of this hundred subjects fifty were male and fifty were female. The sample was drawn from, Tirupati, Chittoor district of Andhra Pradesh. For obvious reasons, equal number of samples from both groups was finally selected. The final sample was subdivided in different subgroups with regard to age and gender.

Tools

Hypochondriasis and Depression Scale: Both Hypochondriasis and Depression Scales consisted of 10 items in each, selected from the original 33 and 61 items Scale of MMPI respectively. Items, having high validity were included in the H-D scale (1—.65 to .92). The Hypochondriasis scale was designed to assess generalized aches and pains, specific complaints about digestion, breathing, thinking, vision and sleep as well as peculiarity sensation, unhappiness, mood swings, fatigue, worthlessness, loss of appetite, palpitation and similar symptoms of depression. All the items could be answered as 'true and false' and were scored as per manual of instructions of MMPI.

Each subject was individually approached at their residence and requested to answer the items in the questionnaire. Responses of illiterate subjects were marked by the investigator. In addition, the interview contained to number of questions designed to elicit demographic data and supplementary information.

RESULTS AND DISCUSSION

The purpose of this investigation was to study the differential patterns of hypochondriasis and depression among rural aged who differed in their age and sex. From the data obtained Means, standard deviations and 't' ratio were computed for statistical analysis. The results have been given table 1 and 2

Table-I: Means, SDs and t-Values between two groups on Hypochondriasis.

Variables		Mean	SD	t-Values
Sex	Male	5.18	1.2	2.64 **
	Female	5.9	1.45	
Age	40-60	6.22	1.28	2.03
	60+	6.85	1.75	

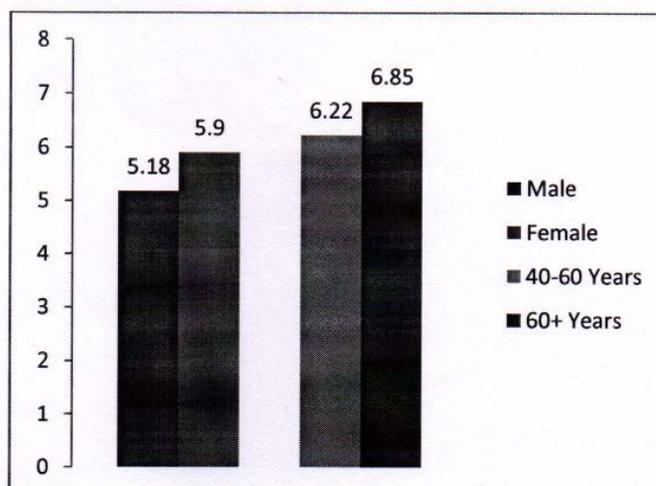
*- Significant at 0.05 level

** - Significant at 0.01 level

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Table 1 presents the means, standard deviations and *f* ratios for age and sex on hypochondriasis scale separately. A close observation of Table-1 shows that female subjects (M= 5.90) and the subjects in the age group of 60+ years have obtained high score(M= 6.85) on hypochondriasis scale than the male (M=5.18) and the age group of 40-60years (M=6.22), indicating high hypochondriacal patterns in female and the subjects in the age group of 60+ years.

Fig:1. Graphical Representation of Hypochondriasis in relation to Sex and Age.



This indicates a significant difference in the mean values of the subjects between 40 and 60 and 60+ years ($t= 2.64$) as well as male and female subjects ($t= 2.03$) in relation to hypochondriasis. As the *T* values are significant the first and second hypothesis, which stated that age and sex would significantly influence the patterns of hypochondriasis, is accepted as warranted, by the results. As age increases, the age group of 60+ years shows more symptoms of hypochondriasis than the age group of 40-60 years. In terms of sex, female subjects have more hypochondriacal symptoms than male subjects and the differences are statistically significant. Higher levels of morbidity were associated with higher levels of hypochondriasis. This was because the most serious illnesses were associated with higher levels of hypochondriasis. Worries about health and illness are a common experience and there is a perception that as a person ages, they become more pre occupied by and worried about their health.

Factors that may contribute to increased health anxiety or patterns of hypochondriasis are psychological distress, medical morbidity, frailty and social isolation (Snyder and Stanley, 2001; Marcus et al., 2007). As people age, they are more likely to worry about their health, particularly if they have an anxiety disorder (Montorio et al., 2003; Lindsay et al., 2006). Some studies showed a positive correlation between hypochondriasis and age (Rief et al., 2001).

Cognitive behavioural theory of health anxiety assumes that innocuous symptoms and stimuli are misinterpreted as a serious threat to health or sign of illness (Warwick and Salkovskis, 1990). These dysfunctional assumptions about health and illness arise from factors such as anxious temperament and childhood experience of illness in self or others. When vulnerable individuals are exposed to a stressor, negative cognitions about health are activated and the patterns of hypochondriasis increases. Hypochondriasis may be heightened by actual disease and somatic change due to increased physical decline. These might be the

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reasons why female and the subjects in the age group of 60+ years have high hypochondrical patterns than the male and the age group of 40-60 years.

Table-2: Means, SDs and t-Values between two groups on Depression.

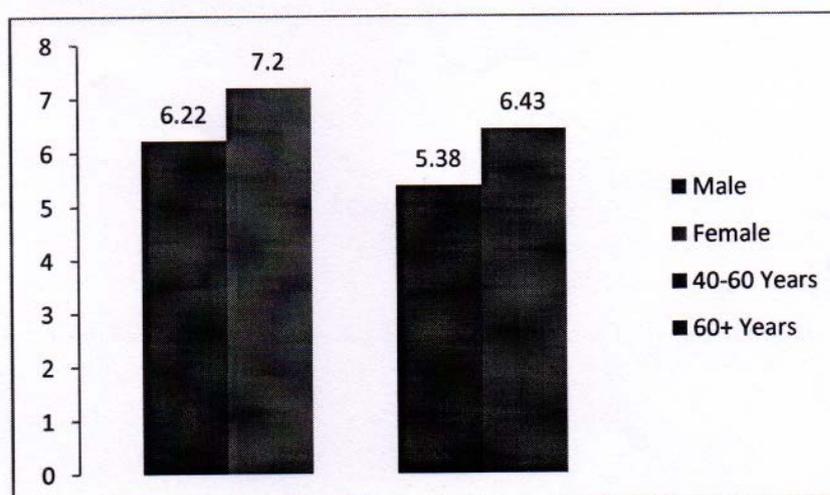
Variables		Mean	SD	t-Values
Sex	Male	6.22	1.26	3.66 **
	Female	7.2	1.92	
Age	40-60	5.38	1.75	3.21 **
	60+	6.43	1.5	

** - Significant at 0.01 level

The analysis displayed in table-2 clearly shows that female subjects obtained statistically higher score (M=7.20) than male (M=6.22) on depression and the subjects in the age group of 60+ years have obtained higher score (M=6.43) than the age group of 40-60 years (M=5.38). This indicates a significant difference in the mean values of the subjects between 40 and 60 and 60+ years ($t = 3.21$) as well as male and female subjects ($t = 3.66$) in relation to depression.

As the T values are significant the first and second hypothesis, which stated that age and sex would significantly influence the depression, is accepted as warranted by the results.

Fig:2. Graphical Representation of Depression in relation to Sex and Age.



The differences in the mean scores of depression between the male and female subjects were statistically significant ($t = 3.66$).

The reasons for these gender differences are not clear, and some believe that females are more "sensitive" and therefore more likely to report symptoms of depression. Living alone or negligence by the family members, a poor status in the family, increased physical dependency, lack of income and poor health may be the reasons for the increased prevalence of depression among the elderly females. Compared to men, women are much more subjected to fluctuating hormone levels. This is especially the case around the time of childbirth and at the menopause, both of which are associated with an increased risk of developing depression. Ramachandran et al., (1982) study observed that depression was significantly more frequent in females than in males, which was similar to the findings of the present study. Goswami et

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al.,(2006) study found that the prevalence of depression was 44.5% and 63.2% among male and female subjects respectively. In the study of Jain, the prevalence of depression was found to be 45.9% in males and 57.8% in females, with the mean score being 5.10+8.26.

Findings which were similar to those of the current study were also observed in the studies which were conducted by Jariwala Vishal et al.,(2010), Nandi et al.,(1997) and Rajkumar et al. (2009) The increased dependency for the activities of daily living and the associated economic dependency, a poor status in the family, loss of the caring spouse, a lack of leisure time activities, an increased feeling of loneliness and poor health may have been the reasons for the increased prevalence of depression in females.

It is evident from the Table-2 that the depression of the subjects in the age group of 60+ is higher than the 40 years. It also shows significant difference in the mean values of the subjects between 40-60 and 60+ years. Elderly subjects in 60+ years scored significantly higher mean score than the subjects between 40-60 years. This seems to be to the fact that aging induces general apathy and feeling of malaise. There is high level of dependence and incapacity in older persons who crosses 60 years. So they are more susceptible to depressive reactions.

The changes that often come in later life -retirement, the death of loved ones, increased isolation, and medical problems can lead to depression in the age group of 60+ years than 40-60 years. As one ages the physiological systems become increasingly less efficient and less resistant to diseases. Consequently, the individual under goes sufferings, disease and disability with accompanying helplessness and frustration produce depression and stress. Added to the problems of a physically wearing out systems are social and psychological consequences of aging. Retirement and reduced income, the social stigma associated with old age, abundant leisure without suitable avenues for occupation of time and social interaction are only some of the important factors that add to the experience of depression in the age group of 60+ than 40-to 60 years.

CONCLUSIONS

In a nutshell, the present study clearly reveals that:

1. Age has significant influence on Depression and hypochondriasis . The subjects in the age group of 60+ have high depression and hypochondriac patterns than the subjects in the age group of 40-60 years.
2. Male and female aged differed significantly in terms of depression and hypochondriasis. Female subjects have high depression and hypochondriac patterns than the male subjects. However, the findings of this study cannot be generalized as it was conducted on limited sample. The issue warrants further investigation with better design and samples.

Implications

The present investigation has brought out the impact of sex and age on hypochondriasis and depression. The present finding implies that female and the subjects in the age group of 60+ years have the patterns of hypochondriasis and depression. There appears to be urgent need for sort of counseling for the rural aged that would be meaningful and helpful in overcoming the symptoms of hypochondriasis and depression. Psychologists, Social workers and N.G.Os need to extend their expertise to the services of the aged by giving training programmes. Doing research on the treatments for hypochondriasis and depression, integrating them in the training programmes for the community and for the general health workers and collaborating

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with non-governmental organizations are the key factors for meeting the mental health needs of the elderly subjects.

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Conflict of Interest

The authors carefully declare this paper to bear not conflict of interests

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