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A community study of generalized anxiety disorder with vs. without health anxiety in Hong Kong

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ABSTRACT

Background: Although generalized anxiety disorder (GAD) is characterized by multiple worries, anxiety about one's health is absent in the DSM-IV description of the illness.
Method: A random community-based telephone survey ($N = 2005$) that covered DSM-IV symptoms of GAD, two core symptoms of major depression, Rome-III criteria of Irritable Bowel Syndrome (IBS), Sheehan Disability Scale (SDS), and help-seeking behavior was conducted.
Results: The 1-year prevalence of 3-month GAD was 5.4%. Among affected individuals, 78.9% reported worry about personal health while 21.1% did not. The former subgroup was significantly older, had higher mean numbers of associated anxiety symptoms and worries, more likely to have worry about finances and sought professional help than the latter subgroup. The two subgroups had similar sex distribution, core depressive symptoms, IBS, distress and SDS impairment profiles.
Conclusion: Health anxiety is common in GAD. Some but not all illness severity indicators differed between GAD with and without health anxiety.

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Hypochondriasis, as strictly defined in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR) (American Psychiatric Association [APA], 2000) or the tenth revision of the International Classification of Diseases (ICD-10) (World Health Organization [WHO], 1993), is uncommon and has a 6-month clinical prevalence ranging from 0.8% to 4.6% (Escobar et al., 1998; Fink, Sørensen, Engberg, Holm, & Munk-Jørgensen, 1999; Gureje, Üstün, & Simon, 1997). When thus clinically defined, it does not capture less severe forms of health anxiety that is dimensionally distributed in community and clinical settings (Asmundson, Abramowitz, Richter, & Whedon, 2010; Ferguson, 2009). Community-based studies indicated that as many as 10% of people exhibited health anxiety or the conviction of a serious illness, as measured by item 64 of the Screening for Somatoform Symptoms (SOMS) which measures the core feature of hypochondriasis (Rief, Hessel, & Braehler, 2001). Another community study using the Illness Attitude Scales (IAS) reported that 9.9% of subjects were often or usually worried that they would develop a serious illness (Bleichhardt & Hiller, 2007). Regarding clinical studies, Abramowitz, Olatunji, and Deacon (2007) noted that "Hypochondriasis is not the only psychological disorder that involves health concerns. Clinical observations and empirical research indicate that anxiety over health-related matters is a feature of several anxiety disorders." (p. 1). Among the anxiety disorders, generalized anxiety disorder (GAD) is characterized by multiple worries and may be particularly likely to involve health concern. It is not surprising that the DSM-V has proposed to include "health anxiety" as one of the domains of worry in GAD (APA, 2010).

Intriguingly, the DSM-IV-TR and ICD-10 have not included "health anxiety" in the diagnostic description of GAD. The DSM-IV-TR (APA, 2000) says that "Adults with GAD often worry about everyday, routine life circumstances such as possible job responsibilities, finances, the health of family members, misfortune to their children, or minor matters (such as household chores, car repairs, or being late for appointments") (p. 473). Although worry about the health of family members is described, worry about one's own health is missing. The ICD-10 (WHO, 1993) also does not include health anxiety in the diagnostic description of GAD, though it mentions that "Fears that the patient or a relative will shortly become ill or have an accident are often expressed." The Structured Clinical Interview for DSM-IV (SCID) (First, Spitzer, Gibbon, & Williams, 2002) does not specify the domains of worries that may occur in GAD. It suggests that interviewers should probe "worry about a number of events or activities" but does not mention health anxiety specifically. SCID interviewers may therefore not ask about health anxiety prior to the somatoform disorders module unless an interviewee initiates to mention it earlier on during the assessment. Consequently, clinical studies on GAD and other anxiety disorders

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may not document the presence of health anxiety that does not reach the diagnostic threshold of hypochondriasis. It is perhaps not surprising that a detailed review of GAD does not mention health anxiety (Rickels & Rynn, 2001). Yet, in discussing the DSM-V options for GAD, Andrews et al. (2010) advised that "The DSM-IV examples of the worry domains appear accurate but inserting 'family, health, and finances' would better reflect the events that are of most concern to GAD patients" (p. 5). The epidemiological and clinical implications of including health anxiety in the diagnosis of GAD are presently unknown.

To our knowledge, no study has examined how common health anxiety in GAD is and how GAD with and without health anxiety may differ in a general population. As a result, the prevalence, socio-demographic profile, severity, impairment, and help-seeking behavior of GAD with and without health anxiety are unknown. Yet, such information is helpful for both nosological and clinical reasons. In this present study, we hypothesize that GAD with health anxiety is common in the community and differs from GAD without health anxiety by some sociodemographic and illness severity indicators.

1. Method

1.1. Sample

A sample of 2005 respondents aged 15–65 years (949 males and 1056 females) was interviewed in a structured telephone survey that examined the prevalence and comorbidity of GAD and Irritable Bowel Syndrome (IBS) (Lee, Wu, et al., 2009). Since over 99% of the domestic households in Hong Kong have a telephone at home (Census & Statistics Department [CSD], 2006) and very few of them have more than one telephone line, the random sampling of telephone lines should generate a representative sample of households. Among the 5212 valid telephone numbers randomly selected from the Hong Kong telephone directory (with the final two digits randomized), 1321 hung-up immediately, 879 had no interviewee in the suitable age range and 1007 rejected the interview. A total of 2005 respondents completed the interview. This resulted in a participation (or cooperation) rate of 66.6% $[2005/(5212-1321-879)\times 100\%]$ in accordance with the recommendation for reporting response rate in telephone surveys (Johnson and Owens, 2003). A strict response rate that took account of those who simply hung up would be 46.3% $[2005/(2005+1007+1321)\times 100]$. Age distributions of our final sample in years were highly comparable to figures from the Census and Statistics Department (CSD, 2006) (Table 1).

Table 1
Socio-demographic characteristics of respondents.

	Total sample (n = 2005)	
	n	% (Census % 2006)[a]
Gender		
Female	1056	52.6 (52.8)
Male	949	47.4 (47.2)
Age		
15–24	351	17.5 (17.9)
25–34	404	20.2 (20.7)
35–44	508	25.4 (24.6)
45–54	467	23.3 (23.5)
55–65	274	13.7 (13.2)
Education level		
Primary or below	257	12.8 (17.1)
Secondary	973	48.5 (50.5)
Pre-college	203	10.1 (15)
College or above	558	27.8 (17.3)
Work status		
Employed	1234	61.5
Unemployed	149	7.4
Retired	115	5.7
Student	242	12.1
Take care of the family	264	13.2
Marital status		
Single	734	36.6 (37.2)
Married/living together	1222	61.0 (57.1)
Previously married	49	2.4 (5.6)
Income level		
HKD30000 or below[b]	1449	72.3
HKD30000–$60000	403	20.1
HKD60000 or above	152	7.6

[a] Data from the Census and Statistics Department, HKSAR, 2006.
[b] USD1 = HKD7.8 approximately.

1.2. Instrument

The survey instrument was a 40-item Chinese questionnaire that covered demographic information, diagnostic symptoms of GAD and two core depressive symptoms based on DSM-IV-TR criteria (APA, 2000), symptoms of IBS based on Rome III criteria (Longstreth et al., 2006), impairment as measured by the Sheehan Disability Scale (SDS), and help-seeking behavior.

1.2.1. Diagnostic criteria for GAD

In order to analyze a larger group of respondents with generalized anxiety, we used a duration criterion of 3 months or more instead of 6 months or more (APA, 2000) in the present study. This was possible because the survey instrument asked respondents to report the number of months that their worry lasted. A 3-month duration for the diagnosis of GAD was consistent with a large-scale cross-national community study which found little difference between GAD of 6 months' duration and GAD of shorter durations in terms of age of onset, symptom severity, persistence, co-morbidity and impairment (Lee, Tsang, Ruscio, et al., 2008). It was also in keeping with what the DSM-V workgroup on anxiety disorders has recently proposed (APA, 2010). Thus, a diagnosis of GAD was made if a respondent reported [1] excessive anxiety and worry, occurring more days than not for 3 months about a number of events or activities; [2] difficulty in controlling the worry; [3] three or more of the six DSM-IV symptoms of GAD in the same 3-month period; and [4] significant distress (extremely or very distressed) or impairment (extremely or very impaired) brought about by anxiety symptoms. Such a telephone-based assessment of GAD had been used in previous community studies (Lee, Ma, Tsang, & Kwok, 2009) and was found to be conservatively concordant with the clinical diagnosis of GAD made by psychiatrists using the SCID (First et al., 2002; Lee, Tsang, Lau, et al., 2008). Respondents were asked whether they had experienced worries or anxiety about six domains of life in the previous year. Domains included worries connected with health, school/work, family, interpersonal relationships, finances and worry for no reason. Multiple dichotomous (yes/no) replies were allowed. Respondents who fulfilled the criteria for GAD of three or more months' duration were divided into two subgroups: those who had health-related worries (health anxiety group) and those who did not (non-health anxiety group).

1.2.2. Sheehan Disability Scale

Respondents rated how GAD interfered with four domains of living as assessed in the SDS: (1) home responsibilities, (2) school/work, (3) close relationships, and (4) social life. They could give a score from 0 to 10, with "0" representing "no interference" and "10" representing "very severe interference". An SDS total impairment score was obtained by adding the four subscale scores. The SDS had been used repeatedly in various Chinese studies (Lee, Wu, et al., 2009; Shen et al., 2006; Su et al., 2007).

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