

A community-based epidemiological study of health anxiety and generalized anxiety disorder



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ABSTRACT

This community-based study examined the frequency of worry about personal health in respondents with and without generalized anxiety disorder (GAD), and the impact of health anxiety on the disorder. A random community-based telephone survey of 5118 Chinese respondents aged 18–64 was conducted. A fully structured questionnaire covered the DSM-IV-TR criteria of GAD, major depressive episode (MDE), eight domains of worry, the seven-item Whiteley Index (WI-7), health service use, and socio-demographic information. Worry about personal health ranked fifth (75.6%) among eight domains of worries examined. GAD respondents with high level of health anxiety were significantly older, less educated, and had lower family income. High health anxiety significantly increased the occurrence of one-year MDE, previous persistent worry, previous persistent low mood, number of domains of worries, number of non-core DSM-IV-TR GAD symptoms, health service use, and mistrust of doctors. Health anxiety is common in GAD and may signify greater severity of the disorder.

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1. Introduction

Although health anxiety is common in both clinical and community settings (Asmundson, Abramowitz, Richter, & Whedon, 2010; Conrath, Cavanagh, Franklin, & Rief, 2006; Ferguson, 2009; Lee, Ng, Ma, Tsang, & Kwok, 2011; Rief, Hessel, & Braehler, 2001), the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR) (American Psychiatric Association (APA, 2000)) captures pathological worry about personal health by the specific diagnostic category of hypochondriasis. However, estimates of the prevalence of hypochondriasis in clinical settings have yielded variable findings (.8–6.3%; Barsky, Wyshak, Klerman, & Latham, 1990; Escobar et al., 1998; Faravelli et al., 1997; Fink, Sørensen, Engberg, Holm, & Munk-Jørgensen, 1999; Gureje, Üstün, & Simon, 1997). Besides, health anxiety has been observed in many other mental disorders (Bouman, 2005; Sunderland, Newby, & Andrews, 2013). This may apply especially to anxiety disorders such as panic disorder, generalized anxiety disorder (GAD), and obsessive-compulsive disorder (Taylor & Asmundson, 2004). Of the different types of anxiety disorders, GAD has undergone various diagnostic controversies and changes over the decades (Andrews et al., 2010; APA, 1980, 1987, 1994; Kessler, 2000). In the

DSM-IV-TR, GAD is characterized by the core symptom of pathological and excessive worry about several domains of life (APA, 2000). It may conceivably be associated with health anxiety which is also characterized by excessive worry, specifically on personal health issues.

Nonetheless, the DSM-IV-TR describes various sources of worries such as job responsibilities, finances, health of family members, misfortune to children, or miscellaneous minor matters (APA, 2000), but not personal health worry. Likewise, the tenth version of the International Classification of Diseases (ICD-10) (World Health Organization (WHO, 2010)) states that “fears that the patient or a relative will shortly become ill or have an accident are often expressed” in the description of GAD. There is no mention of personal health anxiety. Like the DSM-IV-TR, the ICD-10 includes the diagnostic category of hypochondriasis which captures severe clinical health anxiety.

Although empirical studies on the relationship between health anxiety and GAD are limited, we expect them to demonstrate a positive association. Thus, Sunderland et al. (2013) examined the prevalence of health anxiety and its socio-demographic and health risk factors in the Australian general population. Health anxiety was found to be significantly associated with any anxiety or affective disorder. Specifically, GAD, panic disorder, agoraphobia, and bipolar disorder were more likely to be associated with health anxiety. It is worthy of note that respondents with a lifetime history of health anxiety were about six times more likely to experience GAD. This study suggested a close relationship between health anxiety and GAD. Nonetheless, that relationship could not be further

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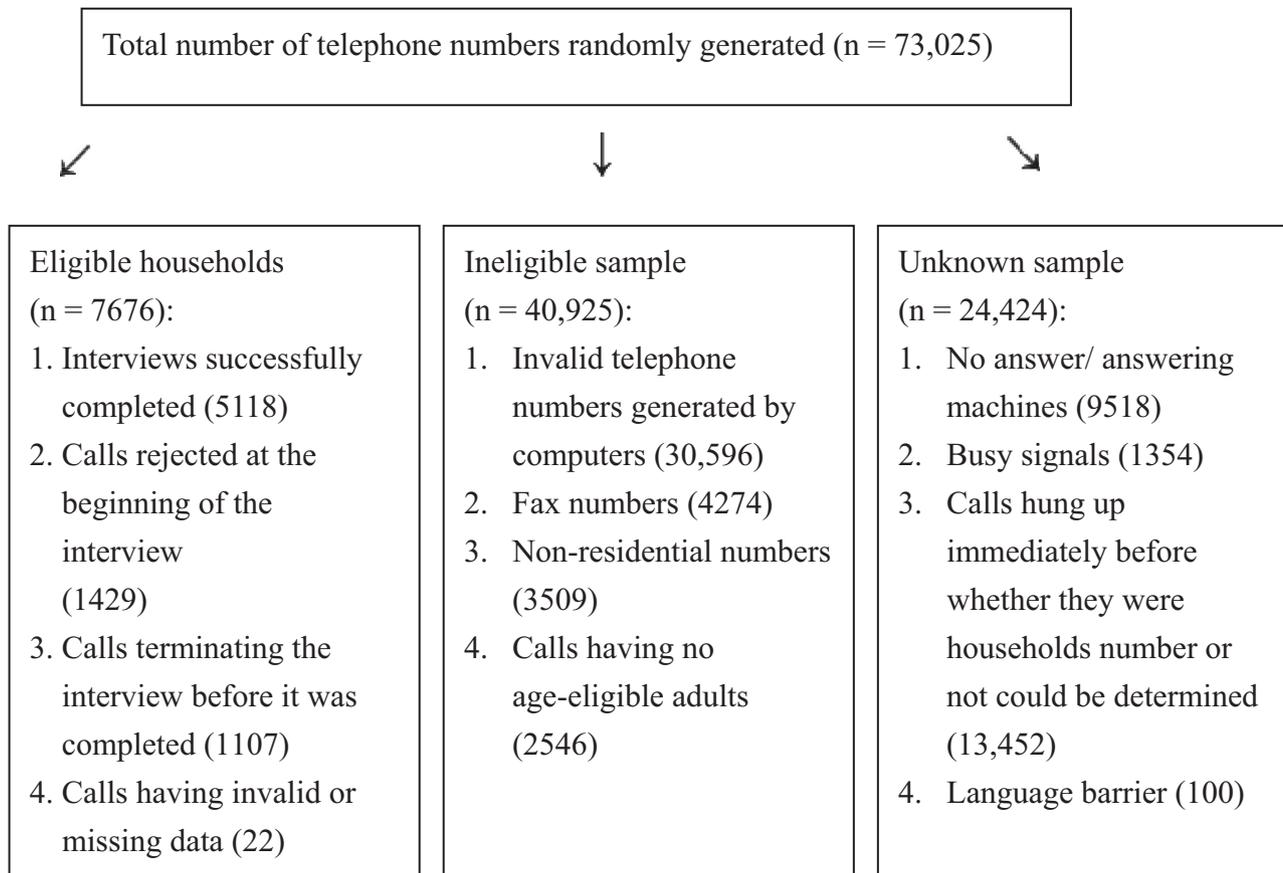


Fig. 1. Flow diagram summarizing the recruitment of participants.

examined partly because health anxiety was only assessed by one brief screening question (namely, “have you ever worried a lot about serious illness despite reassurance from a doctor?”). In the only epidemiological study of health anxiety conducted in a Chinese general population (Lee, Ma, & Tsang, 2011a), 78.9% of people with GAD reported worry about personal health. The study also revealed that people with GAD and personal health worry reported a higher number of associated anxiety symptoms and domains of worries, were more likely to exhibit core depressive symptoms, and a higher frequency of treatment seeking. The findings suggested that the clinical profile of GAD with health anxiety might differ from that of GAD without health anxiety, but the study had several limitations. Although health anxiety varies in severity and is dimensional in nature (Conradt et al., 2006; Fink, Ewald, et al., 1999; Lee, Ng, et al., 2011), it was assessed only by a single dichotomous item about its presence or absence. This not only resulted in a large proportion of people with GAD endorsing a positive response but also precluded the further analysis of GAD and non-GAD respondents with different aspects of health anxiety from being made. The study also did not ask about the health of family members and other domains of worries. Therefore, the significance of personal health worry relative to other common worries in GAD remained unclear. Finally, the study assessed the frequency of core depressive symptoms but not the entire set of diagnostic criteria for major depressive episode (MDE). Consequently, the conclusion could not be firmly drawn that GAD respondents with health worry exhibited more comorbidity with depression than those without health worry.

This present study aims to examine (1) the frequency of worry about personal health, health of family members and other domains of worries among people with GAD and without GAD; (2) the profile of health anxiety in people with and without GAD using a multidimensional measure of health anxiety; and (3) the

socio-demographic profile and severity correlates of GAD with high and low levels of health anxiety.

2. Method

2.1. Sampling

A cross-sectional, structured, random telephone survey of the general population of Hong Kong in the age range of 18–64 years was conducted between October 12 and December 8, 2011. The study was approved by the research ethics committee of The Chinese University of Hong Kong. An independent survey research organization, the Center for Communication and Public Opinion Survey of The Chinese University of Hong Kong (CCPOS), was commissioned to conduct the survey. The interviewers were university students with 1–3 years of part-time experience in administering telephone survey interviews. They were given a briefing session to familiarize themselves with the fully structured questionnaire used. The interview was conducted in Cantonese Chinese, the predominant dialect used in Hong Kong. A supervisory research staff of the CCPOS randomly listened to the interviews conducted by the interviewers each day to ensure their quality.

Since over 99% of the domestic households in Hong Kong have a telephone at home and very few of them have more than one telephone line (Census & Statistics Department (CSD, 2011)), the random sampling of telephone lines should generate a representative sample of households. Telephone numbers were randomly selected from the latest residential telephone directory by computer and the last two digits were replaced by computer-generated random numbers to capture unlisted telephone numbers. Fig. 1 shows the recruitment process in the telephone survey. Respondents were eligible if they were 18–64 years old, were living

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