



Adverse childhood experiences and health anxiety in adulthood[☆]



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ARTICLE INFO

Article history:

Received 5 February 2013
Received in revised form 9 August 2013
Accepted 9 August 2013
Available online 6 September 2013

Keywords:

Childhood adversity
Childhood abuse
Health anxiety

ABSTRACT

Childhood experiences are thought to predispose a person to the development of health anxiety later in life. However, there is a lack of research investigating the influence of specific adverse experiences (e.g., childhood abuse, household dysfunction) on this condition. The current study examined the cumulative influence of multiple types of childhood adversities on health anxiety in adulthood. Adults 18–59 years of age ($N=264$) completed a battery of measures to assess adverse childhood experiences, health anxiety, and associated constructs (i.e., negative affect and trait anxiety). Significant associations were observed between adverse childhood experiences, health anxiety, and associated constructs. Hierarchical multiple regression analysis indicated that adverse childhood experiences were predictive of health anxiety in adulthood; however, the unique contribution of these experiences were no longer significant following the inclusion of the other variables of interest. Subsequently, mediation analyses indicated that both negative affect and trait anxiety independently mediated the relationship between adverse childhood experiences and health anxiety in adulthood. Increased exposure to adverse childhood experiences is associated with higher levels of health anxiety in adulthood; this relationship is mediated through negative affect and trait anxiety. Findings support the long-term negative impact of cumulative adverse childhood experiences and emphasize the importance of addressing negative affect and trait anxiety in efforts to prevent and treat health anxiety.

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Introduction

Health anxiety refers to excessive concern or worry regarding one's health and is thought to arise from the misinterpretation of bodily sensations as being indicative of a serious medical condition. These worries are resistant to extinction and persist despite appropriate medical reassurance that one is physically healthy (Lucock & Morley, 1996; Warwick, 1989). The experience of health anxiety varies from person to person and some (e.g., Ferguson, 2009), but not all (Asmundson, Taylor, Carleton, Weeks, & Hadjistavropoulos, 2012), evidence suggests that health anxiety is experienced on a continuum from mild to severe. Mild forms of health anxiety are common and may facilitate the early detection of medical conditions (Asmundson, Taylor, & Cox, 2001). Despite the potentially beneficial nature of mild health anxiety, severe health anxiety (often diagnosed as hypochondriasis) can cause significant distress. Severe health anxiety is among the most prevalent of psychological disorders and occurs in approximately 5% of the general population (Asmundson et al., 2001). People with

[☆] Funding source: Preparation of this article was supported by Canadian Institutes of Health Research (CIHR) Canada Graduate Scholarship 98205 (Ms. McMillan) and the University of Regina President's Chair in Adult Mental Health Research (Dr. Asmundson).

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severe health anxiety often utilize health care resources in ways that are maladaptive and costly for the health care system (American Psychological Association, 2000). For example, Barsky, Ettner, Horsky, and Bates (2001) found that primary care patients with severe health anxiety had more frequent medical appointments at higher costs compared to those without severe health anxiety. Accordingly, it is critical to identify individuals who may be at a heightened risk for developing this costly and debilitating condition in order to prevent unwarranted use of health care resources and provide appropriate psychological services to those in need.

Adverse childhood experiences refer to potentially traumatic sources of stress that children may endure. These include multiple types of abuse (i.e., physical, sexual, and emotional), neglect, witnessing violence in the household, and other serious household dysfunctions (Felitti et al., 1998). These experiences can be detrimental to long-term mental health; as such, they may be useful for identifying individuals at risk for future psychological disorders. For example, adverse childhood experiences have been associated with an increased risk for depressive disorders (e.g., Chapman et al., 2004; Comijs et al., 2007), anxiety disorders (e.g., Gibb, Chelminski, & Zimmerman, 2007), alcohol problems (e.g., Kestilä et al., 2008), and suicidal behavior (e.g., Dube et al., 2001). Research has identified an association between somatoform disorders and childhood maltreatment (e.g., Haugaard, 2004). A number of studies have demonstrated an association between somatization (i.e., the development and persistence of medically unexplained physical symptoms) and adverse childhood experiences (e.g., Garralda, 1996; Sansone, Wiederma, & Sansone, 2001; Waldinger, Schulz, Barsky, & Ahern, 2006). It has been suggested that children who have been the victims of maltreatment may be more likely to persist in expressing emotions through physical symptoms due to a history of pairing emotional trauma with physical pain (Haugaard, 2004). Together, these studies suggest that adverse childhood experiences may contribute to the later development of mental health disorders, including disorders associated with the perception of negative physical health conditions.

Although research has previously focused on the relationship between childhood adversities and somatization, there is a relative dearth of research examining the relationship between childhood adversities and health anxiety. A limited number of studies have examined hypochondriasis in adults with a history of childhood abuse and household dysfunction. Noyes et al. (2002) found that patients with hypochondriasis more often reported a history of childhood adversities, including having a parent with a drug/alcohol problem compared to patients without hypochondriasis; however, they did not find a difference in reports of parental separation or divorce, childhood physical abuse, or childhood sexual abuse between patients with and without hypochondriasis. In contrast, Barsky, Wool, Barnett, and Cleary (1994) compared patients with hypochondriasis to patients without hypochondriasis and found that significantly more patients with hypochondriasis reported physical and sexual abuse in childhood. Furthermore, Salmon and Calderbank (1996) examined the relationship between childhood physical and sexual abuse and two components of health anxiety (i.e., disease concern and disease conviction) in undergraduate students and found a relationship between both types of abuse and both components of health anxiety. It has been theorized that adverse childhood experiences can foster a pattern of intense care-seeking (directed toward both significant others and medical professionals), which can be reflected in maladaptive illness behaviors displayed by those with elevated health anxiety (Stuart & Noyes, 1999).

Research on adverse childhood experiences and health anxiety has largely been limited to an examination of the effects of these experiences categorically (e.g., examining physical abuse or sexual abuse independently), and in ways that do not allow for an examination of the cumulative impact of multiple types of childhood adversities on health anxiety in adulthood. Adverse childhood experiences are often interrelated and the examination of multiple adverse experiences allows for the assessment of a graded relationship (i.e., the impact of a stressor is related to the level of exposure to the stressor on a continuous scale) between the childhood adversities and mental health outcomes (Dong et al., 2004). The collective impact of adverse childhood experiences on psychological outcomes has been referred to as the *cumulative risk hypothesis*. This theory postulates that it is the accumulation of risk factors, not the presence of any particular risk factor, that negatively affects outcomes (Rutter, 1979; Sameroff, 2000; Sameroff, Seifer, Baldwin, & Baldwin, 1993). A number of researchers have found support for long-term negative consequences of cumulative childhood adversities. For example, Anda et al. (2006) found strong graded relationships between eight categories of adverse childhood experiences and a number of negative outcomes, including depressed affect, anxiety, hallucinations, somatic symptoms, impaired memory, and substance abuse in adulthood. To date, no studies have considered the cumulative impact of adverse childhood experiences when examining their relation to health anxiety.

In addition, it is important to consider constructs such as negative affect (an emotional disposition characterized by personal distress and discontentment) and trait anxiety (one's general level of anxiety) within this domain of research. High negative affectivity and trait anxiety have both demonstrated significant associations with adverse experiences in childhood (e.g., Fillingim & Edwards, 2005; Mancini, Van Ameringen, & MacMillan, 1995) and health anxiety in adulthood (McClure & Lilienfeld, 2001; Watt & Stewart, 2000; Wearden, Perryman, & Ward, 2006). The roles of these associated constructs within this relationship have not yet been examined in the extant literature, which warrants the inclusion of these variables when investigating the link between childhood adversities and adult health anxiety.

The purpose of the present study was to extend previous research by examining the collective impact of multiple forms of adverse childhood experiences on health anxiety in adulthood. The present study had two main objectives: (a) examine the relationships among adverse childhood experiences, health anxiety, and associated constructs (i.e., negative affect and trait anxiety); and (b) investigate the utility of adverse childhood experiences and the associated constructs in predicting health anxiety in adulthood. We hypothesized that (a) there would be significant associations between adverse childhood experiences, health anxiety, and associated constructs; (b) adverse childhood experiences and the associated constructs

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