Adolescents' hypochondriacal fears and beliefs: Relationship with demographic features, psychological distress, well-being and health-related behaviors

Laura Sirri *, Maria Grazia Ricci Garotti, Silvana Grandi, Eliana Tossani
Laboratory of Psychosomatics and Clinimetrics, Department of Psychology, University of Bologna, Bologna, Italy

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A B S T R A C T

Objective: There is little previous literature on hypochondriacal attitudes in teens. We examined the relationship between adolescents' hypochondriacal fears and beliefs, demographic features, psychological distress and well-being, and health-related behaviors.

Methods: Nine hundred and forty-eight students (53.4% males), aged 14–19 years (mean 15.8 ± 1.3 years), completed the Illness Attitude Scales, the Symptom Questionnaire, and the Psychological Well-Being scales. Demographic features and health-related behaviors (smoking, alcohol consumption, illicit substance use, and sedentary, eating and sleep habits) were also collected.

Results: Hypochondriacal concerns were significantly higher among females and correlated with increased psychological distress and reduced well-being. One hundred and forty-nine participants (15.7% of the sample) reached the threshold of the "hypochondriacal responses", identified by Kellner as a screening method for clinically significant hypochondriacal symptoms. The "hypochondriacal responses" were significantly associated with higher levels of psychological distress, decreased well-being, and some unhealthy behaviors: smoking, use of illicit substances, physical inactivity, and short sleep. Female gender, physical inactivity, and higher levels of hostility independently predicted the "hypochondriacal responses" pattern.

Conclusions: A substantial percentage of adolescents experience significant concerns about health. Excessive illness fears are associated with less healthy behaviors. A thorough assessment of illness-related concerns may be crucial for the prevention of both the development of more structured forms of abnormal illness behavior (e.g., severe health anxiety) and the engagement in some unhealthy lifestyles in adolescents. However, it may also be that unhealthy behaviors lead to increased preoccupation with one's own health through adolescents' implicit knowledge about possible consequences of such behaviors.

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Introduction

Adolescents experience rapid and impressive changes both at physical and psychological levels and are particularly vulnerable to the emergence of psychopathology [1,2]. Psychological symptoms occurring during adolescence tend to persist and predict negative psychosocial outcomes in young adulthood [3,4]. Thus, particular attention should be devoted to psychological disturbances occurring in this life stage to prevent subsequent psychopathology. The area of adolescents' own health related concerns has seldom been examined in the literature. There are however several reasons to deeply explore adolescents' hypochondriacal attitudes, fears and beliefs and their correlates. First, pubertal maturation leads to experience new somatic symptoms (e.g., menstruation-related pains) [5], which may foster worries about bodily functioning and physical health.

Furthermore, adolescence is an important life stage for the shaping of illness behavior, that is patterns of monitoring, interpretation and response to one's own somatic symptoms [6]. Inappropriate manifestations of illness behavior, such as excessive reassurance seeking from physicians, are often a consequence of hypochondriacal attitudes [7].

Finally, the internet is the primary source of health-related information among adolescents [8] and it can provide incorrect information about illnesses and a disproportionate amount of serious medical explanations for common symptoms [9]. Adolescents may not have reached the cognitive maturity necessary to appropriately interpret such information gathered via the internet, which may foster health-related worries in vulnerable adolescents [10,11]. As such, health-related fears and beliefs may occur more often than one would expect during adolescence. In a study on 1070 adolescents aged 12–16 years, 54.4% of the participants felt their health should be better and 50% worried a lot about health [12]. Thus, adolescents' health-related worries are worthy...
of attention and their early treatment may be crucial to prevent
difficult-to-treat conditions, such as hypochondriasis and severe health
anxiety [13]. However, there is little previous literature on hypochon-
driacal attitudes in teens and their demographic and psychological cor-
relates. In particular, the relationship between health-related worries
and features of psychological distress remains largely to be examined.
Furthermore, to our knowledge, no study has examined whether ado-
lescents’ hypochondriacal attitudes are significantly associated with
psychological well-being and health-related lifestyles.

The aim of this epidemiological study was threefold: we explored
the relationship of adolescents’ hypochondriacal fears and beliefs with
(a) demographic features, (b) psychological distress and well-being,
and (c) health-related lifestyles.

Methods

Participants and procedure

Adolescents were recruited in different secondary public schools lo-
cated in Northern Italy (Emilia-Romagna region). The research project
was presented to the headmasters of five secondary public schools
who agreed to participate in our study. Then, we randomly selected
40 classes attended by 973 students who thus represented our eligible
subjects. Students and their parents received a complete description of
our research and were asked to sign and return an informed consent
form. Except for students who had already reached their age of majority
(i.e., at least 18 years), written informed consent was requested also by
adolescents’ parents.

Nine hundred and forty-eight of the 973 eligible subjects (97.4%)
agreed to participate in the study. The remaining 25 eligible students
who did not return the signed informed consent form were classified
as refusals; they were not significantly different from the participants
according to age, gender, and ethnicity.

Each participant completed a demographic form concerning age,
gender, ethnicity, and family affluence. Participants’ mean age was
15.8 (SD 1.3; range 14–19) years: 45.8% of participants were aged be-
tween 14 and 15 years (early adolescence), 44.6% between 16 and
17 years (middle adolescence), and 9.6% between 18 and 19 years
(late adolescence). Gender information was provided by 929 partici-
pants: 496 were males (53.4%) and 433 (46.6%) were females. As to
ethnicity, 930 adolescents were Caucasian, 7 Latin American, 7 Arab,
2 African, 1 Chinese, and 1 Asian. Socioeconomic status (SES) was
assessed with the FAS-II, which classifies SES as low (score ranging
from 0 to 2), medium (score ranging from 3 to 5), and high (score
ranging from 6 to 9) [14]. SES information was provided by 947 partici-
pants and, according to the FAS-II, 18 of them (1.9%) were found to
belong to low SES, 414 (43.7%) to medium SES, and 515 (54.4%) to
high SES.

The research protocol was approved by the institutional review
board of the Department of Psychology of the University of Bologna
and questionnaires were administered during class time by trained
researchers. The study was completed between January 2012 and
June 2013.

Measures

Hypochondriacal fears and beliefs

Attitudes, fears and beliefs associated with hypochondriasis and ab-
normal illness behavior were assessed through Kellner’s Illness Attitude
Scales (IAS) [15]. The IAS are nine self-report scales concerning the fol-
lowing features: worry about illness (worries about getting a serious ill-
ness in the future), concerns about pain (worries about consequences of
pain), health habits (tendency to check for something wrong in one’s
body and to avoid unhealthy habits), hypochondriacal beliefs (belief
of having an illness despite medical reassurance), thanatophobia (fear
concerning the idea of death and dying soon), disease phobia (fear of
having cancer, heart disease or another serious illness), bodily preoccu-
purations (increased attention to one’s own bodily sensations), treatment
experience (frequency of medical visits and treatments), and effects of
symptoms (limitations in daily activities due to physical symptoms).

The last two scales are not directly concerned with hypochondriacal
fears and beliefs and we did not administer them in this study. Each
scale contains three items rated on a 5-point Likert scale ranging from
“no” to “most of the time”. For each scale the score may range from 0
to 12, with higher scores corresponding to more severe hypochondria-
cal symptoms. The “hypochondriacal beliefs” and “disease phobia”
scales reflect the two core features of the hypochondriacal syndrome,
while the other scales concern less specific components of health anx-
xiety. A response “often” or “most of the time” on at least one of the items
of the “hypochondriacal beliefs” and “disease phobia” scales was found
to identify subjects with a DSM-III diagnosis of hypochondriasis with
both sensitivity and specificity [15]. Kellner labeled this response
pattern as “hypochondriacal responses” and it was subsequently used
as a screening tool to identify potential cases of hypochondriasis [16].

The “hypochondriacal responses” pattern displayed sensitivity
and specificity rates, against a formal diagnosis of hypochondriasis,
of 50–90% and 81–100%, respectively [15,17,18]. The IAS scores showed
both high discriminant validity in differentiating hypochondriacal
patients from normal controls, family practice patients and non-
hypochondriacal psychiatric patients and sensitivity to changes after
treatment of hypochondriasis [19,20]. The IAS were found to be suitable
for the assessment of illness attitudes among adolescents both in school
and clinical settings [5,21,22].

Psychological distress

Kellner’s Symptom Questionnaire (SQ) [23] consists of four self-
rated scales concerning anxiety, depression, somatization, and hostility.
Each item is made of an adjective or a brief statement rated as
“strongly agree” or “false” or “yes” or “no”. Each scale may be scored from 0 to 23, since it is
made of 23 items rated as 0 or 1. Higher scores indicate more severe
psychological distress. The SQ has been widely administered to both
non-clinical populations and patients with medical or psychiatric disor-
ders, where its excellent sensitivity in recognizing differences between
groups and changes after treatments has been proven [24,25]. The SQ
has proved to be useful for the assessment of adolescents’ psychological
distress [26].

Psychological well-being

Psychological well-being was examined through the 42-item ver-
sion of the Psychological Well-Being (PWB) scales [27]. The PWB scales
are six self-report scales assessing the dimensions of psychological well-
being identified by Ryff’s model: autonomy, environmental mastery,
personal growth, positive relations, purpose in life, and self-acceptance.
Each scale consists of seven items rated on a 6-point Likert scale ranging
from “strongly disagree” to “strongly agree”. The score of each scale may
range between 7 and 42, with higher scores corresponding to greater
psychological well-being. The PWB scales were found to be a useful in-
strument for the characterization of positive psychological functioning
both in adult and adolescent populations [26,28]. Their application
highlighted how psychological well-being does not merely correspond
with the absence of psychopathological symptoms [26].

Health-related behaviors

Alcohol use, smoking and use of illicit substances were assessed by
means of the following questions: “Do you drink alcohol?”, “Do you
smoke?”, and “Do you take recreational drugs?”. These questions have
a dichotomous response format (“yes” or “no”) and were taken from
the self-rated part of the Psychosocial Index [29], which derived them from
the Screening List for Psychosocial Problems [30].

Physical inactivity was assessed through five behaviors: playing
sports, doing physical activity, watching TV, playing video or computer
games, and using the computer. These behaviors were examined by
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