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Health anxiety and habitual rumination: The mediating effect of serenity

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ABSTRACT

Health anxiety and rumination are frequently observed in primary care. The aim of the present study is to examine which role positive affect with low physiological arousal, such as serenity, plays in this relationship. It is hypothesized that serenity moderates the impact of rumination on health anxiety.

In a questionnaire study, a sample of consecutive primary care patients ($N = 219$) completed different measures of health anxiety (Whiteley 7), rumination (Rumination–Reflection Questionnaire) and serenity (Serenity Index).

The findings demonstrated that rumination and health anxiety were positively related. However, serenity correlated negatively with health anxiety and rumination. As hypothesized, serenity is significantly predicted by health anxiety, so that high serenity has a decreasing impact on the cognitive cycle between rumination and health anxiety.

The relationship between health anxiety, rumination and serenity was examined within a framework of the cognitive-behavioral model of health anxiety by Salkovskis and Warwick (2001). The results showed that the buffering function of serenity extend the cognitive-behavioral model of health anxiety and underlined the meaning of resources in coping health-related symptoms.

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1. Introduction

In the DSM-IV-TR (APA, 2000), severe and persistent health anxiety is considered as the psychosomatic disorder ‘hypochondriasis’, which encompasses a wide spectrum of possible characteristics ranging from increased fear of disease to serious forms of bodily complaints. Depending on the different definitions and the clinical phenomenology, the reported prevalence in different epidemiological studies varies considerably. Following the ICD-10 research criteria, a worldwide WHO study reported that 0.8% manifested hypochondriasis cases can be observed in General Practices (in Germany 5.4%; see Gureje, Üstün, & Simon, 1997). Under a modified definition of hypochondriasis according to DSM-IV, in Denmark 9.5% of those questioned in primary care are affected by hypochondriasis (Fink et al., 2004). A survey of 1751 patients in German General Practices showed increased levels of anxiety regarding disease not fully meeting ICD-10 criteria for hypochondriasis accompanied by frequent psychological comorbidity, physical symptoms, and doctor’s office visits in 18.5% of cases (Benedikt et al., 2007; Hinz, Rief, & Brähler, 2003). Furthermore the level of

health anxiety plays an important role for primary care: Patients with high health anxiety used more health care and caused higher costs for the health system (Fink, Ørnbøl, & Christensen, 2010). The efficacy of cognitive-behavioral interventions for hypochondriasis has been demonstrated, however, not their effectiveness in terms of medical cost (Thomson & Page, 2007). In particular, the “frequency of attendance” and the associated “health care utilization” appear to have been impervious to all interventions (Smits, Wittkamp, Schene, Bindels, & Van Weert, 2008).

In the new DSM-V, hypochondriasis was replaced by the diagnosis groups Somatic Symptom Disorder and Illness Anxiety Disorder. For that reason there are good reasons to use the term ‘health anxiety’ because it provides a clearer and more meaningful description of the emotional and behavioral aspects and has no such pejorative implications like hypochondriasis (Abramowitz & Braddock, 2011). Because of the underlying cognitive processes hypochondriasis can be more characterized as an anxiety disorder than as a somatoform disorder (Olatunji, Deacon, & Abramowitz, 2009).

A cognitive-behavioral model of health anxiety that focuses on beliefs and cognitive contents, i.e., what a person is thinking, has been proposed by Warwick (1989), Warwick and Salkovskis (1990) and Salkovskis and Warwick (2001). Persons with high level of health anxiety e.g., misinterpret bodily sensations as serious and overestimate the frequency of serious illnesses. Recent findings

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showed that patients with health anxiety reported experiencing intrusive imagery about illness and death (Muse, McManus, Hackmann, Williams, & Williams, 2010) and showed excessive pre-occupations with illness followed by an increased safety-seeking behavior which maintains the disorder by negative reinforcement, e.g., safety behavior prevents the natural extinction of the health anxiety (see Abramowitz & Moore, 2007).

In recent research, Marcus, Hughes, and Arnau (2008) expanded the model using mediational analysis to include cognitive style (“how”) providing rumination and negative affect as an example. Health anxiety itself showed a strong association with rumination both directly and indirectly via its connection with negative affect. Rumination as cognitive style was originally conceptualized by Nolen-Hoeksema as a “tendency to repetitively focus on symptoms of distress and possible causes (...) without engaging in active problem solving” (see Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008). Rumination belongs to the main symptoms of health-anxiety, as well to other disorders such as depression (see Roelofs et al., 2007) or hallucination proneness (Jones & Fernyhough, 2009). Self-focused rumination seems to increase the cognitive accessibility of self-critical negative affect in health anxiety. A recent study by Pedersen et al. (2011) showed a strong positive association between self-focused rumination and aggressive thoughts and feelings.

In contrast, ‘serenity’ has been described by Roberts and Cunningham (1990) as “a spiritual state that decreases distress and promotes optimal health”. Serenity, as a sustained state of inner peace can be characterized by spirituality in a secular sense, concentration on the important things in life, and the ability to meaningfully allocate resources. As a consequence, serenity has aspects of an inner ability and a learnable skill, fulfills a buffer function against diverse stressors, and can serve as an outcome measure for holistic interventions to improve health and subjective well-being (Kreitzer, Gross, Waleekhachonloet, Reilly-Spong, & Byrd, 2009). Serenity can be considered as a positive affect with a low physiological arousal level (see Watson, Clark, & Tellegen, 1988). In this context, serenity is an important consequence of relaxation procedures and meditation techniques (e.g., Van Hooff & Baas, 2013). Furthermore serenity plays an important role in new forms of psychotherapy, like the Mindfulness-Based Cognitive Therapy (MBCT) (see Surawy, McManus, Muse, & Williams, 2014). In this context serenity is a resource for engaging in the present moment and can help to reduce the anxiety level of patients, who have negative future-oriented mental constructions of reality.

The aim of the present study was to investigate the impact of serenity on health anxiety, and rumination in a sample of primary care patients. Our assumption was that the relationship between health anxiety and rumination is moderated by the level of serenity.

2. Method

2.1. Participants

Totally, 219 participants with an average age of 52 years ($SD = 16.3$ years; range 18–89 years) take part in the present cross-sectional study. The majority of the subjects were female (63.9%), married (62.6%), and approximately half were retired (50.7%). The overall majority of the participants (76.7%) reported no alcohol or nicotine consumption. The participants were recruited from 21 ambulant practices (11 rural and 10 urban) in the eastern part of Germany. A randomization was achieved by inviting all consecutive patients seeking medical care on a randomly chosen weekday, ten patients were registered for each practice. Included were all patients willing to participate who were

18 years of age or older, did not have communication impediments, and did not meet the following exclusion criteria (as assessed by the attending physician): urgent need for medical treatment within the context of a medical emergency, previously known psychological or physical illness restricting the ability to form judgments or give information. The participants completed the questionnaire in waiting rooms of General Practices.

2.2. Questionnaires

2.2.1. Whiteley Index-7 (WI-7)

A 7-item self-report measure with a yes/no answer format (0 = no, 1 = yes) for assessing health anxiety in terms of hypochondriacal worries and beliefs (Fink et al., 1999). The Whiteley Index is a good validated instrument which was used also in samples of primary care patients (see Conradt, Cavanagh, Franklin, & Rief, 2006). The percentage of potentially health anxious patients in the present study was 23% as measured by the Whiteley Index with a cutoff of > 3. Compared to available epidemiological data based on ICD-10 or DSM-IV criteria, this is a very high prevalence for a random sample in primary care. Ultimately, this can only be explained by the assessment of health anxiety traits without meeting the clear criteria for clinical diagnosis of hypochondriasis (Fink et al., 2004; Benedikt et al., 2007; Hinz et al., 2003). The number of patients assessed by us to be potentially high in health anxiety and do fulfill ICD-10 or DSM-IV criteria could not be verified.

2.2.2. Rumination–Reflection Questionnaire (RRQ) (Trapnell & Campbell, 1999)

The RRQ was developed as part of reconceptualizing inner self-awareness for the purpose of differentiating between neurotic and intellectual forms of self-consciousness. As a result, the questionnaire consists of subscales for rumination and reflection with 12 items for each, a five-point answer format (0 = disagree completely ranging to 4 = strongly agree). In the present study only the RRQ-subscale rumination was used. An example item is ‘my attention is often focused on aspects of myself I wish I’d stop thinking about’. The subscale rumination showed substantial correlations to different related personality measures (Joireman, Parrott, & Hammersla, 2002).

2.2.3. Serenity index (SI-7) (Wolfardt & Pohl, 2013)

The SI-7 is a new short self-report instrument and was used in this study to assess positive affect with low physiological arousal. The questionnaire contains seven items that are responded to on a five-point Likert scale (0 = never ranging to 4 = always). Example items are “I think that I am at peace with myself.”, “I am serene and calm” and “Even in unpleasant situations I can stay relaxed”. The total score has a range extending from 0 to 28 with higher values indicating a greater degree of serenity. On the basis of the study sample, the scale yielded average to good item-total correlations and a good internal consistency. The SI-7 showed a good convergent validity with other instruments (e.g., serenity scale by Roberts and Aspy (1993).

3. Results

In the present study all measures reached satisfying internal consistencies. The descriptive findings with means, standard deviations for the constructs are presented in Table 1.

In the first statistical step, the Pearson product moment correlation showed a weak positive, but highly significant correlation ($r = 0.19$, $p < 0.001$) between rumination and health anxiety. In contrast, serenity showed a negative correlation not only with

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