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Health anxiety disorders in older adults: Conceptualizing complex conditions in late life

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HIGHLIGHTS

- Health anxiety disorders are misunderstood in late life.
- Prior estimates of health anxiety disorders in older adults are underestimated.
- Medical morbidity is a risk factor for severe health anxiety in late life.
- Differentiation of disease conviction and adaptive health worry is essential.
- Cognitive and behavioral features and reduced quality of life are indicators.

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ABSTRACT

Health anxiety disorders (e.g., hypochondriasis) are prevalent but understudied in older adults. Existing research suggests that severe health anxiety has a late age of onset, perhaps because of comorbidity with physical health conditions that are more likely to occur with aging. Despite being under diagnosed in later life due to a lack of age-appropriate diagnostic criteria, significant positive associations with age suggest that health anxiety disorders are more prevalent in older than younger adults. Preliminary research also highlights the complexity of these disorders in older adults and the potential importance of medical morbidity as a risk factor. This review explores the complexities of health anxiety disorders in later life with a focus on understanding defining features, prevalence rates, correlates, assessment, diagnosis, and treatment. We offer a theoretical model of the development of severe health anxiety among older adults to encourage further research on this important and under-studied topic.

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Aging is typically associated with a decline in health and onset of multiple physical health conditions (Jette, 1996); but, compared to middle-aged adults, older individuals have a decreased risk of suffering

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from mental health issues, including anxiety (Blanchflower & Oswald, 2008; Gum, King-Kallimanis, & Kohn, 2009; Stone, Schwartz, Broderick, & Deaton, 2010). Whether this is true for severe health anxiety—a condition arising from misinterpretations of bodily sensations and changes as being indicative of serious illness (Asmundson, Taylor, Sevgur, & Cox, 2001)—has been the topic of a growing body of research with older adults. Preliminary research and theory offer insight into the presentation, diagnosis, and treatment of health anxiety disorders among older adults. This review aims to explore health anxiety disorders in later life with a focus on understanding defining features, prevalence rates, correlates, and how they are assessed and diagnosed. In addition, this review uses a mediational conceptualization (see Fig. 1) to enhance current understanding of how severe health anxiety develops in later life, how it is maintained, and how it can be effectively treated.

Because much of the research on severe health anxiety has been based on the health anxiety disorders (see Taylor & Asmundson, 2004), primarily hypochondriasis as defined in the Diagnostic and Statistical Manual of Mental Disorders—4th Edition Revised (DSM-IV-TR; American Psychiatric Association, 2000) and International and Statistical Classification of Diseases and Related Health Problems (ICD-10; World Health Organization, 1993), we refer to both health anxiety and hypochondriasis in this review. When we discuss findings from particular studies or when differentiation is important, we will refer to hypochondriasis and health anxiety separately. It is noteworthy that diagnostic nomenclature has changed in the DSM-5 (American Psychiatric Association, 2013) such that hypochondriasis has been replaced by somatic symptom disorder and illness anxiety disorder; however, introduction of these new classifications for the health anxiety disorders is too recent to have influenced research on this topic at this time.

1. Introduction to health anxiety

Anxiety about health is a ubiquitous experience that occurs when perceived bodily sensations or changes are interpreted as symptoms of a serious disease. As several cognitive behavioral theorists (Salkovskis & Warwick, 1986; Taylor & Asmundson, 2004; Thibodeau, Asmundson, & Taylor, 2013) have suggested, health anxiety comprises core cognitive and behavioral features and, collectively, these appear to range in magnitude along a continuum from mild to severe illness (Ferguson, 2009; Longley et al., 2010; Salkovskis & Warwick, 1986; Taylor & Asmundson, 2004). The core cognitive feature of health anxiety is disease conviction; that is, harmless bodily sensations and changes are perceived as being indicative of disease instead of being perceived as benign bodily perturbations, symptoms of minor ailments, or autonomic nervous system arousal. A range of other dysfunctional beliefs (e.g., the doctor has missed something critical, the lab test must be wrong) may accompany disease conviction. These cognitive factors, together with disease-related preoccupation and worry, motivate several characteristic maladaptive coping behaviors (i.e., safety behaviors), including reassurance seeking, avoidance and recurrent checking behaviors (e.g., checking the body for disease-related changes, checking the Internet for symptom information). These maladaptive coping behaviors, while providing transient relief from health-related distress (Haenen, de Jong, Schmidt, Stevens, & Visser, 2000), perpetuate dysfunctional beliefs, associated distress and functional limitations (Warwick & Salkovskis, 1990).

2. Health anxiety among older adults

Health anxiety typically arises following stress, serious illness, significant loss (Asmundson, Abramowitz, Richter, & Whedon, 2010; Barsky & Klerman, 1983), or following exposure to disease-related popular media or other health-related stimuli (Marcus, Gurley, Marchi, & Bauer, 2007; Taylor & Asmundson, 2004). Disease related fears may be especially likely in older adults given the high prevalence of negative life experiences (e.g., illness and death of social network members, bodily injuries from falls) and health problems (Hoffman, Rice, & Sung, 1996) in later life. In fact, older adults have on average 3.5 physical health conditions (Blazer, 1998), and conservative estimates suggest that as many as 88% suffer from a least one such condition (Hoffman et al., 1996). The common experience of health problems among older adults elevates the likelihood of exaggerated health concerns (e.g., overestimating the consequences of their disease) and generalized health-related worry (e.g., an older adult with diabetes being extremely concerned about cancer). Because older adults are closer to the end of life, they may fear debilitating disease states that they do not have the physical, psychological, and social resources to cope with (Kastenbaum, 1994). Older adults may not only see themselves as having deteriorating health, being socially isolated, and having loss of control and independence (Frazier & Waid, 1999), but also experience these changes in late life making them especially susceptible to severe health anxiety.

Older adults are particularly prone to health anxiety given the close association between general worry and somatic sensations and concerns. Among older adults there is often a prominent somatic component of worry associated with mental disorders in general and anxiety in particular. For example, existing research suggests that mental disorders in older adults are significantly associated with somatic comorbidity (Scott et al., 2008) and that anxiety is more prevalent in chronically ill older adults (Kim, Braun, & Kunik, 2001). A dose–response relationship has been proposed where a greater number of somatic conditions are associated with a greater risk of anxiety in older adults (van Balkom et al., 2000). Additionally, older adults with a physical health condition and an anxiety disorder report poorer perceived physical health compared to older adults with only a physical health condition (El-Gabalawy, Mackenzie, Shooshtari, & Sareen, 2011), demonstrating the effect of anxiety on perception of physical health related quality of life.

Older adults are especially prone to worrying about their somatic sensations, their health, and their physical impairment (Hunt, Wisocki, & Yanko, 2003; Montorio, Nuevo, Marquez, Izal, & Losada, 2003; Skarborn & Nicki, 1996). Approximately 3% of older adults report worrying about their health most or all of the time (Boston & Merrick, 2010). Health-based worries can include fears of sensory loss, loss of independence, loss of memory, and fear of falling (Wisocki, 1988). Moreover, older adults suffering from an anxiety disorder are more likely to experience significant health-based worries (Lindesay et al., 2006; Montorio et al., 2003). The majority of health-based worries likely

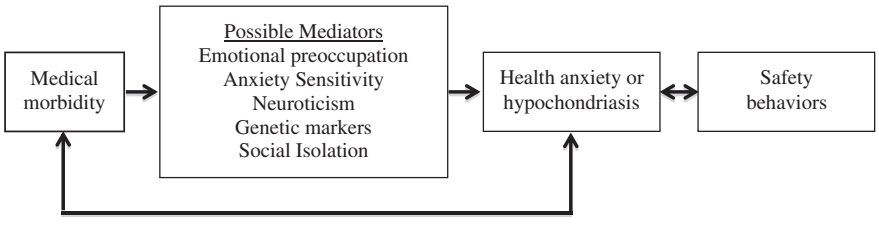

Fig. 1. Proposed primary pathway for severe health anxiety among older adults. Older adults are at an increased risk of medical morbidity, and some of those medically unwell older adults will have characteristics (e.g. emotional preoccupation, anxiety sensitivity, neuroticism, genetic markers, social isolation) that lead them to develop severe health anxiety. Severe health anxiety then leads to safety behaviors, which serve to maintain the condition. Finally, severe health anxiety and medical morbidity may maintain one another, resulting in worse physical and psychological outcomes.