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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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ABSTRACT

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 examine 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

^{*} Corresponding author at: Department of Psychology, University of Bologna, viale Bertini Pichat 5, 40127 Bologna, Italy.

E-mail address: laurasirri@libero.it (L. Sirri).

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 hypochondriacal attitudes in teens and their demographic and psychological correlates. 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 adolescents' 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 located 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 between 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 participants: 496 were males (53.4%) and 433 (46.6%) were females. As to ethnicity, 930 adolescents were Caucasian, 7 Latin American, 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 participants 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 abnormal illness behavior were assessed through Kellner's Illness Attitude Scales (IAS) [15]. The IAS are nine self-report scales concerning the following features: worry about illness (worries about getting a serious illness 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 preoccupations (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 hypochondriacal 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 anxiety. 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 "true" 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 disorders, 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 version 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 instrument 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 to 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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