



Somatic symptom burden and health anxiety in the population and their correlates



Sing Lee^{a,c,*}, Francis H Creed^b, Yee-Ling Ma^a, Candi MC Leung^c

^a Department of Psychiatry, The Chinese University of Hong Kong, Hong Kong, China

^b School of Community-based Medicine, The University of Manchester, United Kingdom

^c Hong Kong Mood Disorders Center, The Chinese University of Hong Kong, Hong Kong, China

ARTICLE INFO

Article history:

Received 19 August 2014

Received in revised form 10 November 2014

Accepted 12 November 2014

Keywords:

Somatic symptom burden

Health anxiety

Impairment

Psychological distress

Health care utilization

ABSTRACT

Objective: Somatic symptom burden and health anxiety demonstrate overlapping clinical characteristics but their relationship in the general population is unclear. This study examined the association between these dimensions after adjustment for confounders and their respective correlation with outcome measures.

Methods: A randomly selected population-based sample of 3014 respondents aged 15–65 was interviewed by telephone using a structured questionnaire that included the 15-item Patient Health Questionnaire (PHQ-15), Whiteley-7, Kessler-6, Sheehan Disability Scale, socio-demographic variables and items regarding health care utilization. Respondents who scored 10 or above on PHQ-15 and 4 or above on Whiteley-5 were regarded as having high somatic symptom burden and high health anxiety respectively.

Results: Somatic symptom burden and health anxiety are moderately correlated after adjustment for confounders ($p < .001$). Both have important effects on psychological distress, functional impairment and health care utilization independent of each other ($ps < .001$). A considerable number of respondents (5.7%) reported both high somatic symptom burden and high health anxiety and this group showed the greatest general psychological distress, functional impairment and health care utilization.

Conclusion: This study demonstrates the close association of somatic symptom burden and health anxiety but also their independent association with psychological distress, functional impairment and health care utilization. The findings support the concept of the DSM-5 category of somatic symptom disorder, but also demonstrate that individuals with high somatic symptom burden or high health anxiety alone may merit separate diagnoses. More sophisticated studies of the relationship between somatic symptom burden and health anxiety are needed.

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Introduction

Somatic symptom burden and health anxiety are common in both general population and primary care settings [1–4]. Clinical studies have indicated that somatic symptom burden is associated with health anxiety. Somatisation disorder is much more common in patients with hypochondriasis than those without [5,6] and in primary care 20% of somatisation disorder patients were found to also have hypochondriasis [7]. Other primary care studies have shown somatic symptom burden to be positively associated with health anxiety [8], including in Hong Kong [9].

Apart from diagnostic overlap, studies have also demonstrated overlaps in the correlates for somatic symptom burden and health anxiety. People who suffered from somatic symptom burden and/or health anxiety exhibited somatic concern, increased disability, elevated healthcare utilization and dissatisfaction with doctors' explanation of their symptoms and management of their illnesses [4,9,10]. A recent

clinical study confirmed that patients with both high somatic symptom burden and high health anxiety showed greatest dissatisfaction with doctors' explanation of their symptoms and doctor–patient communication, and the poorest functional outcomes [11].

Nonetheless, the overlap between somatic symptom burden and health anxiety is not complete. In primary care one-tenth of those with somatic symptom burden did not have high health anxiety, and a similar proportion of the respondents with high health anxiety did not show high somatic symptom burden [8]. There are differences between the two conditions in terms of correlates; only somatic symptom burden is associated with female sex [4]. Cognitive behavior therapy may alleviate both conditions [12,13] but some studies indicated that the treatment response of health anxiety was much better than that of somatic symptom burden [14,15]. Predictive validity may differ as one study showed that health anxiety predicted mental (but not physical) functioning more clearly than somatic symptom burden [16].

Partly because of the above reasons somatic symptom burden and health anxiety have tended to be studied separately as somatoform pain disorder/undifferentiated somatoform/somatisation disorders and hypochondriasis [17,18] despite the fact that somatic symptom

* Corresponding author at: Department of Psychiatry Tai Po Hospital, N.T., Hong Kong, China. Tel.: +852 2144 7662; fax: +852 2144 5129.

E-mail address: singlee@cuhk.edu.hk (S. Lee).

burden and health anxiety often cluster in patients [19]. The DSM-5 diagnosis of somatic symptom disorder (SSD) combines somatic symptom burden and certain features of health anxiety as well as allows a separate diagnosis of illness anxiety disorder [19,20]. The diagnosis of SSD has been commended for abandoning the distinction between medically explained and unexplained symptoms and being based on positive psychological criteria, including both somatic symptom burden and health anxiety. However, it has posed diagnostic controversies, such as whether it is an over-inclusive condition [14,21,22]. Clinical studies of somatic symptom burden and hypochondriasis or high health anxiety were likely to be biased by help-seeking behavior and the selection of patients with more severe conditions. Their findings need to be replicated in population-based studies in which a broad spectrum of individuals with the two conditions is examined. A recent validation study of the Chinese Whiteley-7 in the Hong Kong general population examined both somatic symptom burden and health anxiety, but provided only preliminary evidence for a positive association between the two conditions [9]. The study did not address several issues including examination of somatic symptom burden and health anxiety as dimensionally distributed variables [9,10] or the issue of the clinical relevance of these dimensions in people with high scores. The study also did not address the correlates of somatic symptom burden and health anxiety including functional impairment, health care utilization and patients' satisfaction health care utilization [9]. We included satisfaction with doctors in this study because it is closely associated with somatic symptom burden, health anxiety, and health care utilization in the literature, but their relationship has not been examined in population-based studies.

Therefore, the present study aimed to examine the relationship of somatic symptom burden and health anxiety and their correlates in a population-based sample. We examined: 1) the association of somatic symptom burden and health anxiety; 2) the independent effects of the high levels of each on several clinically relevant psychosocial correlates; and 3) the prevalence and correlates of high somatic symptom burden alone, high health anxiety alone and their comorbidity. Using cut-off scores on two commonly used dimensional scales (namely, the PHQ-15 and Whiteley-7), we captured four groups of respondents who exhibited different degrees of somatic symptom burden and health anxiety, namely, "high scores on both", "high somatic symptom burden alone", "high health anxiety alone" and "low scores on both" groups respectively.

Methods

Sampling

The research ethics committee of The Chinese University of Hong Kong approved the study. The Hong Kong Institute of Asia-Pacific Studies, an independent survey organization, was commissioned to conduct the telephone survey from September 2 to September 22, 2009. Telephone numbers were selected randomly from the latest Residential Telephone Directory and the last two digits were deleted and replaced by two computer-generated random numbers to capture unlisted telephone numbers. A noncontact status was assigned to telephone numbers that could not be contacted after three attempts on different occasions. In each successfully contacted residential unit in the present survey, only one person was interviewed. The interviews were conducted in Cantonese, the predominant dialect spoken in Hong Kong. Verbal consent was obtained from respondents at the beginning of each interview. Interviewers were carefully trained before the interviews and provided with reminder notes on how to ask questions in the questionnaire properly.

A total of 11,120 calls had successfully established contact with the selected households, with 1625 calls having no interviewee aged between 15 and 65 years, 4004 calls being hung up immediately by receivers, and 2477 calls being rejected for an interview. Thus, 3014 telephone interviews were successfully completed with verbal

informed consent. Of the households that were successfully contacted and had interviewees within the age range, the participation rate was 54.9% ($3014 / [3014 + 2477] \times 100\%$) in accordance with the recommendation for reporting response rate in telephone surveys [23]. The strict response rate, defined as the number of completed interviews divided by the total number of households contacted, was 27.1% ($[3014 / 11,120] \times 100\%$). To render our sample representative of the Hong Kong general population, the final sample was weighted according to the gender distribution of different age groups as reported in the latest population by-census in 2006 by the Census and Statistics Department of the Hong Kong Government [24]. With a 95% confidence level, the maximum sampling error was $\pm 1.76\%$.

Instruments

The fully structured questionnaire included Chinese versions of the PHQ-15, 6-item Kessler Scale (Kessler-6), 7-item Whiteley Index (Whiteley-7), Sheehan Disability Scale (SDS), perceived helpfulness of and satisfaction with doctors, questions on the presence of chronic illness(es), frequency of health care utilization, and socio-demographic variables.

PHQ-15

The PHQ-15 asks respondents to rate how much they had been bothered by each of the 15 somatic symptoms during the past four weeks on a "0" (not bothered at all) to "2" (bothered a lot) scale. The total score ranges from 0 to 30 representing the grading of somatic symptom severity from minimal (0–4), mild (5–9), moderate (10–14), to severe (15–30) [25]. The scale has been shown to have satisfactory reliability and validity in a community-based study in Hong Kong [10]. The Cronbach's alpha of the PHQ-15 was .79 in this study.

Whiteley-7

This consists of seven items and measures the affective, cognitive and somatic components of health anxiety [26]. It has been shown to have excellent psychometric properties in primary care and community samples [9,27]. A dichotomous yes/no version of the Whiteley-7 was used in the present study. A score of "1" was given to each "yes" response. Since two items ("are you bothered by many different aches and pains?" and "do you find that you are bothered by many different symptoms?") concern somatic symptom burden, they were removed in statistical analyses and the total score ranges from 0–5 (Whiteley-5). The Chinese Whiteley-7 exhibited satisfactory internal consistency, stable test–retest reliability, and expected correlates in Hong Kong [9]. The Cronbach's alpha of the Whiteley-5 was .68 in this study.

Kessler-6

It is a 6-item scale of non-specific psychological distress which has been shown to have excellent internal consistency and a good predictor of depressive and anxiety disorders in the general population of Hong Kong and other countries such as the United States [28,29]. The six items include two anxiety symptoms and four depressive symptoms: "nervous", "restless or fidgety", "hopeless", "so depressed that nothing could cheer you up", "everything was an effort", and "worthless". Respondents rated how frequently they had been bothered by these mood symptoms in the past four weeks on a "0" (none of the time) to "4" (all of the time) scale. The total score ranges from 0–24. A score of 13 or higher indicates high psychological distress, a score of 8 to 12 indicates moderate psychological distress, and a score of 0 to 7 indicates low psychological distress [30]. The Cronbach's alpha of the Kessler-6 was .84 in this study.

Sheehan Disability Scale (SDS)

It is a widely used instrument for assessing impairment, including Chinese communities [31,32]. Respondents rated how their somatic symptoms interfered with each of the four domains of living: 1) home

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