



# Health anxiety and medical utilization: The moderating effect of age among patients in primary care



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## ABSTRACT

Health anxiety is commonly seen in medical clinics and is related to the overutilization of primary care services, but existing studies have not yet considered the possible moderating effect of age. We examined if age moderated the association between health anxiety and medical utilization. A secondary aim was to examine potential racial/ethnic differences in health anxiety. An ethnoracially diverse group of patients ( $N = 533$ ) seeking treatment from a primary care clinic completed a self-report measure of health anxiety. Three indices of medical utilization were assessed using medical records, including the number of: (a) clinic visits over the past two years, (b) current medications, and (c) lab tests over the past two years. Age moderated the effect of health anxiety on multiple indices of medical utilization. Supplemental analyses found that the moderating effect of age was specific to a somatic/body preoccupation, rather than health worry, dimension of health anxiety. Mean-level differences in health anxiety were either not supported (health anxiety composite, somatic/body preoccupation) or were small in magnitude (health worry) among self-identifying Black, Latino, and White participants. Results indicate that assessing for health anxiety could be particularly important for older adult patients who frequently seek out medical services.

## 1. Introduction

Health anxiety broadly represents the wide range of worry individuals can have about their health (Asmundson & Taylor, 2005), with cognitive-behavioral models conceptualizing health anxiety as originating because of cognitive factors (Rachman, 2012). For example, Salkovskis and Warwick (2001) proposed that dysfunctional beliefs related to overestimating the likelihood and cost of health problems, as well as beliefs related to difficulties coping with and inadequacy of medical resources treating health problems, contribute to health anxiety. To date, extant research supports the role of those dysfunctional beliefs, as well as other cognitive factors (e.g., attentional bias to health threat, dysfunctional symptom attributions), in relation to health anxiety (Fergus, 2014; Neng & Weck, 2015; Norris & Marcus, 2014; Witthöft et al., 2016).

Existing data generally converge on viewing health anxiety as a dimensional construct, such that differences in the severity of health anxiety are best conceptualized quantitatively rather than qualitatively (Ferguson, 2009; Longley et al., 2010). Clinically severe presentations of health anxiety were once conceptualized as hypochondriasis (Warwick & Salkovskis, 1990), but hypochondriasis was eliminated as a

disorder in the fifth edition of the *Diagnostic and Statistical Manual for Mental Disorders* (i.e., DSM-5; American Psychiatric Association, APA, 2013a). More precisely, hypochondriasis was split into two DSM-5 diagnoses: somatic symptom disorder and illness anxiety disorder (Rief & Martin, 2014). The symptom presentation of somatic symptom disorder primarily consists of health anxiety and severe somatic symptoms, whereas the symptom presentation of illness anxiety disorder primarily consists of health anxiety and either no or mild somatic symptoms (APA, 2013a, 2013b). The majority of individuals diagnosed with hypochondriasis appear to qualify for a diagnosis of somatic symptom disorder rather than illness anxiety disorder (Bailer et al., 2016). Nevertheless, the traditional definition of hypochondriasis conceptually parallels illness anxiety disorder (Rief & Martin, 2014; Scarella, Laferton, Ahern, Fallon, & Barsky, 2016). One reason being that somatic symptom disorder includes somatic symptoms that are medically explained (Rief & Martin, 2014), which contrasts with conceptualizations of hypochondriasis as being a presentation of a *misinterpretation* of symptoms as a medical condition (Warwick & Salkovskis, 1990). Moreover, illness anxiety disorder captures fundamental aspects of hypochondriasis (i.e., preoccupation with having or acquiring a serious illness; Rief & Martin, 2014). Whereas

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additional research examining the distinctiveness of somatic symptom disorder and illness anxiety disorder is needed, health anxiety remains prominently featured in the DSM-5.

Consistent with the symptom presentations of somatic symptom disorder and illness anxiety disorder, two prominent dimensions of health anxiety are the tendency to worry about health (i.e., health worry) and a preoccupation with somatic/body symptoms (Asmundson, Carleton, Bovell, & Taylor, 2008; Welch, Carleton, & Asmundson, 2009). Health worry relates to the tendency to perseverate about one's health and somatic/body preoccupation relates to the tendency to focus on the possibility that somatic/body sensations may be indicators of health problems. Although research examining these two specific dimensions of health anxiety is in its relative infancy, preliminary research findings suggest the possibility of distinct correlates. For example, Bardeen and Fergus (2014) found that somatic/body preoccupation, rather than health worry, relates particularly robustly to the tendency to act impulsively in the face of negative emotions. Based upon these findings, Bardeen and Fergus (2014) noted that individuals experiencing heightened health anxiety-related preoccupation with their body may be particularly likely to engage in reassurance seeking behavior to mitigate associated distress.

Cognitive-behavioral models suggest that medical utilization is a safety behavior used by individuals experiencing health anxiety. More precisely, medical utilization may temporarily reduce health anxiety and, yet, utilization of medical services typically serves to sustain health anxiety because individuals do not get corrective experiences that dysfunctional beliefs contributing to health anxiety are unfounded (Abramowitz, Schwartz, & Whiteside, 2002; Salkovskis & Warwick, 2001). A repetitive cycle can develop in which individuals experience health anxiety, seek out reassurance from health professionals to mitigate health anxiety, health anxiety subsequently returns, and individuals engage in repeated medical utilization (Abramowitz et al., 2002; Salkovskis & Warwick, 2001). Consistent with these conceptual models, studies have found small-to-moderate positive associations between health anxiety and medical utilization (*rs* ranging from 0.20–0.45; Fergus, Bardeen, Gratz, Fulton, & Tull, 2015; Fergus & Valentiner, 2009; Fergus & Valentiner, 2010; Longley, Watson, & Noyes, 2005).

Given noted conceptual and empirical links between health anxiety and increased medical utilization, it may not be surprising that severe health anxiety (defined using a cutoff score of 20 on the Short Health Anxiety Inventory [SHAI, Salkovskis, Rimes, Warwick, & Clark, 2002]) is reported by nearly 20% of patients attending medical clinics (Tyrer et al., 2011). The prevalence and impact of health anxiety among patients in primary care clinics has received particular attention (Looper & Dickinson, 2014). For example, Fink, Ørnbøl, and Christensen (2010) found a 41–78% increase in primary care service utilization among patients with severe health anxiety (defined using diagnostic criteria for hypochondriasis in the DSM-IV (APA, 2000) or an alternative diagnostic criteria for health anxiety proposed by Fink et al., 2004). Based upon these findings, Fink et al. (2010) opined that health anxiety should be more consistently assessed and treated in primary care clinics. To help explicate when health professionals in primary care clinics may want to strongly consider assessing for health anxiety, it is important to examine factors that impact the relation between health anxiety and medical utilization.

Age is a potential moderating variable to consider for better understanding the relation between health anxiety and medical utilization. Existing research suggests that age is positively associated with medical utilization (Boston & Merrick, 2010; Thomsen et al., 2004), although medical morbidity may help explain that association (Barsky, Orav, & Bates, 2005). Moreover, there have been calls for increased attention to the relation between age and health anxiety. For example, El-Gabalawy, Mackenzie, Thibodeau, Asmundson, and Sareen (2013) noted that older adults are at an increased risk for physical health ailments and, thus, may be particularly susceptible to health anxiety.

Boston and Merrick (2010) examined health anxiety among a sample of older adults and found that over 7% of the participants reported severe health anxiety (defined using a cutoff score of 15 on the SHAI). Boston and Merrick (2010) further found that health anxiety (assessed using the SHAI) was related to greater medical utilization independent of the effects of physical health functioning among their sample of older adults.

Whereas El-Gabalawy et al. (2013) note that mild health anxiety may lead to adaptive outcomes among older adults (e.g., serving as a motivator for seeking appropriate care), these researchers further note that early detection of elevated health anxiety among older adults is especially important in helping to reduce the likelihood that health anxiety progresses to more severe presentations. Conceptually, age may impact the association between health anxiety and medical utilization because health anxiety can negatively influence older adults' perceptions of physical health, thereby further worsening their health anxiety (El-Gabalawy, Mackenzie, Shoostari, & Sareen, 2011; El-Gabalawy et al., 2013). Older adults often face difficulties with emotion regulation in situations in which they experience heightened distress (Charles & Luong, 2013). Consequently, older adults with elevated health anxiety may be likely to seek out medical services as a form of reassurance seeking in an attempt to mitigate health-related distress.

The present study further examined interrelations among age, health anxiety, and medical utilization, while providing the first known examination of the moderating effect of age on the association between health anxiety and medical utilization. We examined three indices of medical utilization, including the number of: (a) clinic visits over the past two years, (b) current medications, and (c) lab tests over the past two years. We predicted that health anxiety would positively relate to each index of medical utilization. We further predicted that health anxiety would relate to *greater* medical utilization as age increased. Supplemental analyses examined which of two health anxiety dimensions – health worry and somatic/body preoccupation (Asmundson et al., 2008) – may be most impacted by the moderating effect of age.

When examining the potential moderating effect of age on the association between health anxiety and medical utilization, it is important to account for shared variance with covariates. Potentially relevant covariates include other sociodemographic variables, such as gender and race/ethnicity. For example, women report greater health anxiety in respect to certain dimensions of health anxiety, such as health worry, than men (MacSwain et al., 2009). Further, prior research has found women seek out greater primary care services than do men (Bertakis, Azari, Callahan, & Robbins, 2000). There are inconsistent findings regarding differences in the frequency of primary care utilization across racial/ethnic groups, with some research finding no differences in certain primary care settings (Koo, Madden, & Maguen, 2015). Other research indicates patients who are racial/ethnic minorities may be less likely to use primary care services relative to other sources of care relative to patients who are White (Arnett, Thorpe, Gaskin, Bowie, & LaVesit, 2016). Potential racial/ethnic differences in the severity of health anxiety remain unexamined in the literature. Pursuant to potential differences, Hunter and Schmidt (2010) proposed that individuals who self-identify as Black may report heightened catastrophic interpretations of specific somatic symptoms rather than cognitive symptoms of anxiety (e.g., worry). Such findings provide indirect support for possible racial/ethnic differences in the health anxiety dimensions of health worry and bodily/somatic symptom preoccupation.

Two additional covariates to consider are medical morbidity and depression symptoms. As noted, Barsky et al. (2005) noted that age accounts for little unique variance in medical utilization scores once medical morbidity has been taken into account, while finding that primary care patients with severe somatic symptoms had heightened medical morbidity relative to patients without severe somatic symptoms. Additionally, depression positively correlates with both medical utilization (Kimerling, Ouimette, Cronkite, & Moos, 1999) and health

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