

# ILLNESS ANXIETY DISORDER AND SELF-CARE BEHAVIORS IN GENERAL POPULATION

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## Introduction

The illness anxiety disorder has as characteristics the wrong attribution and the catastrophic interpretation of the physical symptoms as evidence of serious diseases, in spite of the absence of such evidence (Torales, 2017). Unreal fear of having or developing a disease and concern for the meaning of perceived somatic symptoms, generates anxiety (Pastorelli, 2011). In turn, these dysfunctional thoughts, lead to put in place different strategies to control them, reduce their emotional impact or suppress them (Arnáez, García-Soriano and Belloch 2017), appearing so, verifiable behaviors, avoidant behaviors or repeated search for reassuring information that it is not always effective to take care of them health (Torales, 2017). This conduct of overvaluation and action on the state of health that leads to the overuse of health services is coined by Pilowsky (1996) as an abnormal behavior of disease. Beyond this dimension linked mainly with the health system, it would also be useful to analyse if certain characteristics of the anxiety disorder by illness could modulate self-care, specifically, lifestyles. This is the reason for this project.

## Objectives and hypotheses

The objective of the research is to assess if there is a relation between health habits and some manifestations of anxiety due to illness.

According to past studies (Torales, 2017, Pastorelli, 2011, Arnáez, García-Soriano and Belloch 2017), people with dysfunctional intrusive thoughts about the possibility of suffering from a disease, perform strategies to avoid it, therefore, it is expected that have beneficial health habits that people, on the contrary, do not have that series of obsessive worries. From these statements, the hypothesis that is raised is:

H1: People who score high on the Hypochondria and Disease Conviction scales have better health habits.

## Method

*Participants.* 334 participants where 72.2% of them were women and 27.8% men. There are no significant differences between both with respect to the average age, whose total mean is 31.68 (SD=12.87). In relation to the level of study, there is a higher mean in women ( $\bar{X}$ =3.74, SD=.599) with respect to men ( $\bar{X}$ =3.47, SD=.669), these differences are significant ( $t$ =3.568  $p$ ≤.001).

*Instrument.* General Hypochondriasis and Disease Conviction of the Disease Conduct Questionnaire (IBQ) of Pilowky and Spence (1983) were used, adapted by Ibanez et al (1996) with good psychometric properties, as indicated by Cronbach's alpha of 0.84. On the other hand,

two scales were included that explored the realization of 9 items of Health Habits, with Likert format.

*Process.* The information of the study was disseminated through social networks, by means of messages which contained the link to the online questionnaire. Once they gave their informed consent, they proceeded to complete it voluntarily and anonymously. The results were carried out by the statistical program SPSS 23, making descriptive, differential, correlational and regression analyses. For the study the request of the Deontological Commission of the UJI.

## Results

First, in the analysis of the variable hypochondria, a higher score was observed in women ( $\bar{X}=2.42$ ,  $SD=1.76$ ) compared to men ( $\bar{X}=1.52$ ,  $SD=1.33$ ), with differences significant ( $t=4.45$   $p\leq.001$ ) and medium effect size ( $d = 0.54$ ,  $CI = 0.301, 0.785$ ). In addition, the Disease Conviction scores with an average of 1.31 ( $SD=1.16$ ) in women, while in men it is 0.98 ( $SD=.99$ ) also with statistical significant differences ( $t=2.351$   $p\leq.019$ ) and small effect size ( $d=0.29$ ;  $CI=0.055; 0.534$ ). Regarding the analysis of the relation of these variables and health behaviors in women, we did not find a significant correlation. Instead, it is related to some specific aspects such as: the belief of having a health problem with more medical check-ups ( $r=.189$   $p\leq.003$ ), the interference that may cause the thought of suffering from a disease and more safe sexual practices ( $r =-.209$   $p\leq.001$ ), between sensitivity to pain and the habit of practicing sports ( $r=-.162$   $p\leq.012$ ), the subjective sleep quality is correlated significantly with both tobacco ( $r=.192$   $p\leq.003$ ) and precooked food ( $r=.262$   $p\leq.0001$ ). With respect to men, only a significant correlation between the Conviction of illness and sport is evidenced ( $r=.267$   $p\leq.010$ ). More specifically, there is the relation between the belief of having a health and habit of drinking alcohol ( $r=-.211$   $p\leq.041$ ) and of eating precooked food on a regular basis ( $r=-.219$   $p\leq.035$ ), people who consume more drugs have greater interference due to concerns about having a disease in a significant way ( $r=.224$   $p\leq.031$ ) and they are more sensitive to subjective pain ( $r=.257$   $p\leq.013$ ), the fear of getting sick correlates negatively with compliance with medical prescriptions ( $r=-.234$   $p\leq.024$ ), the belief of the possibility of sudden illness has a significant inverse correlation with safe sexual practices ( $r=-.236$   $p\leq.023$ ), and people susceptible to the disclosure of diseases and risks on television perform have a less dangerous driving ( $r=-.290$   $p\leq.005$ ).

## Conclusion and discussion

In general terms, women show a higher score in hypochondria and disease conviction. However, there is an existing relationship between some of the components and certain health habits, in men and women, and in recent authors in relation to medical check-ups (Pastorelli, 2011) and physical activity (Munguía et al, 2007) These results might respond to different explanations. Firstly, in line with Ajzen and Fishbein (1980) the beliefs and subjective norms are related to the intention of final behavior. However, the analysis of the perceived risk, which causes the interference with the population with greater disease anxiety, without it actually influences behavior but rather the post-behavioral concern (Rovira et al, 1994). On the other hand, people who have a very high anxiety because of the disease, may resort to the harmful substances as the external form of self-regulation to mitigate negative emotional states or cause more pleasant (Trinidad and Johnson, 2002). Finally, regarding the relationship with health

professionals, people with an irrational fear of the disease feel dissatisfied with the care received (Torales, 2017), so they would reiterate the search for help.

The limitations of the study were the size and characteristics of the sample, as well as the possible social desirability associated with the self-report.

From the results emerges from the deepening of the analysis, in relation to other variables that may influence the relationship of abnormal behavior of disease and health habits. Or to detail other lifestyles with which the study can be extended. On the other hand, practitioners should use these results to guide the intervention of health programs, for example, including prevention programs for people with higher levels of anxiety than behavior that remains the same pattern as the normal population. At the clinical level, it can be used to justify the need to incise in psychoeducation during the therapy with people with abnormal behavior with the goal of eliminating beliefs and maladaptive behaviors in self-care.

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