

# Health Anxiety and Perceived Stress: A Comparative Study among Kerala Adults

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## Abstract

**Background:** This study examined the relationship between health anxiety and perceived stress among Kerala adults, considering the impact of gender and occupational differences (healthcare vs. non-healthcare professionals).

**Methods:** The tools used were Short Health Anxiety Inventory by Paul M. Salkovskis, Kate A. Rimes, Helen M. C. Warwick and David M. Clark (2002) to assess health anxiety and Perceived Stress Scale by Sheldon Cohen and his colleagues (Kamarch & Mermelstein) in 1983 to measure the degree to which situations in one's life are appraised as stressful.

**Results:** A sample of 151 adults aged between 20 and 60 participated in the study. Linear regression, Spearman correlation, and Mann-Whitney U tests were used for analysis. Results showed a significant correlation between health anxiety and perceived stress. Healthcare professionals reported higher health anxiety than non-healthcare professionals, while no significant differences were found between genders or in perceived stress across occupations.

**Conclusion:** These findings highlight the need for targeted interventions to manage health anxiety and stress, particularly among healthcare professionals, to promote overall well-being.

**Keywords:** Health Anxiety, Perceived Stress, Kerala Adults

## Introduction

### Population

Keralites, the people of Kerala, a state on India's southwestern coast, are known for their high literacy rates, progressive social indicators, and rich cultural heritage. The adult population in Kerala shows a mix of traditional values and modern ideas, influenced by widespread education, strong healthcare systems, and notable migration patterns, especially to

the Gulf countries (Jeffrey, 1993; Zachariah & Rajan, 2012). Adults in Kerala manage complex roles, managing family responsibilities while actively engaging in economic, social, and political areas. This involvement contributes to the state's impressive human development results (Kumar, 2010). Kerala's focus on improving human capital has led to a better quality of life, increased life expectancy, and lower infant mortality, making it a model for other Indian states (Sen, 1999). Adults in Kerala are increasingly vulnerable to health anxiety and stress, driven by factors such as high educational awareness, lifestyle changes, and exposure to health information through media. Studies indicate that Kerala's adult population experiences elevated health-related worries, partly due to better health literacy and access to medical information, which sometimes leads to heightened anxiety about illnesses (Rathod et al., 2020). Also, rapid urbanization, work-related pressures, and social transitions contribute to increased stress levels among Kerala adults (George & Thomas, 2018). This combination of health anxiety and stress affects overall well-being and healthcare utilization patterns in the state.

### **Health Anxiety**

Being concerned about one's health serves an important purpose; it increases survival. Addressing illness symptoms quickly is helpful. However, some people become overly worried about their health and develop concerns that range from mild to severe (Rachman, 2012). This condition is known as health anxiety (HA). Health anxiety is characterized by a heightened awareness of bodily sensations, which are often linked to viral infections, and a tendency to interpret them as signs of serious medical conditions (Salkovskis et al., 2002). It is also called illness anxiety or hypochondria. People with health anxiety have excessive fears or beliefs that they have a serious illness based on misinterpreting bodily changes or symptoms (American Psychiatric Association, 2013; Barsky & Ahern, 2004). This condition leads to an increased focus on bodily symptoms (Asmundson et al., 2010; Haenen et al., 2000; Starcevic, 2005).

Severe health anxiety is marked by cognitive, physical, and behavioral features that often appear after stressful events, serious illness, or the loss of a loved one (Taylor S et al., 2004). It can also arise after exposure to disease-related media. One key cognitive feature is disease conviction; this is the belief that bodily sensations result from disease (e.g., "This headache means I have a brain tumor") rather than being benign symptoms or feelings caused by the autonomic nervous system. Other negative beliefs, such as seeing oneself as weak or vulnerable, may accompany disease conviction, leading to worries over the cause and authenticity of bodily sensations and changes, which drives unhealthy coping behaviors.

## Perceived Stress

Perceived stress is a complex and multifaceted concept that arises from the dynamic interplay between an individual and their environment. It's not just about the stressful events that occur in one's life, but rather how they perceive and interpret these events. It is the feelings or thoughts an individual has about how much stress they are under during a given period. It includes how over-whelming life events are and how they impact an individual's well-being (Phillips, 2013). According to Moschis (2007), the stressfulness of an event depends on its characteristics, such as importance, desirability, controllability, and unexpectedness. When individuals perceive stress, they're evaluating their life situation and assessing their ability to cope with the demands placed upon them. This evaluation encompasses various aspects, including feelings of uncontrollability and unpredictability, the frequency of daily hassles, the extent of change in one's life, and confidence in their problem-solving abilities (Cohen et al., 1983). Perceived stress is a highly subjective experience, and people can respond differently to similar stressful events due to factors like personality, coping resources, and social support (Lazarus & Folkman, 1984).

## Method

### Research Design

The study employed a quantitative research design, involving a total of 151 participants comprising both males and females from diverse occupational backgrounds. The sampling process utilized convenience sampling technique and the data were collected through online platforms. Participants were provided with a set of instructions, a consent form, and standardized questionnaires. Upon obtaining their informed consent, participants completed the questionnaires, and subsequently, they were thanked for their valuable participation and cooperation in the study.

### Participants

The study employed a quantitative research design, involving a total of 151 participants comprising both males and females from diverse occupational backgrounds. The participants were between 20 and 60 age including both males and females from healthcare and non healthcare professions. The study included participants who had access to the internet and the educational background necessary to comprehend and respond to the study questions.

## Instruments

The following tools are utilized for evaluating the two psychological factors:

- Short Health Anxiety Inventory by Paul M. Salkovskis, Kate A. Rimes, Helen M. C. Warwick and David M. Clark in 2002.
- Perceived Stress Scale by Sheldon Cohen and his colleagues (Kamarch & Mermelstein) in 1983.

## Short Health Anxiety Inventory

The Short Health Anxiety Inventory (SHAI) is an 18-item measure that assesses health anxiety, regardless of physical health status (Salkovskis et al., 2002). It uses a 4-point scale (ranging from 0 to 3) with varying response choices. However, Alberts et al. (2011) suggest that only 14 items directly assess health anxiety, which is why the 14-item SHAI was used here. The total scale score was used, as no predictions were made about the performance of Alberts et al.'s two SHAI component scales. The SHAI has shown moderate to strong correlations ( $r$ s ranging from .28 to .65) with other health anxiety indices (Fergus & Valentiner, 2011).

## Reliability

The Short Health Anxiety Inventory (SHAI) shows good psychometric properties based on the given data. In terms of reliability, the SHAI has excellent internal consistency with values ranging from .74 to .96 across 16 studies (Alberts et al., 2013). However, test-retest reliability was reported in only one study by Olatunji et al. (2011), where it was found to be adequate ( $r = .87$ ) over four administrations in a 3-week period.

## Validity

Regarding validity, the SHAI has sound factorial, convergent, divergent, and criterion validity (Alberts et al., 2013). Additionally, the scale has been shown to be sensitive to treatment effects with Cognitive Behavioral Therapy (CBT) for severe health anxiety (Williams et al., 2011; Hedman et al., 2011).

## Perceived Stress Scale

The PSS is a 10-item instrument developed by Sheldon Cohen, Tom Kamarck, and Robin Mermelstein in 1983 designed to measure the degree to which situations in one's life

are appraised as stressful. The PSS assesses global perceptions of stress with a rationale that stressful events can increase risk of health problems when they are appraised as threatening or otherwise demanding. The PSS provides information about the processes through which stressful events influence pathology, and also can be used to assess whether a factor known to moderate stress-illness relations, such as social support, operates through its influence on stress appraisal or through some other pathway. The scale can be used to investigate the role of overall stress appraisal and situations in which the objective sources of stress are difficult to measure. The PSS also can be viewed as an outcome measure examining the experienced level of stress as a function of objective stressful events, coping processes, and personality factors.

### **Reliability**

The Perceived Stress Scale (PSS) has good internal consistency with an alpha of .78. No data on stability were reported.

### **Validity**

The PSS has established good construct validity. The PSS scores were moderately related to responses on other measures of appraised stress as well as to measures of potential sources of stress as assessed by stress event frequency. Small but significant correlations were also found between higher PSS scores and some self-reports of health behaviors. The PSS was also related to scores on the Health Youth Services Utilization Scale and the three factors of the Psychosomatic Index. The frequency of physical illness and symptoms of physical illness also were positively related to reports of stress. The PSS was significantly correlated with the Life Satisfaction Scale and with measures of help-seeking behaviors.

### **Statistical Analyses**

Data was compiled in Microsoft Excel and subsequently analyzed using SPSS statistical software. Because the data did not follow a normal distribution, non-parametric statistical methods were employed. The internal consistency and stability of the measurement tools were evaluated using a reliability test. To examine the relationships between variables without assuming normality, a Spearman correlation test was conducted to measure the strength and direction of monotonic relationships, while linear regression was utilized to model the relationships between independent predictors and dependent outcomes. Additionally, a Mann-Whitney U test was performed as a non-parametric alternative to the independent samples t-test to compare differences between two independent groups.

## Ethical Considerations

Throughout the study, the well-being and rights of participants were prioritized. The research was conducted with the utmost care to ensure that no individuals were harmed physically or psychologically. Participants were randomly selected and provided informed consent, indicating their voluntary agreement to participate. Their privacy was protected, and confidentiality was maintained throughout the process. Also, participants were given the autonomy to withdraw from the study at any point without facing any penalties, and their anonymity was guaranteed and upheld. This ensured a safe and respectful environment for participants to share their experiences.

## Result

The internal consistency of the study measures was assessed using Cronbach's alpha. The Health Anxiety Scale demonstrated good reliability ( $\alpha = .83$ ), while the Perceived Stress Scale (PSS) showed acceptable reliability ( $\alpha = .76$ ), indicating that both instruments were suitable for use with the present sample ( $N = 151$ ).

Descriptive statistics revealed that participants reported a mean Perceived Stress score of 18.60 ( $SD = 5.97$ ), with scores ranging from 4 to 40. Health Anxiety scores had a mean of 13.85 ( $SD = 6.72$ ), with values ranging from 0 to 41. These findings indicate moderate levels of perceived stress and health anxiety among adults in Kerala, with substantial variability across participants.

Tests of normality were conducted to assess the distribution of Perceived Stress scores. Both the Kolmogorov–Smirnov test,  $D = .142$ ,  $p < .001$ , and the Shapiro–Wilk test,  $W = .936$ ,  $p < .001$ , were statistically significant, indicating a deviation from normality. Therefore, non-parametric statistical procedures were employed for subsequent analyses.

A Spearman rank-order correlation was conducted to examine the relationship between Health Anxiety and Perceived Stress. The results revealed a significant positive correlation between the two variables,  $r_s = .31$ ,  $p < .01$ , suggesting that higher levels of health anxiety were associated with greater perceived stress.

To further examine this relationship, a simple linear regression analysis was performed to determine whether Health Anxiety predicted Perceived Stress. The regression model was

statistically significant,  $F(1, 149) = 13.75$ ,  $p < .001$ , accounting for 8.5% of the variance in Perceived Stress ( $R^2 = .085$ , Adjusted  $R^2 = .078$ ). These findings indicate that increases in Health Anxiety were associated with increases in Perceived Stress among adults in Kerala.

A Mann–Whitney U test was conducted to compare Health Anxiety and Perceived Stress across occupational groups. The analysis revealed a statistically significant difference in Health Anxiety between healthcare professionals and non-healthcare professionals,  $U = 2275.00$ ,  $z = -2.14$ ,  $p = .032$ . Healthcare professionals (Mean Rank = 83.57) reported significantly higher levels of Health Anxiety than non-healthcare professionals (Mean Rank = 68.33). However, no significant difference was found in Perceived Stress between the two groups,  $U = 2844.50$ ,  $z = -0.02$ ,  $p = .984$ .

Gender differences were also examined using the Mann–Whitney U test. The results indicated no statistically significant difference between males and females in Health Anxiety,  $U = 2459.50$ ,  $z = -1.46$ ,  $p = .146$ . Similarly, no significant gender difference was observed for Perceived Stress,  $U = 2584.50$ ,  $z = -0.99$ ,  $p = .321$ . Although females obtained slightly higher mean ranks on both variables, these differences did not reach statistical significance.

#### ***Spearman Correlation Between Health Anxiety and Perceived Stress***

| Variable  | 1      | 2      |
|-----------|--------|--------|
| HA Total  | —      | 0.31** |
| PSS Total | 0.31** | —      |

Note. \*\* $p < .01$ (two tailed).

#### ***Linear regression predicting PSS from Health Anxiety***

| Predictor | R    | $R^2$ | Adjusted $R^2$ | F Change | p      |
|-----------|------|-------|----------------|----------|--------|
| HA Total  | 0.29 | 0.085 | 0.078          | 13.75    | < .001 |

Note. Dependent variable: PSS Total

## Discussion

The present study examined the relationship between health anxiety and perceived stress among adults in Kerala and explored differences in these variables based on gender and occupational status. The findings revealed a weak positive correlation between health anxiety and perceived stress, indicating that individuals who reported higher levels of health-related anxiety also tended to experience greater perceived stress. This finding is consistent with the Cognitive Appraisal Theory of Stress proposed by Lazarus and Folkman (1984), which emphasizes that stress is influenced by an individual's interpretation of potentially threatening situations. Individuals with elevated health anxiety may be more likely to perceive bodily sensations or health-related information as threatening, thereby increasing their overall stress levels. The present findings are also consistent with previous research, including the study by Koshy and Lokesh (2022), which reported a significant association between health anxiety and perceived stress among young adults.

With respect to gender differences, no significant differences were observed between males and females in either health anxiety or perceived stress. These findings suggest that both genders experience comparable levels of health-related concerns and perceived stress within the present sample. While earlier studies have reported higher levels of stress and anxiety among women (Hall et al., 2006), recent evidence suggests that gender differences in psychological distress may be narrowing. However, the present findings contrast with studies indicating that women generally report higher levels of health anxiety and anxiety disorders than men. Such inconsistencies may be attributable to cultural, demographic, or contextual differences across study populations.

Regarding occupational status, no significant difference was found in perceived stress between healthcare and non-healthcare professionals. This finding suggests that perceived stress may be influenced by a wide range of personal, social, and environmental factors that extend beyond occupational roles. Previous research has often reported elevated stress among healthcare professionals due to heavy workloads, emotional demands, and exposure to illness and suffering. The absence of such differences in the present study may reflect variations in workplace conditions, coping resources, or broader life circumstances experienced by participants.

In contrast, a significant difference emerged in health anxiety, with healthcare professionals reporting higher levels of health anxiety than non-healthcare professionals. This finding may be explained by healthcare professionals' greater exposure to medical information, frequent encounters with illness, and heightened awareness of disease symptoms. Cognitive-behavioral models of health anxiety (Salkovskis & Warwick, 1990) suggest that increased attention to health-related cues and bodily sensations can contribute to heightened health concerns. The professional knowledge and clinical exposure of healthcare workers may therefore increase vigilance toward potential health threats, resulting in greater health anxiety.

Overall, the present study contributes to the growing body of literature on health anxiety and perceived stress by providing evidence from a Kerala-based adult population. The findings support theoretical perspectives that emphasize the role of cognitive appraisal and health-related beliefs in shaping psychological well-being. Furthermore, the observed occupational differences highlight the influence of professional exposure on health-related anxiety, while the absence of gender differences adds to ongoing discussions regarding changing patterns of psychological distress. These findings underscore the importance of considering contextual and occupational factors when examining mental health outcomes and provide a foundation for future research within culturally diverse populations.

## Conclusion

The present study demonstrated a weak positive relationship between health anxiety and perceived stress among adults in Kerala, indicating that individuals with higher levels of health anxiety are more likely to experience elevated stress. No significant gender differences were observed in either health anxiety or perceived stress. However, healthcare professionals reported significantly higher levels of health anxiety compared to non-healthcare professionals, although perceived stress did not differ significantly between occupational groups. These findings highlight the role of health-related concerns in shaping psychological well-being and emphasize the importance of considering occupational context when addressing health anxiety among adults.

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