Health Anxiety and Hypochondriasis: The Patient's Perspective

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Abstract

This qualitative study using a social constructionist epistemology looked at seven individuals' experiences of health anxiety and hypochondriasis. Participants were recruited using advertisements on local public notice boards, word of mouth and a published newspaper interview. Participants self-identified as having health anxiety or hypochondria and ranged between 18-64 years of age. There were three male and four female participants. A thematic narrative analysis was undertaken. Common themes that were identified were: childhood attachment styles, trauma, personal experience with illness, the function of health anxiety, health anxiety developing into adulthood, stigma of being labelled a hypochondriac, participants' positioning of self and others, participants' views on their doctors and communication styles.

Also outlined were participants' recommendations for managing symptoms and coping with doctors' consultations. Implications include integrating attachment theories into therapy for health anxiety and working towards improving communication skills between medical doctors and health anxious and hypochondriacal patients.

Preface of Terms

The present study included interviewing people who self-identified as having health anxiety and/or hypochondria. Research that is discussed in the current study refers to health anxiety, hypochondria and/or somatization in the same way. These terms will now be defined for the present study as:

Table 1 - Health Anxiety
Health anxiety is a term differentiated from hypochondriasis, as it does not meet the full Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for hypochondriasis (as listed below). Health anxiety includes an individual's excessive worry about their health, stemming from beliefs that the person's physical integrity is threatened. Health anxiety is multifaceted and consists of distressing emotions (e.g. fear), physiological arousal (e.g. palpitations), thoughts and images of danger, and avoidant behaviours. Health anxiety ranges from mild and transient, to severe and chronic (Taylor & Asmundson, 2004).

Table 2 - Hypochondriasis	
A.	Preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.
B.	The preoccupation persists despite appropriate medical evaluation and reassurance.
C.	The belief in criterion A is not of delusional intensity (as in delusional disorder, somatic type) and is not restricted to circumscribed concern about appearance (as in body dysmorphic disorder).
D.	The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
E.	The duration of the disturbance is at least six months.
F.	The preoccupation is not better accounted for by generalized anxiety disorder, obsessive compulsive disorder, panic disorder, a major depressive episode, separation anxiety, or another somatoform disorder (American Psychiatric Association, 2000).

Table 3 - Somatization
Somatization is the conversion of psychosocial stressors into bodily symptoms. This involves the tendency to experience and communicate psychosocial stressors physically, through bodily symptoms.

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1. Hypochondria and Health Anxiety

Although the 'butt' of many jokes, hypochondria is no laughing matter! The costly and time consuming medical treatments of patients with hypochondria and high health anxiety are enormous. The impact is huge on our health care systems, with medically unexplained symptoms accounting for 25-50 percent of all primary care visits in the general population (Barsky, 2000). According to Taylor and Asmundson (2004), people with hypochondria make up to 26 percent of this population. Hardy, Warmbrodt & Chrisman (2001) argue that a higher percentage bracket of 25-75 percent of all primary care office visits involve somatic presentations.

This impact extends beyond primary care settings, as health anxious and hypochondriacal people pay more visits to general practitioners and specialists than other people (Barsky, 2000). They have more medical laboratory tests and surgical procedures (Barsky, Ettner, Horsky, & Bates, 2001), both of which place great economic burden on healthcare systems. People who have high health anxiety tend to have more sick days off work than average and are also more likely to be on disability benefits (Sternberg, 1999).

Often there is a stigmatized view in society of hypochondriacal, health anxious people. This is reflected in some of the labels often used in describing the hypochondriacal patient, for example, as the *'worried well'*. There are unspoken 'rules' about who is entitled to *'the sick role'* (Parsons, 1975). This is evident in statements such as: *'Don't take any notice of him, he's just being a hypochondriac'*. Who is, and who is not, deserving of the sick role can be seen as socially constructed (Gergen, 1985). Adoption of the sick role, which includes time off work and gaining care from others, is permissible only when the sickness or disability is genuine, well known, accepted by society, and is easily demonstrated (as in a cast for a broken arm) (Hyden & Brockmeier, 2008). The sick role requires the patient to cooperate in efforts to return themselves to good health if possible, and do all that they can (Henderson, 1974; Rapport & Wainwright, 2006). In contrast, the hypochondriacal and health anxious patient may not meet

the constructed criteria of this sick role. They may not have accepted, well known illnesses, and they appear not to be complying with their doctor's advice and reassurance. That is, health anxious patients often seek second opinions, and further reassurances (Maj, Akiskal, Mezzich & Okasha, 2005).

The sick role of entitlement is not the only socially constructed phenomenon. According to social constructionist epistemology (which forms the framework for this study), knowledge lies within the process of social interchange (Gergen, 1985). At the same time, reality is different for all of us. Our social reality is seen through our individual lenses, based on our own unique life experiences and understandings of the world (Berger & Luckman, 1966). Reality can be seen as socially constructed by, and between, the people who experience it, in the hypochondriac's case, construction often lies between doctor and patient interactions.

Constructs such as hypochondria are shaped by the historical, cultural, political, and social norms which operate within a context and time (Gergen, 1999). Hypochondria has been described as an *'ancient malady'* (Starcevic & Lipsitt, 2001), along with other labels. The names over time have changed, including 'hysteria', but the symptoms have remained the same. As society and language have been constructed over time, so have our meanings and understandings for the set of behaviours that are commonly referred to in Western society as hypochondria (hypochondriasis for the medical experts!). To learn more about the construct of hypochondria, we need to first look at the language and context of this malady in history, to be informed on how it is constructed and understood by ourselves and wider society today. Thus an outline of the changing conceptualization of hypochondria will now be given, starting with the actual language construct of *hysteria* in ancient Greece. This overview starts with discussion on hysteria, which, according to the current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) definition, was the initial name for hypochondriasis (American Psychiatric Association, 2000).

2. Historical overview of Hypochondria

Hypochondria is rooted in language constructs and gender stereotypes from around 2AD. The womb (named *hystera*) was said to be the origin of *hysteria,* a medical illness that affected women. Hysteria was said to be characterized by a variety of physical symptoms at one time or another. Common symptoms included chest pains, a lump in the throat, difficulty swallowing (globus hystericus), aches and pains and shortness of breath, to name but a few. These are common symptoms that people with hypochondriasis still suffer from (Fallon, 2007). Unlike the current stigma of hypochondria (Maj et al, 2005), in ancient Greek times hysteria was seen as a purely medical condition occurring only in women. However it seems the etiology and treatment back then had much stigma also, highlighting the sexist nature of those times as much as the lack of anatomical understandings of the human body (Showalter, 1997).

2.1 The Wandering Womb:

The cause of hysterical symptoms was thought to be related to the woman's womb. The theory was that the woman's uterus somehow began to move to various parts of the body (Starcevic & Lipsitt, 2001). Therefore painful symptoms reported throughout the body were affected by this 'wandering womb'. Twenty-first century Western etiology for hypochondria is discussed in terms of typical age of onset and socio-cultural factors such as gender that may influence the disorder (Maddux & Winstead, 2008). For example, similar to many other mental illnesses, typical age of onset for hypochondria is late teens to early adulthood, with slightly more women reported as being affected (Sadock & Sadock, 2003). Similarly in ancient Greek times, there was talk about the illness afflicting *"young unmarried virgin women, and on occasion widows"* (Pilowsky, 1997,p.121). The societal context at the time would have been an underlying factor in differentiating our current definitions of age, as teenage years were not defined as they are now. The theory of the wandering womb concluded that the womb must be wandering in these young unmarried women and widows, to be seeking semen. The womb

therefore would settle once semen was found, and thus treatments consisted of finding hysterical patients husbands very quickly! Main treatment goals were marriage, intercourse and pregnancy (Shapiro & Rosenfeld, 1987).

Reflecting this oppressive nature in society is Aretaeus of Cappodocia's second century description of hysteria:

> In the middle of the flanks of women lies the womb, a female viscous, closely resembling an animal; for it is moved hither and thither in the flanks, also upward in direct line to below the cartilage of the thorax and also obliquely to right or left, either to the liver or spleen; and likewise is subject to prolapsus downwards, and, in a word, it is altogether erratic. It delights also in fragrant smells and advances towards them, and it has an aversion to foetid smells and flees from them and, on the whole the womb is like an animal within an animal *(Slaveney, 1990, p.13).*

It should be noted here that women are differentiated, in some way, from their wombs. It is not their wombs as part of them, but talked about as a separate object in this piece of writing, having a life of its own. While the '*husband search*' was on, the little animal inside the sufferer was lured back to its place via the vagina, with sweet smelling substances (perhaps administered by physicians) or repelled downwards by administering evil tasting and foul smelling substances (Showalter, 1997).

As well as typical objectification of that time, women were not allowed to inherit anything, were not to be educated as well as males, and, in financially secure families, were kept indoors, only making appearances in public places with a chaperone. Simon (1978) suggests that considering these women's inferior status and restrictive lives, hysterical behaviour might have been one of the few ways to express their dissatisfaction. Therefore these meanings mirror the culture of the time (sexism, power relations, women's roles and the lack of technology to have an understanding of physiological interactions in the body). However, what about male sufferers?

2.2 From Hysteria to Hypochondria - Men Become Included

Although traditionally thought of as a female ailment, conceptualizations were forced to change, as men persistently presented with symptoms of hysteria (Shapiro & Rosenfeld, 1987). This would have caused considerable conflict at the time, as men with hysteria must have impacted on the theory of cause, as well as treatment of hysteria (men not having wombs to wander about!). So much about hysteria was imbedded in the language and cultural constructs of that time, especially it being a female ailment. There may have been political implications for this gender label also, to keep women in place as married mothers. It appears, from the literature, that the theory behind hysteria was not ready to change very drastically. To incorporate males into the concept of hysteria was not possible, nor did it seem possible to change conceptualizations of hysteria into something larger to include both genders. Instead, existing views on hysteria continued and a separate but similar condition was reserved especially for the male sufferer of these same symptoms.

The word hypochondria, which came from the word *"hypochondruim"* was given to diagnose men (Maj et al, 2005; Pillowsky, 1997). Physiologically based in language like hysteria, Hippocrates used this word to describe the lower chest in front of the heart and the upper abdomen below the ribs (Starcevic & Lipsitt, 2001). In today's definition of hypochondria, the DSM-IV continues to refer to hysteria as the historical definition of hypochondria (American Psychiatric Association, 2000) and many authors have, over time, agreed that the two are actually the same (Fallon, 2007; Maj et al, 2005; Pilowsky, 1997; Showalter, 1997; Starcevic & Lipsitt, 2001). At this early stage in ancient Greece the medical conceptualization continued, but separated underlying causes by gender. As women would have hysteria, men would have hypochondruim pains and problems. Unlike women, men were not thought to have 'an animal inside an animal'. Their pains came from medical problems in the hypochondruim area. Thus men were not prescribed marriage, intercourse and pregnancy; in fact there was a lack of any treatment for men at this time. As hypochondria has been seen as resistant to treatment up until very recent times, perhaps this view began here. The ancient Greek view dominated understandings of hypochondria until the mid-sixteenth century.

2.3 Hypochondria as a Nervous Condition

In the mid-seventeenth century the concept of *'nervous disorder'* emerged. Thomas Willis (1621-1675) was the first person to conceptualize hysteria/hypochondria as involving the mind, rather than only physiological mechanisms originating in the womb and hypochondrium (Starcevic & Lipsitt, 2001). His quote illustrates this:

> *As we have shewn before that the passions vulgarly called hysterical do not always proceed from the womb, but often from the heads being affected: so though it has been vulgarly held that the effects called hypochondrical are caused by the most part by vapours arising from the spleen and running hither and thither; yet in truth those distempers are for the greatest part convultions and contractions of the nervous parts"* (Starcevic & Lipsitt,2001,p.9).

Willis' inclusion of the mind still took the purely physical form, but his was the first to extend beyond the long lasting typical conceptualizations, and it did sow the seeds for later mind/body discussions. As discussed, in ancient Greek times, the stigma of having hysteria was reflected in terms of gender. Symptoms were initially only diagnosed in women, treatment being marriage, intercourse and pregnancy. Behind this idea was that the hysterical patient *'just needed a man to make her better'* and her role of sexual object, wife and mother would correct her problems. However as more and more cases of males with bodily symptoms were being diagnosed, with the less stigmatized "hypochondriasis", scholars began to use the terms interchangeably. There was much agreement that the two labels were actually the one illness. This is reflected by narratives such as from Willis (1750) *"Since however much antiquity may have laid the blame of hysteria upon the uterus, hypochondriasis {which we impute to some obstruction of the spleen or viscera} is as like it, as one egg is to another"* (Starcevic & Lipsitt, 2001,p.156). With less use of the stigmatized word *"hysteria"*, the construct hypochondria, in time, became stigmatized itself.

Once known as an illness of medical gender based origin, the new label that encompassed both genders came under speculation as a feigned illness. This speculation still seems current today,

stigmatizing sufferers so much that many do not come forward to access help (discussed shortly). This controversy was first expressed in the writings of Sir Richard Blackmore (1729), physician to William III and Queen Anne. Blackmore argued:

> *Patients are unwilling their disease should go by its right name because the public regard their symptoms as an imaginary and fantastick sickness of the brain, filled with odd and irregular ideas. Such individuals often become an object of derision and contempt. However their sufferings are without doubt real and unfeigned* (Starcevic & Lipsitt, 2001, p.9).

Blackmore appeared to be a pioneer of his time. He may have provided the first narrative of a psychological meaning-making of hypochondria. In his work, *A Treatise of the Spleen and Vapours,* Blackmore rejected the past biological etiology, instead arguing: *"Terrible ideas, formed only in the imagination will affect the brain and the body with painful sensations".* He followed this theory by asserting that the hypochondriac's *"terrible imaginings"* physically affected the brain then body, thus hypochondria, he argued, was not a form of malingering or insanity (Starcevic & Lipsitt, 2001). Unfortunately much of Blackmore's advanced psychological explanations and defences against stigma fell on deaf ears. The next part of history continued the focus on biology, in *reflex theory* in the nineteenth to early twentieth century's.

2.4 Reflex Theory

Up until the early twentieth Century, reflex theory became a popular way of making sense of (mostly) female hypochondriacal suffering. According to this theory, every organ in the body could influence the other bodily organs (Shorter, 1992). The belief persisted that female hypochondriasis started with the uterus. However, reflex theory departed from ancient Greek views at this point; instead of the wandering womb going to organs and areas in the body, the womb used the spine as the 'go between', which then affected other organs in the body. Like the womb, the ovaries were also thought to be in contact with the spine and to irritate the rest

of the body. Here treatment of female patients consisted of applying pressure, often violently, to the ovaries. Clitoridectomy also became popular, as the clitoris was regarded as a potent source of reflex irritation. It is beyond the scope of this study to discuss at length the power relations and political issues involved in performing such operations on these women; however it does seem appropriate to mark the theme emerging of where the power resides in such relationships, notably in the medical profession. This treatment, as well as the occasional male circumcision, was reported in medical journals up until the outbreak of the world war in 1914 (Pilowsky, 1997). During this time period, the famous French physician Charcot added public humiliation to the list of treatments for sufferers.

2.5 Charcot - Theatrical Hysteria!

This section is thus titled because Charcot (1825-1893) headed a clinic in the Paris hospital, La Sapetriere, where he paraded hysterical patients on stage (Sternberg, 1999). Doctors from America and all over Europe came to France to watch these performances and patients came a great distance also. Said to be charismatic, Charcot had planned to be an artist before medical training, and had a studio in the hospital where he and his interns painted and sketched hysterical patients during their '*attacks*' (Shorter, 1997). Many of these paintings (mostly of women) were reproduced and sold, and a photographer was employed to increase this revenue as well. Two paintings were highly profitable - one was of a young woman named *Augustine.* The second was a picture of Charcot and his most famous patient *Blanche Wittman*, which hung in the lecture hall at the hospital. Even Freud had a copy in his office (Showalter, 1997), see figures 1 and 2.

Figure 1 – Augustine in a straitjacket

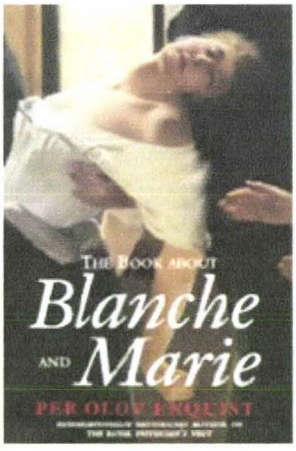

Figure 2 – Blanche and Charcot

Blanche Wittman's 'hysterical symptoms' started after an attempted rape. Likewise Augustine, the patient most photographed, reported that at age 13 she had been raped at knife-point, by her mother's lover, and soon after had hysterical symptoms. These included repetitive thoughts of being chased by a knife wielding man and experiencing pains. For these experiences she was treated with psychotropic drugs, straitjackets, solitary confinement, hypnosis and further objectification of having to frequently pose for photos and paintings. After five years in Charcot's hospital she eventually escaped by dressing up as a man (Showalter, 1997). Meanwhile Charcot continued on stage with his new patients.

Each week Charcot would publicly diagnose these women, without ever meeting them before the 'show'. The stage was set, including decorations and pictures applicable to each performance and according to his students, he often walked in with some distinguished guest at his side (Pilowsky, 1997). Charcot had a way of illustrating a point which often involved ridiculing his patients. For example, *"On one occasion, when he planned to discuss tremors, he brought in three women wearing hats with long feathers, each of which trembled in a way characteristic of its disease"* (Showalter, 1997, p.32). Furthermore, when he did do private consultations he had patients brought to his office, stripped naked, and then he would observe them. He would ask the patient to perform certain movements - stare, meditate, and then

have them led out, rarely exchanging words with them (Evans, 1990). According to Matlock (1994) these women were not consulted at all about their own bodies and symptoms. They were *"ridiculed, silenced, and reduced to storied bodies"* (Matlock, 1994, p.137). Charcot's methods were by today's standards completely unethical, and he may thus far look like a 'quack'. However it is worth noting today that in other roles he was a chief physician, who although his bedside manner may seem appalling, was responsible for differentiating multiple sclerosis from Parkinson's disease, and mapping out the spinal forms of Neuro-syphilis (Showalter, 1997). Charcot did shed some light on hysteria, which, until his time, was often not the focus of attention.

Charcot believed the causes of hysteria were biological. He believed hysteria to be due to either a hereditary defect, or a traumatic wound in the central nervous system that at times caused epileptiform attacks (Starcevic & Lipsitt, 2001). Charcot tended to move away from, and then come back to, the reflex theory of the times, as it waxed and waned in fashion. Therefore it is likely that his beliefs had their foundations in reflex theory, e.g. involving the spine/central nervous system. The epileptiform attacks resemble reflex theory in the general notion of the spine affecting other bodily organs. He further theorized that this genetic or traumatic nervous system dysfunction could be triggered by an emotional or physical trauma in vulnerable people. This then resulted in the different symptoms in patients' bodies that waxed and waned throughout their lives (Starcevic & Lipsitt, 2001). Also as in reflex theory, Charcot was interested in his patients' ovaries.

During autopsies on hysterical women, Charcot focused his attention on the ovaries, most probably looking to tie in the ovarian link with his spinal/central nervous system theory. When examining patients in general, he found ovarian sensitivity and as in reflex treatment, he applied pressure on patient's ovaries to initiate and stop attacks (Starcevic & Lipsitt, 2001). This can be likened to the old witch hunts of the past, where women were strapped to wooden trunks and then held under water for long periods of time. If they somehow survived they were proven witches, and dunked further. If they drowned then they were not! (Hicks & Gwynne, 1995). *'Damned if you do and damned if you don't'* logic must have applied to Charcot's

patients, as strangely enough pushing hard on these women's ovaries did bring on '*hysterical symptoms*'. Furthermore, in the end, if the only way to get Charcot to stop the painful pressure was to hold in their symptoms, many patients must have complied with this self-fulfilling prophecy.

Charcot provided details to his interns of how the hysterical patient's ovaries should be examined: *"It is indispensable to push on with the investigation, by penetrating in the abdomen with the fingers. The doctor should plunge his closed fist in the area of the ovarian pain"* (Evans, 1991, p29). Charcot's statement to his interns had plenty of seemingly sadistic and sexual undertones, with the usage of such terms as *push, plunge,* and *penetrate* (Showalter, 1997). Perhaps these relate again to the male dominated power and control in the history of medicine, and how that power relates to the construct of hysteria.

Foucault describes late nineteenth century medicine which played a part in constructing hysteria as follows:

> *(medical surveillance) was an enormous apparatus for observations, with its examinations, interrogations and experiments, but it was also a machinery for incitement, with its public presentations, its theatre of ritual crises, carefully staged with help of ether or amyl nitrate, its interplay of dialogues, palpations, laying on of hands and postures* (Foucault, 1978, p.55).

Unfortunately for his patients, Charcot took ovarian pressing further than reflex theory treatments by inventing the "Ovarian Compressor"! (Showalter, 1997), see Figure 3.

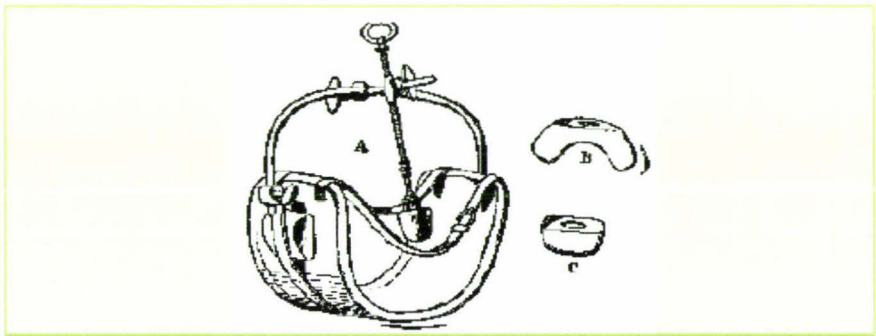

Figure 3 – Ovary Compressor as used by Charcot (Evan, 1991).

This tool was a heavy leather and metal belt which was strapped on to the patient and often left on for up to three days. In the few hypochondriacal men whom he treated, he compressed their testicles, which, not surprisingly, made symptoms worse (Showalter, 1997).

When Charcot died, so did many of his theories on hysteria. However his influence on hypochondria and health anxiety stigma can only be speculated. Research has shown a tendency for the medical profession to ridicule health anxious people although in present times nowhere near as blatantly as Charcot. Studies on doctors' perspectives of health anxious/hypochondriacal patients have reported the doctors' disparaging remarks, for example, labelling patients *'the worried well'* (Hayden & Brockmeier, 2008; Fraser & Greco, 2005; Persing, Stuart, Noyes & Happel, 2000). As the medical profession is ascribed much power in society, our current biases and ridiculing jokes about sufferers may have been impacted by Charcot's work. His teachings affected the course of many lives, one of which was a student at his hospital, Sigmund Freud.

2.6 Freud and the Talking Cure

Apart from Willis, who was ahead of his time, Freud was the first to truly deviate from basing hysteria, and interchangeably hypochondria, purely in biological terms. Freud had several revised theories on the subject, but generally he defined the condition as a neurosis that was caused by repression, sexuality issues and fantasy (Breuer, Freud, & Strachey, 1957).

After Charcot, Freud was influenced by his friend Dr Fleiss, who believed somatic symptoms were caused by excessive masturbation (Breuer, Freud & Strachey, 1957). Freud followed this doctor's theory that these sexual problems were due to a source in the nose, and allowed Dr Fliess to operate on his 27-year-old patient, Emma Eckstien. Dr Fleiss made serious errors during the nose operation, leaving gauze in the patient's nose which soon became infected. Freud argued that her post-operative symptoms (including haemorrhages) were merely

hysterical manifestations (Showalter, 1997). This example again illustrates the power of the medical profession, and the acceptance by society, of medical authority.

In *The History of Sexuality (*1978) Foucault wrote that women have been made into inert objects, for the power of medicine. Foucault argued that women's bodies were 'hystericalised', by the means of doctors turning patients' symptoms into a collection of psychological and physical symptoms.

Freud quickly revised the nose/masturbation theory. He later argued that all female hysteria and male hypochondria were due to a traumatic case history or life event. He applied to this his theories about defence mechanisms, such as repression, advocating that a traumatic event could be repressed, that is, that the memories of a traumatic event were then converted from consciousness into symbolic physical symptoms (Bernhiemer & Kahane, 1990). For example, a patient complaining of *globus hystericus* (tight throat, difficulty swallowing) might have converted the memory of being held around the neck, during a sexual assault. Later, in times of stress, the throat complaints and fixation and anxiety surrounding the throat may manifest but the sexual attack is blocked or repressed from memory. The converted trauma could be seen as a reflection of oppressive times for women in Freud's era. For example, one of Freud's patients, Anna O, was described by Breuer as *"very intelligent, with a quick grasp of things and a penetrating intuition, bubbling over with intellectual vitality"* (Breuer, Freud, & Strachey, 1957,p.217). Despite Anna's potential, she had led an extremely limited life within a very restricted family of origin. Under hypnosis, she regularly spoke of her memories, but also of her aspirations. During these conversations, her multiple physical symptoms would clear up. It was Anna herself who labelled Freud's therapy 'the talking cure' (Breuer, Freud, & Strachey, 1957).

While documenting his many case studies, Freud observed that the traumatic experiences of his patients centred on early childhood sexual abuse. In 1896, in a paper he addressed to the Viennese Society for Psychiatry and Neurology, he announced these views on the etiology of hysteria. He wrote *"At the bottom of every case of hysteria there are one or more occurrences of premature sexual experience, occurrences which belong to the earliest years of childhood"*

(Showalter, 1997, p.40). He called his theory the seduction theory. However, later, believing that so many cases of child abuse could not be so, he revised his theory again.

The new theory suggested that real traumas had actually not occurred, but instead desires from the unconscious and interrupted psycho-sexual phases were to blame. Such phases included the *Oedipus complex*, where young female children purportedly wish for sexual intercourse with their fathers (Sternberg, 1999**).** Feminist critics have pondered Freud's focus on the child's role in this complex and his lack of focus on the parents. Many feminists also criticized his theory revision in the first place (Bernheimer & Kahane, 1990; Fraser & Creco, 2005; Reiff, 1997; Schnurr & Green, 2004). This was especially so since Masson, then project director of the Freud archives, found many letters about sexual abuse of children and a pattern of omitting sexual abuse histories in later published case histories (Masson, 1984). According to Masson, Freud shifted the emphasis from an actual world experience of misery to an internal stage on which actors performed for an invisible audience. Freud was also said to have pressured patients into producing narratives that matched his revised etiological theory (Showalter, 1997).

Literature on the past language and stigma shows where some of our underlying beliefs and prejudices about health anxiety and hypochondria have stemmed from. This is related to entitlement of the sick role. The literature frequently suggests that the medical profession has some power in shaping views of this entitlement. History also highlights fluctuating doubt about whether symptoms are biologically or psychologically based. There has been, and still are, suspicions of malingering.

Although the term *hysteria* has been replaced by the more gender neutral *hypochondria*, the historical roots are evident in today's language. For example, even today we talk of slapping someone if they become so upset that they become hysterical 'to snap them out of it', reminiscent of pressing the ovaries. We now must take this understanding of historical background and stigma into more current etiology, treatment, definition and understanding of hypochondria and health anxiety. When discussing hypochondria from this point it is important

to keep in mind that the hysteria label has been dropped and hypochondria used to diagnose both genders now. In this thesis hypochondria and health anxiety will be used interchangeably.

3. Towards a Definition

As we come towards a twenty-first century definition of hypochondria, we see many clusters of symptoms that were previously diagnosed as hysteria now being diagnosed under different names. Modern technologies, such as x-ray and magnetic resonance imaging (MRI), for example, have identified physical causes for aches and pains, once labelled hypochondria. Also many physical complaints that were previously being clumped under the hysterical label have been given other names and meanings, many being biologically based. For example, arthritis is now a known cause for some peoples' aches and pains. Syndromes and clusters of complaints that still have ambiguous causes are now being diagnosed separately to hypochondriasis – such as chronic fatigue syndrome and fibromyalgia (Hyden & Brockmeier, 2008). Even people with environmental poisonings were once thought of as hypochondriacal, in the stigmatized sense, have begun to be distinguished from the hypochondriac label. For example, in a New Zealand study, Jones (2004) ran a qualitative study on people who have been medically diagnosed with mercury poisoning. Some participants from her study had spent years searching for a medical explanation and treatment for their ailments and many had been told that their problems were psychosomatic, with doctors advising that they were 'making it up'. As her participants' symptoms persisted without a medical label to justify their sick role, they reported experiencing the negative social stigma attached to hypochondria until diagnosed with mercury poisoning.

So what is left from the large groups of the past who were labelled hysterics and hypochondriacs? Are those who are left undiagnosed, the *true* hypochondriacs, or could they have illnesses not yet been given a name that entitles them to the sick role? Some people left in the hypochondriacal and high health anxiety category may have other, perhaps undiagnosed, psychological disorders. This again puts the emphasis and power back on to who decides what is psychologically normal and abnormal. What about unresolved trauma reflecting in physical symptoms like that of Charcot's famous patients? Where do the findings of frequently hidden child sexual abuse from Freud's archives fit in? Many questions have been left unanswered. Research in this area so far has been slow and mostly based on the medical perspective.

The social constructivist perspective keeps in mind the view that definitions such as hypochondria are ideas that are collected and defined by people, and so reflect their values; personal, cultural and professional. The meanings of psychological definitions are not 'discovered' by scientific methods. They are culturally and historically negotiated amongst stakeholders. All categories of disorders are the product of humans constructing meaning to understand their worlds (Raskin & Lewandowsky, 2000). To make sense of our current perceptions of hypochondria, we need to take into account past narratives and practices throughout history.

Like physiological disorders, many psychological disorders have been diagnosed, appearing as if more and more disorders having been 'discovered'. From a social constructivist standpoint, the DSM-IV categories, to which we turn next, have not been 'found' in the same manner as an archaeologist would discover a buried artefact. The diagnosis we are about to look at does not only describe and classify characteristics of a group of people with unknown physical symptoms, it also actively constructs a version of what is considered normal and abnormal within our Western culture, involving a power relationship between those who deem the group abnormal, and the so-called abnormal patient (Parker, Geogaca, Harper, Mclaughlin & Stowell-Smith, 1995). The category of hypochondriasis can be considered a social artefact that serves the same socio-cultural goals as do our concepts of gender, race, social class and sexual orientation, that is of maintaining/increasing the power of certain individuals and institutions and maintaining social order as defined by those people holding the power (Beall, 1993; Parker, 1995).

The social construct of psychopathology seems to have a pattern according to Maddux and Winstead, (2008). Someone observes a pattern of behaviour, thinking, feeling or desiring that deviates from some social norm. This occurs more in some people than others. A group with power and influence, for example, doctors and psychiatrists in the case of hypochondria, decides what control, prevention, or treatment of this 'problem' is desirable and/or profitable. This can be seen in the societal control in early times, when hysterical women were coerced by their doctors and public into marriage, sexual intercourse and pregnancy for treatment of

physical symptoms. This pushes woman back into their societal determined roles rather than, for example, expressing their oppression physically. Maddux and Winstead (2008) continued that this pattern of behaving is given some kind of scientifically sounding name, preferably Greek or Latin (e.g. hysteria, hypochondriasis). For some reason, unlike many other mental illnesses, hypochondria does not follow with the pattern of construction formation. The new name is typically capitalized and often reduced to an acronym, for example Obsessive-Compulsive Disorder (OCD), Attention-Deficit Hyperactivity Disorder (ADHD), or Post Traumatic Stress Disorder (PTSD). The label of hypochondria may possibly be as wide spread in the home as say ADHD, but it seems to be used as a derogatory term, often to describe malingering or wild imagining. For example; *'Stop being such a hypochondriac, it's all in your head'*. In contrast, most other mental health labels may be used to serve a purpose for understanding, justification, or to excuse behaviour. For example; *"My child is jumping about today, because his ADHD is playing up"*. Often this use of language can even elicit understanding responses, which is not seen to be the case with hypochondriasis. Also, there is no official acronym for hypochondria.

The construct for hypochondria fails to follow the last parts of Maddux and Winstead's (2000) stages of psychopathology construction as well. They describe a newly labelled disorder eventually taking on an existence of its own, becoming a disease-like entity. News about 'It' travels, people identify with having 'It', professionals begin diagnosing and treating 'It' more often, and there is public lobbying for health insurance to recognize and pay for 'It's' treatments. Finally, once socially constructed, scientific methods can further study 'It'. Hypochondria, as a construct, did not follow this pattern. News about hypochondria did not spread, possibly because the condition is ambiguous to diagnose, stigmatized, and considered for so long to be intractable. People often will not identify with having hypochondria, maybe because having hypochondria does not serve a purpose or hold perceived benefits for the sufferer, unlike many mental illness constructs. Professionals have not been over-zealous in diagnosing this condition, as medicine can never be certain about whether an illness has a purely organic basis or not, and it is human nature to be uncomfortable with uncertainty. The

public have therefore not lobbied for insurance compensations to treat a condition that they do not like to identify with having; for a condition that has not had many advances in treatment. It is worth mentioning, though, that study in this area has begun again (Maj et al, 2005; Oosterbann, Balkom, Boeijen, DeMeij & Dyck, 2001; Taylor & Asmundson, 2004). The DSM-IV does have an official diagnostic category too, which at least outlines the socially constructed category that attempts to make sense of confusing symptoms.

3.1 DSM-IV – The Last of the Hysterics

As of the year 2000, Hypochondriasis is listed under the Somatoform Disorders section of the DSM-IV. The somatoform section consists of categories of separate constructs for disorders that seem from the literature to be all historically identified as hysteria, that is, they all share the presence of physical symptoms that cannot be fully explained by a general medical condition. These constructed disorders are Somatization Disorder, Undifferentiated Somatoform Disorder, Conversion Disorder, Pain Disorder, Hypochondriasis and Somatoform Disorder Not Otherwise Specified (American Psychiatric Association, 2000).

According to Guillain (1959), many of the traditional symptoms of hysteria have been reclassified, examples from the DSM-IV including Post-Traumatic Stress Disorder, Acute Stress Disorder, all of the different somatoform disorders; Somatization Disorder, Conversion Disorder, Panic Disorder, Bipolar and Unipolar disorders. The patients have not changed, Guillain argues, but the terminology applied to them has (Guillain, 1959). As all the somatoform disorders incorporate hysteria and hysteria was used interchangeably with hypochondriasis throughout history, this study will focus on one DSM-IV construct of this for an overall classic definition, that of hypochondriasis (refer back to Table 4, reprinted below).

Table 4 - Diagnostic criteria for 300.7 Hypochondriasis	
A.	Preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.
B.	The preoccupation persists despite appropriate medical evaluation and reassurance.
C.	The belief in criterion A is not of delusional intensity (as in delusional disorder, somatic type) and is not restricted to circumscribed concern about appearance (as in body dysmorphic disorder).
D.	The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
E.	The duration of the disturbance is at least six months.
F.	The preoccupation is not better accounted for by generalized anxiety disorder, obsessive compulsive disorder, panic disorder, a major depressive episode, separation anxiety, or another somatoform disorder (American Psychiatric Association, 2000).

The DSM-IV dictates that the essential feature of hypochondriasis is preoccupation with fears of having, or the idea that one has a serious disease, based on misinterpretation of bodily symptoms (**Criterion A**). It is interesting to see the change in language here, as it reads like the 'preoccupation' has its own identity. It becomes the fault of the 'preoccupation', and indeed current treatments aim to rid people of hypochondria by getting rid of their 'preoccupations' (Asmundson & Taylor, 2004; Greenberger & Padesky, 1995; William & Poijula, 2002). The language in this first section continues: **Criteria A** *'based on the person's misinterpretations of bodily symptoms'.* This has now shifted, as throughout the historical overview there was example after example of the medical doctors misinterpreting symptoms (look no further than the wandering womb, the animal inside an animal was surely a bit of a misinterpretation). There was no mention of the patients misinterpreting symptoms in past history, as patients solely relied on the doctors for an interpretation of what was wrong with them. Now much medical language is shared with society, and this may be why health anxious people can misinterpret symptoms in the first place. In **Criterion B**, the preoccupation persists despite appropriate medical reassurance. Who deems and defines what appropriate medical reassurance is? Much of the current literature (soon to be discussed) has focused on the reassurance seeking of hypochondriacs, and doctor/patient relationships. Though it appears

that reassurance is sought by the hypochondriacal patient, it may well be a doctor and patient relational issue. Again with **Criterion C**, *'clinically significant'* is another questionable measure, giving the power to the medical/psychological professional to decide, based on their values, judgments, culture and training, which is not completely value free.

3.2 Continuum versus Categorical Definitions

Even taking all of the DSM-IV somatoform disorders into account, physical symptoms with no known cause can fall into many of the DSM-IV listed disorders as secondary complaints. Such examples include somatic experiences of depression, psychotic somatic delusions within psychotic illnesses and physical symptoms amplified in panic disorder (Kaplan & Sadock, 2003). As there are so many problems with constructs that put people into concrete categorical boxes, many researchers have argued for a better meaning-making system. Focusing on hypochondria and the somatoform disorders, some authors have advocated for a spectrum continuum, rather than having discrete boxes (Abramowitze, 2007). Hollander and Benzaquen (2001) argue that hypochondria should be part of an obsessive-compulsive spectrum disorders continuum, as hypochondriacal sufferers share an obsessional focus on bodily symptoms, which resonates with the obsessional nature of OCD symptoms. However Falloon, Qureshi, Laje and Klein (2000) dismiss this, stating that although similar intrusive thoughts occur, hypochondria patients do not share a co-morbidity profile comparable with patients who have OCD.

3.3 Health Anxiety Spectrum

Another spectrum conceptualization for defining and understanding unexplained physical symptoms is the Health Anxiety Spectrum. Many people are reluctant to be labelled as hypochondriacs, and many do not meet DSM-IV's strict criteria. Even the most severe health anxiety may not meet the DSM-IV's entire criterion. For example, an individual may respond to

medical reassurance sometimes, or still may be able to manage their jobs reasonably well, hiding their hypochondrical concerns. This makes sense, as symptoms have been reported to wax and wane with many gaps of living well in between hypochondrical episodes (Maj et al, 2005). Not quite meeting full DSM-IV criteria has been called abridged hypochondriasis by some researchers (Gureje, Ustin & Simon, 1997).

Taylor and Asmundson, (2004) talk of health anxiety as a spectrum that represents a spectrum of severity (see Figure 4). At one end is the relatively mild conditions such as health anxiety/high health anxiety, then abridged forms of hypochondriasis, and then full blown hypochondriasis, as defined in the DSM-IV, occupies the middle part of the spectrum. At the severe end lie poor-insight hypochondriasis and then lastly, the somatic form of delusional disorder. This health anxiety spectrum is useful for the current study, as it allows the inclusion of people who meet the abridged forms of hypochondriasis, which is said to afflict more than 5% of the population according to Taylor and Asmundson, (2004). This also allows for people to be included who might not otherwise want to identify with hypochondria. Due to the many factors discussed throughout, hypochondria is not commonly diagnosed.

Figure 4 - The Health Anxiety Spectrum (Beckett, 2009).

Now that the definitions for this study have been outlined, I will discuss typical characteristics within the Health Anxiety Spectrum as they have only been briefly mentioned thus far.

4. Common Characteristics of Hypochondriasis

Cognitive Features:

Disease conviction is the belief that one is physically ill. People who fall within the health anxiety spectrum have strong disease convictions, often believing to some degree that they have an undetected illness. This can include a preoccupation with the possibility of having an illness, that is, fear that one currently has a disease, or fear that one might contract a disease (Taylor & Asmundson, 2004). This is often paired with hyper-vigilance of bodily sensations, and worrying thoughts of death entering consciousness (Warwick & Salkovski, 1989). Disease conviction can be persistent regarding one disease over time (for example thinking one has cancer) or the patient may present to their doctor with changing concerns, maybe once a lump in the throat, then chest pains, appendix pain or visual distortions. Often when one concern is addressed, another one comes up a short time later. This shift in symptoms is very common (Hardy et al, 2001). Disease conviction often persists despite medical reassurance (Pilowsky, 1997).

Information processing errors are commonplace in health anxiety; presented here are some typical information processing errors that patients within the Health Anxiety Spectrum often make, as identified by Beck (1995):

Black or White Dichotomous Thinking:

This is a thinking error when people can see things as though there is only one possibility. For example; *"A headache can only mean a brain tumour!".*

Selective Attention/ Mental Filtering:

In the case of health anxiety, selective attention or mental filtering is seeing only the worrying aspects of a symptom while screening out more balancing information. For example; *"My heart is racing, I must be about to have a heart attack".* An example of information screened out may be that the person had been running for a bus for some time prior to the symptom arising.

Catastrophic Thinking:

This thinking error may be at the heart of health anxiety and hypochondriacal concerns. Catastrophic thinking involves predicting things will go a certain way before all of the facts are considered. For example; *"I have a new spot on my skin, it must be cancer".*

Emotional Reasoning:

This thinking error occurs when people think that something must be true, because it *feels* true. A current example might be; *"I'm getting a cold, but I just know that I've contracted the swine flu, I just feel it this time".*

Cognitive features of hypochondria and health anxiety can directly impact on the physical aspects of sufferers' characteristics. For example, with the last thinking error, if a person thinks that their cold symptoms indicate that they have caught swine flu, then they are likely to experience bodily (somatic) feelings consistent with that thought (Greenberger & Padesky, 2002).

Somatic Features:

People in the health anxiety spectrum tend to misinterpret natural bodily fluctuations and aches and pains, over-estimating the seriousness of their symptoms (Maj et al, 2005). That is, normal bodily fluctuations such as occasional muscle cramps, heart palpitations, twitches, aches and pains are often misconstrued as a sign of something more serious. Another hypothesis is that people with hypochondriasis have extra-sensitive biology, and engage in somatosensory amplification. Somatosensory amplification is the perception of normal bodily sensations as unusually intense, noxious and disturbing (Barsky et al, 1995). Somatosensory amplification has been hypothesized by Barsky, Goodson, Lane and Cleary (2001) to be due to a biological predisposing factor in somatization and hypochondriasis. It seems unclear, as to whether this amplification is due to some people's bodies being biologically more sensitive than others, or whether psychological factors, such as the cognitive error of selective thinking apply.

Some studies have shown distraction to reduce health anxious people's perceptions of amplified bodily fluctuations (Hardy et al, 2005). One study compared people who somatize to people who do not where somatizers were found to be particularly sensitive to both normative and ambiguous somatic sensations (Aronson, Barrett & Quigley, 2001). Smeets, Jong & Mayer (2000) concluded from their study on somatic amplification, that study participants searched for threat-confirming information when investigating health information.

Behavioural Features:

Fear of having a disease is linked with the reassurance seeking behaviours (Taylor & Asmundson, 2004) that are central to hypochondria and health anxiety. Health anxious patients may have a pain or concern, take this concern to the doctor and want some kind of reassurance. Often however any reassurance given is not enough for the health anxious patient who may typically worry that something has been missed. Alternatively, reassurance can be received by the patient, but later they have the tendency to worry again, either that something has been missed, or regarding a new concern (Nijenhuis, 2004; Stacevic & Lipsitt, 2001). Health anxious patients often engage in the behaviour of 'doctor shopping' (Pilowsky, 1997), that is to get second, and sometimes third opinions for reassurance. Also health anxious people may look for signs and information on illnesses that fit with their symptoms, via text books and the internet (Maj et al, 2005).

5. Current Research on Etiology and Treatment

Until the late 1980s psychological debates were at a standstill (Shorter, 1992) and treatments for hypochondriasis were generally considered a waste of time (Abramowitz, McKay & Taylor, 2008). Since the 1990s research on hypochondria and health anxiety has started to progress. Cognitive-behavioural therapy etiology and treatments seem to flow together when reviewing literature on this topic, so they are categorized together under this section. Following this is biological etiology and treatment is outlined, including on this the role of trauma etiology.

5.1 Cognitive Behavioural Perspective

Without a specific model for treatment, Cognitive Behavioural Treatment (CBT) which has had success in similar disorders, such as panic and other anxiety disorders was applied to hypochondriasis (Barsky & Ahern, 2004). The use of CBT for anxiety suggests an assumption that some CBT etiology has been generalised to health anxiety and hypochondria. Such treatments included systematic desensitization, thought stopping and relaxation training.

In 1992, Visser and Bouman led the first study of CBT, comparing six sessions of cognitive therapy, with the same number of behavioural therapy sessions. Interestingly, both treatments slightly improved hypochondrical symptoms. After this success in treatment, Warwick, Clark, Cobb and Salkovskis (1996) published a study that compared hypochondriacal patients on waiting lists with 32 patients participating in a 16 week CBT treatment. Building on the average success of CBT for anxiety applied to hypochondria, the treatment was then modified with hypochondriasis in mind. This involved targeting misinterpretation of bodily symptoms, and balancing thinking errors, such as selective attention and black or white thinking (Warwick et al, 1996). Improvement in this study was made in 76 percent of the CBT group, in contrast with only 5 percent on the wait list, however it was not clear how this improvement was measured. At the three-month follow-up, the treatment gains were still maintained. Despite some

methodological problems and the fact that it was the first CBT study to address treatment for hypochondria, the study suggested CBT can be beneficial for the health anxious population.

A useful CBT conceptualization of panic, which could be modified for health anxiety by using more specific health anxious examples, is the Clark hook model. It could be modified with the aim of illustrating health anxiety and hypochondria from a CBT perspective (See figure 5).

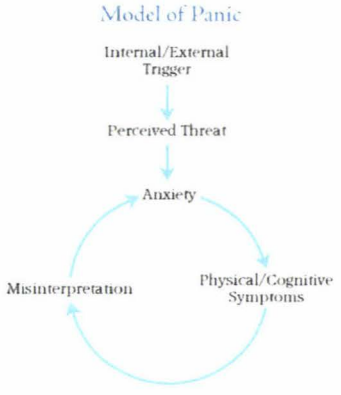

Figure 5 - Clark hook model

For example, an internal trigger might be of a health anxious person feeling their heart slightly palpitate. The perceived threat may be that this person thinks that they might be about to have a heart attack. Further anxiety kicks in, and with it the release of cortisol, producing a fight or flight response (Kalat, 2007). The physical symptoms of this then are a faster heart rate, tightness in the chest, shallow breathing and dizziness. Cognitive thoughts might be of fears of death and dying. Finally, misinterpretations of the triggered physical symptoms lead on to utter panic and health anxiety. It is usually at this time that the health anxious person seeks help from their GP, where, as they are often in such a state of panic, they do not communicate well during the consultation.

The largest study so far on CBT treatment of hypochondriasis was carried out by Barsky and Ahern in 2004. These researchers found 102 participants (which must have been difficult to find due to stigma and low diagnostic rates), put the participants into CBT treatment condition, and, compared their outcome with patients who received standard medical care. At the end of the

treatment, and follow-up, all patients had a moderate decrease in hypochondriacal fears, convictions, and behaviours. A confounding variable in this study, however, was that participants passed on a letter to their doctor about the study and their condition of hypochondriasis (Barsky & Ahern, 2004). Interestingly, in a previous study in 1994, these same researchers (Barsky & colleagues) investigated histories of childhood abuse in adult hypochondriacal patients. Like Freud's initial findings, these researchers recorded that 29 percent of the hypochondriacal participants reported a history of child sexual abuse, and 32 percent reported exposure to physical violence, compared with collectively 7 percent of the control group (Barsky, Wool, & Barnett, 1994).

5.2 Psycho-education

Fava, Grandi, Rafanelli, Fabbri and Cazzaro (2000) sought to discover whether or not simply informing hypochondriacal patients about the nature of their illness would decrease their anxiety. Such information could include principles of selective attention, thinking errors, and providing accurate information on illness. Fava et al (2000) recruited 20 patients who met the DSM-IV criteria for hypochondriasis, and then divided them into two groups. One group continued on a waiting list, and the other group received explanation therapy. Explanation therapy was reported as significantly associated with a reduction in hypochondriacal fears and beliefs. However, these researchers did note that substantial residue symptoms still remained for these participants. So, some gains were made merely from education, however explanation therapy is not enough in itself (Fava et al, 2000).

5.3 Biological Perspective

Biological perspectives have changed significantly from the days of the wandering womb theory, moving with modern technological advances. Biological etiology for hypochondria and health anxiety focuses haphazardly on pharmacological and neurobiological strategies based on other disorders etiology and treatments. Such disorders include depression, anxiety and OCD.

Pharmacologic etiology and treatment for health anxious people propose the sufferers have less of the neurotransmitter serotonin. Etiology appears to have been assumed, as trials of Selective Serotonin Reuptake Inhibitors (SSRIs) have been used with some success for the treatment of hypochondria and heath anxiety (Hardy et al, 2005; Kaplan & Sadock, 2003). SSRIs block the re-uptake of serotonin at the synapse, diminishing anxiety reactivity (Kalat, 2008).

A neurobiological strategy used to treat OCD is exposure to anxiety provoking stimulus (Hollander & Benzaquen, 1997). This has been suggested for use with health anxious people (Hardy et al, 2005). The workings that underlie exposure to anxiety provoking situations are the habituation or 'wearing out' of the physiological mechanisms that produce the anxiety response (Lambert, 2004). That is, repeat exposure to feared stimulus hypothetically results in the reduction of anxiety. For health anxiety, for example, it may involve doing repeated exercise and getting used to tolerating a faster heartbeat afterwards as a function of normal bodily fluctuation.

5.4 Current Treatment Summary

Currently there finally seems to be some agreement amongst researchers, that hyochondriasis and health anxiety may be treatable, is psychological as well as physical, and that CBT may be the best treatment offered to date. CBT works at changing maladaptive beliefs, behaviours and combining physical relaxation training for the body, to help sufferers read their bodily symptoms without excessive distress. There seems to be some limited support for the use of medication, however CBT studies look more promising for long term treatment outcomes and perhaps medication can be of value to the more serious, near psychotic symptoms/thoughts, on the anxiety spectrum. Some gaps still exist though, especially with regards to the construct of hypochondriasis and health anxiety in general. If, looking back at the history of 'hysteria', these, mostly female, sufferers were using bodily symptoms as a language to talk of their perceived oppression and life stress, then that may be just as relevant today, when women have probably a similar degree of work and life stress.

The developing success of CBT treatment with health anxiety may be due to several factors in the language of physical distress. For example, it can be likened to Freud's *'talk cure'*, but with more of an equal footing between therapist and client (Beck, 1995). CBT therapists give the client (note CBT language changes from patient to client) the opportunity to be heard, and to discuss frustrations and issues openly, taking into account their unique history, and making meaning with the client about the ways in which their past experiences affect their present beliefs, physiology and behaviours.

However, CBT often has a focus on the present, is often manual based, and a major problem may be the length of therapy. For example, in the studies outlined above, the course of treatments was between 6-16 sessions (each session being roughly an hour). Improvements even at follow-ups were reported and maintained, however, those *'improvements'* were defined, measured and reported statistically by the researchers, rather than from the clients' feedback themselves. For such an ancient malady, 16 hours worth of treatment may not be enough.

The literature has suggested that a large portion of hypochondriacal clients have a history of trauma and early childhood abuse, both physical and sexual. Reassurance seeking and trust issues are prominent for these people, so rapport with the therapist, and more than a superficial exploration of the past may be warranted. Successful CBT may depend on treatment length, and attachment issues could be useful to integrate into the therapy.

6. Attachment Style and Reassurance Seeking

An alternative theory about the etiology of hypochondria, is that hypochondria and high health anxiety represents the physical language of insecure attachment. Stuart and Noyes (1999) reviewed research on childhood antecedents to the cluster of somatoform disorders classified in the DSM-IV. Their findings replicated what the Freud archives did, that a vast majority of child physical and/or sexual abuse was present in the health anxious population. However in addition to this, Stuart and Noyes hypothesized that hypochondriacal patients are actually displaying anxious attachment behaviour, derived from childhood experiences with caregivers. In times of stress, as adults, these patients use physical complaints to elicit care and reassurance from others. Also, congruent with the theory those physical symptoms are a language of life distress. These researchers suggest that somatizing behaviour can be a means of communicating environmental distress, for example, family dysfunction (Stuart & Noyes, 1999).

Parenting responses to childhood illness is associated with somatizing behaviour. Parker and Lipscombe (1985), ran a family therapy study, and noted that somatizing patients reported that their parents gave them more attention when they were sick. These parents gave what is called 'selective attention' to their children's physical complaints, while often ignoring their emotional needs. This kind of response from parents could negatively reinforce illness behaviour (Stuart & Noyes, 1999). From information based on a longitudinal study of somatization, Craig, Boardman and Mills, (1993) advised that both selective parental care giving and childhood illness could result in later somatizing behaviours. They conclude, *"among somatizers, childhood illness afforded an escape from neglect and abuse, or encouraged some badly needed attention from a withdrawn or indifferent parent, and thus set in motion a pattern of care-eliciting behaviour that was to be repeated later in life"(Craig, Boardman &Mills, 1993,p. 582).*

Attachment has survival value and is designed to attain/retain proximity to others, usually for the purpose of receiving care. Children, when they are securely attached, will seek comfort and closeness from their parents in times of emotional upset (Clinton & Sibcy, 2002).

6.1 The Strange Situation Experiment:

Ainsworth (1976) set up an experiment called the *'strange situation'* to measure secure and insecure attachments. Ainsworth brought mothers and their babies into her university laboratory which was deliberately a 'strange' place for the infants. The theory was that bringing the infants into a strange environment should naturally trigger some anxiety. The experiment involved mother and infant sitting in the room with a stranger sitting in a chair nearby until Ainsworth had the mother abruptly leave the room for short intervals, leaving her baby alone with the stranger. Ainsworth concentrated her attention on how the infant responded to their mother when she returned to the room. Her work identified distinct types of attachment styles. These are; Secure Response, Anxious/Ambivalent Response, Avoidant Response, and the Disorganized Response (Ainsworth, 1976).

The Secure Response:

When their mothers left the room, securely attached infants were very upset. When their mothers returned, these babies made a beeline towards their mothers, both were happy to see each other. These babies wanted to be picked up, and once held, they were comforted and all signs of distress faded (Ainsworth, 1976).

The Ambivalent Response:

Based on the intensity of their crying, babies in this category were slightly more upset than securely attached infants when their mothers left the room and were angrier, often having violent tantrums. When their mothers returned and went towards them, the infants wanted to be picked up, however when held, they were not comforted. These infants were ambivalent, wanting to be close to their mothers and be picked up, but when held they squirmed, kicked and threw toys. These mothers needed their babies to cry more than securely attached

mothers before they were triggered to attend to their infants or before they would respond effectively (Ainsworth, 1976).

The Avoidant Response:

These babies showed little response when their mothers left the room. However later replication studies have repeatedly shown children in this group to be just as emotionally distressed when their mother leaves, as based on measures of physiological arousal (Clinton & Sibcy, 2002). When the mothers returned to the room, these infants did not seem to care, some just looked away. These infants looked calm on the outside, but were overwhelmed by anxiety on the inside. However they did not seek their mother's comfort.

The Disorganized Response:

These children showed a mixture of responses, and had no consistent style of relating to their mothers (Ainsworth, 1976).

Attachment research has been applied to a few studies of hypochondria and health anxiety. The attachment style hypothesized to play a role in hypochondria is the anxious/ambivalent attachment type. The parent and child relationship seem to have a consistent theme in anxious/ambivalent attachment. The hallmark of the mothers with these children has been reported to be inconsistency. At times these mothers are very responsive and attuned to their babies needs, but then for no apparent reason to the infant, they become distant and aloof, sometimes even hostile. This selective care-giving has been implicated in the development of hypochondria (Clinton & Sibcy, 2002). In turn the children of these parents often fear abandonment, are clingy and preoccupied with whether they are loved or not. The slightest misattunement seems to trigger disappointment and rejection in them. A fragile sense of self develops and they are often filled with strong but ambivalent emotions (Clinton & Sibcy, 2002).

6.2 Anxious/Insecure Attachments:

Anxious/insecure attachment leads to more intense care-seeking behaviours. According to Stuart and Noyes (1999) early life experiences resulting in anxious attachment style, serve as

diatheses, influencing illness behaviour, thus leading to the development of maladaptive personality traits. Interpersonal stresses in adulthood seem to trigger somatizing behaviour, as communications about physical suffering have interpersonal meaning stemming from attachment. The anxious attachment style of care-seeking behaviour is designed to evoke responses from others that offer comfort and restore a sense of security (Clinton & Sibcy, 2002). Unfortunately, under stress, these patients often escalate their care-seeking behaviours by increasing their demands for care via somatic complaints. Accordingly, if the base of the language of distress is attachment related, that might explain why many seek proximity to care providers in the form of doctor consultations, and emergency room visits (Stuart & Noyes, 1999).

The medical relationship then, reassurance seeking behaviour, which is a most treatment resistant component of health anxiety, may involve a relational regression on the part of the patient, triggered by interpersonal stress (Stuart & Noyes, 1999). That is, the doctor/patient relationship can resemble the doctor as the person's parent in the role of being powerful and perceived as a care provider. The patient relives childhood roles of being the seeker of care and comfort during stressful times. However the doctor will typically attend only to the physical complaints, in most cases not recognizing the emotional need behind symptoms.

Therefore, there is good reason to believe that the doctor/patient relationships are vital to address, when understanding and treating hypochondria. This is reinforced when adding that it is estimated that between 30-60 percent of patients in primary care settings complain of symptoms that have no known medical basis and that as high as 25 percent of these people would meet diagnostic criteria for a somatoform disorder (Stuart & Noyes, 1999).

7. The Doctor's Perspective

People with hypochondria and high health anxiety often have poor relationships with their doctors. Frequently by the time they start their consultation (which usually has a time limit of 10-15 minutes) they are highly anxious, and difficult to interrupt (Pilowsky, 1997). Many doctors may not be trained to accurately assess and manage health anxious patients, leading to a variety of problems including doctor/patient frustration, the patient 'doctor shopping', and the patient undergoing many different medical and surgical treatments, often resulting in more pain and scarring. Thus hypochondria can be impacted on further by iatrogenic (physician induced) factors (Taylor & Asmundson, 2004).

As mentioned before, a possible confounding variable in Barsky and Ahern's (2004) large scale CBT study was that all participants in the treatment group and control group were given a letter for their doctors to read. The letter provided a cognitive-behavioural definition of hypochondria, and gave practical suggestions for managing these patients. This included the scheduling of regular appointments, and having a focus on improved management of symptoms, rather than symptom elimination (Barsky & Ahern, 2004). The impact of this letter may have caused a shift in doctor/patient attachment variables, with regards to availability. Also, doctors receiving these letters may have become more tolerant of these patients, if CBT definitions at all reduced any stigmatized views.

Many hypochondriacal patients repeatedly visit hospital and after hours care emergency rooms, worried that there is something seriously wrong with them (Pilowsky, 1997). In their book *Treating Health Anxiety*, (Taylor & Asmundson, 2004) discuss a common practice amongst ER doctors. Apparently, when patients repeatedly *'cry wolf'*, physicians often become dismissive about these patients' complaints. Frequent ER attendees are sometimes put in *'time out'*, by the doctors, where the patient is made to wait an inordinate amount of time before being seen. The reported purpose of this is to make the ER visits unpleasant, reducing the incentive for health anxious people to make unnecessary visits. Taylor and Asmundson, (2004)

go on to warn that such a dismissive approach by doctors can actually fuel patients concerns that they are not getting proper medical care, increasing doctor shopping, ER visits and strengthening the patients' beliefs that they have a serious undiagnosed condition (Taylor & Asmundson, 2004). Relating back to attachment theory, the experience of having the care provider (in this case ER doctor) unavailable for such a long time could re-enact selective care-giving situations, through intermittent reinforcement.

Doctors' values come into play when interacting with hypochondriacal patients. The official DSM-IV code states that to meet the diagnosis of hypochondriasis, there is to be no malingering present (American Psychiatric Association, 2000). However it is questionable as to whether doctors are up-to-date with the many DSM-IV categories. More likely medical professionals act instinctively and defensively with these patients, for example when having their competency questioned by frequent visits. Chronic care-seeking behaviour is reportedly viewed negatively by many doctors, and patients are often avoided, disparaged and quickly dismissed (Henderson, 1974; Rapport & Wainwright, 2006).

Unlike the stereotypical hypochondriac, who is supposed to be certain he or she has an illness, most hypochondrical patients do have some doubt. In reality they have some degree of insight into the gap of what they think is wrong and what the doctor believes. As with attachment theory, many may want to be reassured. Kleinman (2005) believes that the hypochondriac's persistent fear is not based on the certainty of delusion, but, on the uncertainty of persistent doubt. This, he says, is why hypochondriasis and health anxiety lead to so many futile and sometimes dangerous tests, because no test is certain enough to alleviate the niggling doubt. It is within the doctor/patient relationship that the hypochondriac feels obliged to act as if they lack irony. For example, Kleinman hypothesizes that the person might be very humorous in his or her day to day life, but, when in the role of patient, may act stolid and self-righteous, unable to laugh at him or herself. If the patient was to hold an ironic smile during the consultation, or allow for doubt to be acknowledged, they could not portray their problem as a serious one (Kleinman, 2005). So, accordingly, the hypochondriac must maintain the social fiction of not allowing their own doubt to surface. This contradiction creates further communication break-

downs in the already frustrating doctor/patient consultations. The hypochondriacal patient can elicit the doctor's own doubt, which can be uncomfortable, as much medical work is about probabilities; doctors can never be completely certain (Kleinman, 2005). Furthermore, many doctors do work at 'arms length', keeping a seemingly professional distant relationship with patients. Doctors have been reported to appear aloof (Hardy et al, 2001), and emotional detachment may be involved in some aspects of medical training programs. It appears, unless something more is done, that doctors and hypochondriacal patients have reached an impasse, as illustrated in the classic Dr Seuss tale, 'The Zax' (see Figure 6).

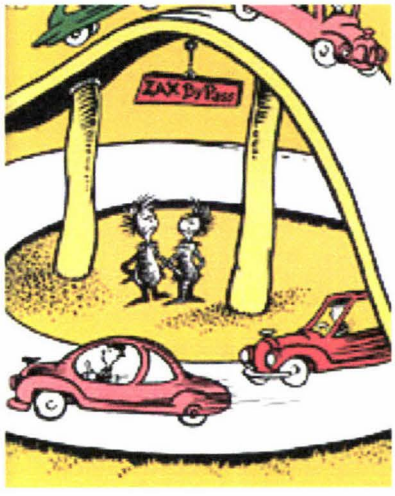

Figure 6 - The Zax

Stuart and Noyes' (1999) hypothesis seems to make sense in seeing somatizing behaviour as a form of interpersonal behaviour, driven by an anxious, maladaptive attachment style. In their article they conclude that the primary clinical implication of their research is that physicians must take responsibility for breaking the doctor/patient relationships' self-defeating cycles. They advocate that the medical profession needs to take some responsibility for their own reactions towards these patients, even knowing that these patients can, at times, evoke hostile and rejecting responses. Physicians need to maintain a constant care-giving stance with good boundaries, and understand that these patients contend with a great deal of suffering and

distress, worrying that they will not be cared for. Such distress, they argue, is every bit as disabling as depression or anxiety, and needs to be treated in a respectful manner (Stuart & Noyes, 1999).

Far more research needs to be focused on these doctor/patient variables. Of the small body of research in this area to date, the studies have focused on the doctors' perspectives on these patients. Like Stuart and Noyes work, some feedback to the medical profession about how to best manage health anxious/ hypochondriacal patients, could benefit both parties. The doctor/patient research in this area has also been confined mostly to statistical methods; psychometric testing and quantitative pre-answered questionnaires. The public are informed from the doctors' perspective, we form impressions from the history and media of stereotypical hypochondriacal patients, we use discourses of hysteria, and we make inferences, from our socio-historical lenses about stereotypical hypochondriacal behaviours. However, what about the patients' perspective in all this? Patients' voices need to be heard.

8. The Patient's Perspective

Noyes and Stuart paired up with two other researchers a year later, and took their previous study one step further. Like the leap Freud took in actually listening to his patients, these researchers wrote an article from the hypochondriac's perspective. The purpose of their investigation was to learn how patients viewed their physicians and medical care in general. Persing, Stuart, Noyes and Happel (2000) recruited 20 patients from a primary care clinic who scored 15 or 23 on the Health Anxiety Questionnaire (HAQ). They excluded those with severe physical and mental illnesses and also chose a control group. Persing et al, (2000) then administered semi-structured interviews to participants, regarding participants' health care and past six months of medical history. Recorded interviews were then transcribed, and investigators identified common themes and reported back patient narratives throughout their article. Four broad categories emerged: physician personal characteristics, physician professional characteristics, characteristics of the health care system; and characteristics of the patients themselves (Persing et al, 2000). Conclusions were drawn from mean averages of positive and negative comments from the health anxious group and the control group. Both groups made positive comments, and, as expected, the hypochondriacal group reported greater negative comments. These researchers then highlighted some of the negative narratives to end their article. Interestingly, in no cases in these narratives did the doctors make a diagnosis of hypochondriasis, and patients felt like their doctors did not take them seriously and were often hostile, ending consultations quickly (Persing et al, 2000).

The Persing article shone some light into existing research by writing from the patient's perspective. However, although they used the qualitative method of narrative, their overall study had a quantitative framework, with an apparent post-positivist, empirical epistemology. For example, the interview used was fairly structured, and the final analysis was statistics based. Much more research could be done here, from the perspective of the patient. It would be interesting to look at patients' narratives from a social constructionist epistemology. There are gaps in this beginning research area. It would be interesting to see, in conjunction with

Stuart and Noyes attachment hypothesis, whether participants from this last study identified with having an anxious attachment style. As hypochondriasis is starting to see resurgence in research interest, and people are realizing the crisis in general medical care and health care burdens, more research should focus on the patient's perspective; to explore what is happening for them personally. Doctor/patient relationships have had only a small amount of research activity. Considering what a large part of health anxiety it may impact upon, and how negative doctor input can exacerbate symptoms and further burden health care systems, it seems imperative to add to this body of research.

9. The Present Study

The overall aim of the present study is to begin to bridge the gap between doctors' perspectives and patients' perspectives on hypochondriasis and high health anxiety, by adding some awareness of patients' perspectives. The study is exploratory in nature and aims to replicate some of the work of Persing et al (2000), but with a social constructivist stance. Participant focused issues will be explored, such as reported childhood attachments, doctor/patient experiences and relationships, and the perceived stigma of being a hypochondriac.

10. Methodology

Reflexive note: *The researcher (now referred to as 'I') acknowledges that like all others, I bring to this study my cultural assumptions and beliefs. Not all of these are conscious enough to attend to, but reflexive notes are written throughout this process to access and attend to those of my thoughts and assumptions that might impact on the present study. With regards to methodology, I am positioned with a growing social constructionist voice. This voice is clouded from a past foundation of being a student taught for many years in an empiricist post-positivist epistemological environment; however my new social constructionist voice has grown stronger during the process of literature review, as has my feminist voice.*

Personally, in my work experience managing a 24-hour anxiety phone line, I have many times noticed the difference in listening to a person's health anxious voice, compared with someone who is generally anxious. I had a growing awareness that there were no specific pamphlets, videos or other media to send to health anxious people in the mail, for themselves and their families. These pamphlets and the like were given to other callers, to educate sufferers about their specific types of anxiety, to provide the words to start conversations and build awareness. These people often fell through the cracks of our mental health service, as there was nothing specific to offer them. The experiences of talking to these sufferers while they were in crisis has shaped my view that, in order to offer insight into this area, sufferers' narratives need to be used as a foundation for our understandings of health anxiety.

Power relations are inextricably bound up with meaning, language and knowledge (Foucault, 1980). In the field of hypochondria/health anxiety, the medical profession possess much of this power, and patients who report medically unexplained symptoms have very little of it. Medical diagnosis (or the lack of diagnosis) has been given, in our society, the authority to allocate entitlement to the sick role, and to prescribe how we should make sense of people who do not

fit this category. With very little power, the voices of people labelled or assumed hypochondriacs are often silenced.

The current study, therefore, takes as a starting point, the voices and life narratives of a group of people who have high health anxiety. Listening to the subjective experiences of participants' life stories is central to this study, as these stories represent subjugated knowledge that has been marginalized and ridiculed within mainstream medical theories of hypochondria. By listening to the ways in which participants make sense of their hypochondriacal experiences, there may come some understanding of how power relations, including with the medical profession, contribute to the construction of these people's identities. Furthermore, these examples may highlight commonalities on how these power relations may work to maintain high health anxiety and hypochondria stigma. It is also hoped that, as hypochondriacal patients are often difficult to empathize with, hearing these people's narratives will be valuable in itself to the issue of stigma.

10.1 Participants

This study had seven people agree to participate. The group of participants were three men and four women, with ages ranging from 18 to 63 years at the time of the interviews. Participants identified themselves as having high health anxiety and/or being labelled as a hypochondriac. Participants were recruited through three methods. Initially flyers about the study were put up on public notice boards within the North Shore area (see appendix A). A phone number with an answer-phone was set up specifically for this study and the number, with some information about the study, was printed on the flyers. Along with this, the researcher recruited participants through the technique of 'snowballing'. This involved using the researcher's personal contacts to spread the word about the study, and need for participants. Lastly, a local newspaper interviewed the researcher about her study, and provided contact information in the community news section of the newspaper (see appendix

C). The only criterion for people to participate in the study were that people identified themselves as having high health anxiety.

Participant Descriptions and Pseudonyms:

Paul was the first participant for this study and is an acquaintance of mine. Upon hearing about the study he identified as *"being a bit of a hypochondriac"*. He offered to participant, but was one of the last to be interviewed, as he had some study to complete first. This participant faced stigma in day to day life for a physical disability that was not related to high health anxiety. He, as did the other participants, chose to use a pseudonym instead of his real name.

Kay was recruited using the snowballing technique. When she heard about my study, she was excited, and said *"Oh my gosh, I'm such a hypochondriac! You can so interview me!"* Kay is the youngest participant; she is a bright, flamboyant 18 year old university student, who is enthusiastic and energetic.

Jackie is a 63 year old woman who was happy to be interviewed about her health anxiety. She was nervous that she may not be able to formulate her answers well, and that she may have memory recall issues. Jackie lived in Wellington at the time of the interview; she was interviewed via video conferencing at the Wellington Campus, Massey University.

Eric was the next participant. He is in his early 30's and is newly married. Eric recently immigrated to be with his partner, and it was his partner who convinced him to participate in this study. Eric places himself on the lower end of the health anxiety spectrum, and offered some excellent insights into the study. We met in person initially, and discussed the study, however Eric reported having the 'flu at our interview time, and so the interview was recorded over speaker phone.

Dave, at time of interviewing, was in his late 50's. He is a New Zealand author, and has recently relocated to America. He was referred to the study by a mutual friend, who thought that he would be ideal for the study. I corresponded with Dave over Skype and a series of emails which

included both the open questions from the interview, and follow up questions being emailed. Dave said he was *"over"* his high health anxiety. His valuable recollections of high health anxiety and doctor/ patient relationships focus on the 1960s.

Eve is a young woman who responded to one of flyers. She reports "the *picture on the flyer drew me over to the notice board, as it reminded me of how I feel sometimes".* Eve is an articulate, intelligent student. Like Kay, another young participant with high health anxiety, Eve has a flamboyant personality that shines through, and is a student in the humanities field. She is a hard worker, juggling work, study and parenthood.

Margaret is a mother of three children. She plays sport professionally and operates a small educational business from home. Margaret has a sister who lives in Auckland. Her sister noticed my interview in the local paper about this study. She cut out and posted the information to Margaret, who lives in Tokoroa. After sending an information sheet and consent form, Margaret confirmed that she has severe high health anxiety. I interviewed her over the phone.

Reflexive note: *I realized that I had made an assumption, based on the much of the literature review on hysteria, that potential participants coming forward would be women. This was not the case, and I stayed open to hearing these men's stories throughout the interview process, noting any differences that came up between genders.*

10.2 Procedure

Prior to recruiting participants, approval for the research was sought and granted by the Massey University Human Ethics Committee (MUHEC) (see appendix B). Members from the general public, who identified as health anxious, were invited to participate in the study via flyers on notice boards, word-of-mouth (snowballing) and two local newspaper interviews with the researcher (see appendix C). Potential volunteers then had the option of either leaving

their details on a confidential phone number, or an email address, for the researcher to contact them at a convenient time. Potential participants were then contacted by phone or email, and some general information was given, rapport building being an important part of general conversations. An information sheet was sent out to potential participants (see appendix D). Contact was made with those people who decided to participate, and further arrangements were made; organizing meeting times and venues for the interviews to take place. Participants read and signed a consent form (see appendix E). Consent forms also included a space for participants to choose a pseudonym to protect their anonymity.

Interviews were undertaken in the form of conversations about the participants' life stories. Interviews were semi-structured, with general probe questions which focused on participants' childhoods and attachment styles, doctor/patient relationships, and stigma, if any, of being thought of as a hypochondriac (see appendix F).

Reflexive note: *When I initially came up with interview probe questions, and reviewed them with my supervisor, it was discussed that there were too many questions, and some might shape participants' answers. Although I had decided not to use grounded theory methodology for this particular study, I still wanted to hold my assumptions and literature review at bay somewhat when interviewing participants. When I interviewed the first few participants, it appeared both the participants and myself were uncomfortable without the structure; my first participant asked me for more specific questions. However as more interviews were facilitated, we became more comfortable, so I think much of this may have been due to my lack of confidence in using a less structured method than I was used to.*

Initial interview times ranged from 30 minutes to one hour and 45 minutes. Often there were follow up questions to clarify understandings, in the form of phone calls and/or emails. Apart from the three broad areas that the participants were asked about, there was free interaction between myself and the participants, including opportunities for clarity, discussion, and

participant-led conversations. This was purposeful, as Reinharz (1992) recommends this flow of researcher/participant communication in open interviews.

Reflexive note: *In her book, Reinharz (1992) advocates free interaction in interviews to access participants' own words. I wanted to encourage participants' words, and not put my words in their mouths. However this was easier said than done. When participants spoke, I paraphrased what they had said to check that I had understood accurately, and also asked questions to clarify ambiguities. However, I noticed, when transcribing the first few interviews, that some of my questions were positioned in certain ways. For example: Kay; "Mum's always got a problem with her back, which I think is arthritis. Where as if I get a sore throat I think it's lung cancer". Researcher; "Do you mean that you think your mum has a more genuine reason?"* I might have elicited more information in the participant's own words if I had said something like "*what does that mean to you?*" or *"can you tell me some more about this?"* I grew more aware of myself as interviewer as the study progressed.

Some follow-up questions aimed to identify the cultural and historical voices of others, such as family, friends and social support networks, and the meanings that these other people's voices had for participants. I included myself in this, taking part in the conversations and sharing myself where appropriate with regards to empathy and rapport building, and openness to researcher bias (for example awareness of any underlying assumptions as they arose). In the second part of the interview, probe questions were based around stigma on hypochondria and how this may have impacted on participants' lives. These questions focused on the effect excessive health anxiety had on the participant, their family, friends and occupational lives. By turning questions around in such a way, it was hoped that the hypochondria stigma and construct itself became objectified in a way that took the objectification off the participant. Other questions related to doctor/patient relationships and issues, exploring power roles, and the participants positioning (for example as 'docile bodies') when consulting with doctors. Each

interview was audio-taped and transcribed by the researcher, and included laughs, pauses and any other gestures.

10.3 Analysis

The overall aim of this study was to start to bridge the gap between doctor and patient perspectives of hypochondria and health anxiety. This study aimed to build on the Stuart and Noyles (2000) research, focusing on the patient's perspective, but took a social constructionist epistemology. Other epistemological frameworks such as hermeneutics, phenomenology or realism, require a commitment at the level of theory, where other theories such as CBT, and types of analysis, such as thematic narrative analysis, could not be utilized (Gergen, 1999). Social constructionism can allow for a more balanced perspective, taking into account many theories and methods of analysis. All theories are invited to be considered, as long as no one theory marginalizes the other theories (Gergen, 1999). Gergen argues: *"To have a single, unified theory in psychology would be similar to destroying all the world's religions, all genres of literature, and all newspapers-save one"* (Misra, 1993, p.404).

An aim of this study is to expand on the single, unified side of the doctor/patient perspective on health anxiety and hypochondria. Patient's voices needed to be heard and conclusions drawn from their words. Language has been thought of as the vehicle that *truth* has been traditionally carried on (Misra, 1993), and as the literature has illustrated, has been socially constructed over time. Therefore using a narrative method of analysis meets both the main study aims of listening to patient's voices, and fits in well with the studies social constructivist framework.

Narrative analysis in the human sciences refers to a group of approaches to diverse kinds of texts, which have in common a storied form. As nations, governments, and those in positions of power and authority (such as the medical profession) construct narratives about history, so do social movements, organizations, scientists, ethnic/racial groups and individuals, through stories of experience (Riessman, 2008). What makes such diverse texts 'narrative' is the sequence and consequence, that is, life events are selected, organized, connected and evaluated as meaningful to their particular audience. The difference between life narratives

and storytelling is that storytellers interpret the world and experience in it, often to create moral tales about how the world should be. The included work of Dr Seuss is a good example of storytelling, whereas narratives represent storied ways of personal knowing and communicating (Hinchman & Hinchman, 1997).

Narrative research is a term that many social scientists use. Some researchers argue that scientists have taken over the term, and attached an abundance of theory to it, some of which it does not necessarily have in everyday life (Norman, Denzin & Lincoln, 2003; Reinharz, 1992). Narrative can simply equate to people's life stories and the meanings that people attribute to their experiences. This study collected and transcribed, in the first person, some extracts of life stories of the participants, in order to begin to explore what it means to experience high health anxiety. Once the interviews and transcriptions for each interview had been completed, it was necessary to make sense of the data. Information needed to be broken down and its components studied for importance and meaning. However there are few concrete and easily understood instructions regarding how to gain analytical insight into narrative data collected.

10. 4 Coding

10.4.1 Initial/Open Coding

Armed with the transcriptions, I needed to organize a large amount of data into smaller, more manageable segments. Bailey (2007) gives a good metaphor of the task of coding data. She says it is like entering a fabric store, and being told to *make something.* There is free access to all sorts of materials, patterns, crafts, buttons etc, but all the items are piled together haphazardly in the middle of the store. Worse, imagine only having a vague idea of how to sew! One thing is for certain though; organizing all the materials in the store will make things easier. So, a place to start is to label all of the items, knowing that soon all those with the same label will go into the same pile. If some item looks hard to label and group with others, they are labelled miscellaneous; a few items may require more than one label. A list should be made of things that could or should be in the store, but are missing.

Bailey's metaphor describes the process of initial/open coding. Researchers engage in the process of initial/open coding with the purpose of breaking up multiple pages of text into more manageable segments that can then be used in later stages of the analysis (Strauss & Corbain, 1990). This made sense as a useful way to initiate the first stage of analysis in the present study, working with the transcribed data. Some researchers view coding as a mechanical process that informs the analysis, but they believe it is not analysis per se. However qualitative researchers Miles & Huberman (1994), Bailey (2007) and Riessman (2008) argue that coding is analysis, and the process of coding itself is an important element, as researchers have to make decisions about what to code and how to code items.

Reflexive note: *It was tempting to define coding along the popular lines of 'the process of finding themes that emerge from the data'. This was especially tempting, as my narrative analysis is thematic. However, after much thought, I took heed of the words from Bailey who wrote "One does not search through one's qualitative garden at the right time of year and find themes like daffodils emerging through the ground" (Bailey, 2007, p.127). What she means by*

this, and what I kept in mind, is that the researcher controls what is produced. For this research, my initial idea, my interview probe questions and interviewing style, my coding and the interpretation of these codings, were all shaped to some extent by me as the researcher. Rather than attempting to minimize or deny this by appearing unbiased (white lab coat comes to mind), I am acknowledging this and attending to potential bias and shaping throughout this study.

Each transcription was read and in every line of data, a tentative code was made. Below are the initial codes that were attached to Kay's transcribed interview.

Table 5 – Initial Coding
Others who are genuinely ill because they don't attribute catastrophe to their symptoms
Others who are genuinely ill (x4)
Justifications of other people's genuine illness (x7)
Others who don't have a genuine illness but who have psychological disorder
Justifies other peoples illness by severity and speech (x5)
Justifies other peoples' illness as real if the doctor gives pills/ diagnosis (x4)
Severity of genuine illness as a qualifier for the sick role (x9)
Mistrust of doctors (x7)
Attachment to primary caregiver
Enmeshment (x9)
Separation anxiety (x6)
Faking illness to avoid school and bullies
Secondary gain
Faking illness as a coping technique
Trauma (x3)
Self as a burden
Negative impact of other peoples' genuine illness on participant
Past care-giving and experience of *"the genuine sick"*
Care-taking of others (x2)
Meaning making out of others genuine illness (perseverance, strength)

Table 5 – Initial Coding (Continued)
Other people's misunderstanding of genuine illness
Other people's misunderstandings leading to loss
Self stigma (what is genuine vs. fake illness)
Others' stigma of who participant perceives as genuine illness (evoked feelings)
Separating other peoples genuine illness from hypochondria
Separation of self from others
Positioning self in terms of sticking to her high health anxiety actions *"being an anal bitch"*
Perception of doctors (as incompetent for example)
Symptoms going away if doctors give pills/ diagnosis
Reassurance seeking
Doctor views (positive and negative)

10.4.2 Focused Coding

Returning to the fabric store metaphor, initial coding has now enabled me to reach the point where the items have been placed into many piles. However there are still far too many piles to be able to do anything useful with the materials. In focused coding, similar groups of items now need to be placed under larger categories. For example, zippers, buttons and snaps could be all put together under the broader label *'fasteners'*. At this stage I begin to pick out items that I might potentially use, identify a few fabrics that I like, and then look out for buttons and thread to match (Bailey, 2007). Focused/axial coding is a process in which the data, now labelled, becomes reduced further, as initial coded data is combined into larger categories. This process also involves looking for specific targets, for example links and contrasts with literature review findings (Strauss & Corban, 1990).

Reflexive note: *The idea of reducing some of the rich data that was collected within the transcriptions left me feeling hesitant about this part of the process of analysis. Perhaps 'condensing' is a better fit for this research. However I had to keep in mind that in later analysis some of these rich texts would have a chance to be reported in full.*

During focused coding, I read over the labels that had been assigned in the initial coding process then began to cluster some of the labels into larger groups, while others, that could not

be reduced, were put aside, but kept in mind. After several attempts I came up with the following tentative focused codes.

Table 6-Kay's focused code list. Larger categories:
Others : positive and negatively grouped views of this participant
Separation: self from others /self with hypochondria from perceived genuine illness
Doctors: positive and negative views
Childhood attachment: enmeshment/trauma
Positioning of self when "sticking" to hypochondriacal worries
Meaning of illness

10.5 Thematic Analysis

Creating themes is a common, appropriate and important method for analyzing data (Bailey, 2007). My initial open and focused coding steps form a foundation for thematic analysis. Instead of linking the first participants transcribed codes with other participants' raw data, I have used initial and focused coding on each transcribed interview as if it were the first one. That is, I held back searching for only the themes that were coded in the first interview with the others. I needed to keep an open mind so that, at this stage, I could look at all of the themes and tie themes together that umbrella across the transcriptions. I was also interested in items that did not seem to fit with other participants' narratives. Flick (2002) provides support for this method, he points out that although this individual process may be a little difficult, researchers should code each case as if it were the first one.

Once individual codings are completed, focused codes are finally compared. Combining two cases to start with, notes were made on the similarities and differences between the two cases. Focused codes were then revised and sometimes added to. I then compared the third case with the earlier two, and continued this procedure until all of the cases had been analyzed. By constantly comparing the data in this way, I then moved forward to make sense out of common themes and inconsistent themes. I wanted to make sense of the themes by framing them

conceptually, exploring links between them, and putting themes together with sections in the study's literature review (Bailey, 2007).

11. Findings

When searching through each participant's coded themes, I found many similarities, differences, and contrasting views. Although many participants shared common experiences of the dominant themes, the thread that wove the themes together was the frequent experience of having a minor physical symptom turn into a catastrophic worry.

Paul gives a good example of having such an experience: *"My health has been pretty good, but I do worry with anything minor. Um, I think it's something major. Like, the other week, I had cramps in my calves. First it was in one, and then in the other one at the same time. I swore down that I was getting muscular dystrophy. As soon as I get one symptom or ache or pain I immediately jump to the worst case scenario".*

Contrary to popular belief about hypochondriacal people, all of the participants in the current study report having a good understanding, in hindsight, that their worries were unfounded. Paul's example highlights the good insight that sufferers have, after the event.

Eve tells of a similar experience: *"Often I would blow something small and harmless way out of proportion. Last year, after spending my day weeding the garden, I noticed a slight pain on the right hand side of my body. I poked at the sore spot, and noticed and panicked at any slight pain radiating from that area. I was sure I had appendicitis (laughs nervously), and imagined that my appendix might rupture at any moment. I went to the doctor, he didn't think anything of it, and eventually the pains went away. Now, um, looking back, I think it was all the bending over in the garden that did it!"*

As with Paul, Eve illustrates both the experience of blowing up a small benign physical symptom as well as having, in hindsight, the knowledge that her symptoms were probably just normal bodily sensations. Eve also mentioned poking the sore area and then panicking when slight pain came from that part of her body. Here she is engaging in selective attention.

Kay enthusiastically spoke of one of her many chest pain scares: *"I remember sitting in class, listening to a lecture when I felt my heart palpitate. I quickly put two fingers on my wrist to feel my pulse, and it seemed to be running very fast and missing beats. I was so anxious, my ears started ringing, and I felt dizzy and began to feel very tight in the chest. Breathing, um, it was difficult, I think because I was so scared that I was going to have a heart attack. Luckily the student doctors were like one minute away. In the end I had another EEG, which showed that my heart was fine. One thing leads to another, and I had totally worked myself up over nothing again".*

In Kay's example, selective attention was happening when she put her fingers on her wrist and attempted to confirm something was wrong with her heart beat. Again, with the wisdom of, hindsight Kay reports that she had worked herself up over nothing.

Eric has good insight about his tendency to blow minor bodily aches and pains into catastrophic thinking. He does not go to the doctor very often to check out his concerns; instead he turns to his husband to vent: *"It's like, I'll get a headache, and within minutes of lying down, I'm like calling out for reassurance that it's not a brain tumour. Until the headache intensity goes down, I panic".*

The headache example is a common symptom that can be blown out of proportion. Dave states: *"Illness was a constant during my 30s and 40s, and the anxiety increased to an alarming extent. If I had a headache I thought it was a brain tumour".*

Margaret mentioned a time in her life when she was visiting her local hospital up to three times a week with headaches: *"I had headaches and the like, but eventually I found out I just needed to get glasses".*

Jackie also gives an example of having a small symptom amplified: *"I woke up one morning and discovered a small vein in my arm that I hadn't notice before. I couldn't take my eyes off it, I pressed hard on my skin around it, it drove me crazy, I didn't know what it might mean, um, I mean what might come from it, and so I went to see my nurse straight away".*

Experiences such as these can provide insight into the common and frequent types of anxieties that health anxious people suffer. I was interested to find out when these experiences started for the participants. We will now explore some more about how these experiences actually fit into the participant lives, when they started, where participants think that they come from, and how they cope. Six main themes have been highlighted from the data. The themes that most participants have in common, or contrast each other about are:

Table 7 – Overall themes
Childhood experiences
High health anxiety progressing into adulthood experience
Positioning of "self"
Stigma
Doctor/ patient variables
Communication styles and coping techniques

11.1 Childhood Experiences:

In this category, participants discussed their primary attachments and relationships; any childhood experiences with ill health (both of others and themselves); trauma experienced if applicable; and functions of health anxiety in their childhoods.

Attachment and Enmeshment:

As discussed in the literature review, there is speculation about certain attachment styles influencing a person's inclination to express distress physically. Research on doctor/patient relationships and reassurance seeking in hypochondria/health anxiety have been hypothesized to have a base in attachment. Although reports on this aspect from these seven participants cannot be generalized to all sufferers, I was particularly keen to hear how their experiences might fit with the literature. For example, Stuart & Noyes (1999) hypothesize that somatizing patient's display anxious attachment behaviour that derives from childhood experiences with caregivers. However there is only a small amount of research that exists in this area. Anxious attachment to a caregiver can be seen as clingy behaviour from the child; whereas

enmeshment is an unhealthy relationship between child and caregiver where appropriate boundaries are not adhered to, for example smothering. Often the two go hand in hand.

Kay discussed her attachment with her mother several times spontaneously during the interview: *"Mum was the most over-protective mother, I'm my mum's only child, and she was very, very protective. Nana and dad would joke about it when I was a baby. If I so much as sneezed, mum would rush me to the doctors, any time when I was sick, even for a slight headache".* Kay goes on to describe her other primary attachment: *"Me and nana were as close as anything, she was like my second mum. I was a home baby. If mum was mean to me, I'd go to nana* (who lived with them). *I've been babied, and been the centre of everyone's world".* Kay seems to display an anxious attachment style in the next statement: *"Mum's the only one who can calm me down when I'm in pain, not as calm as in "don't worry, it's ok", but she comforts me. When I was seven years old, I fell over and scraped my knee at a friend's house. Mum was hours away, and my friend's mum was like "come on, it's ok". But I called mum and she came and picked me up because of the grazed knee".*

Eve's primary attachment was with her mother too: *"I was very clingy with my mum. She was quite stand-off-ish though. I would initiates hugs and physical affection, and she would always be the first to pull away. Mum was away a lot, and I remember, um, I used to lie in my bed at night imagining that she might have had a plane crash, and that I'd never see her again. I was a clingy child".* Eve talked about her secondary attachment figure: *"I was also very attached to my grandmother, and she just loved me, we were very close. When she died, when I was a kid, I was gutted".*

Eric also called himself clingy, in relation to his mother: *"Yes, I was clingy. I was definitely a lot closer to my mum than with my dad. I would say that she was um, sort of the um, the person who took care of me more, if you will, than my dad".* Unlike Kay and Eve, Eric was quick to mention his father: *"It wasn't like he* (dad) *wasn't around though. I think emotionally though, she* (mum) *was just more available. Whereas dad took care of all the practical matters, like making sure I was rushed to hospital ASAP when I was sick".*

Dave fits into this group as well: *"I was definitely clingy towards my mum; I think so, definitely at an early age".*

Jackie was close to her mother: *"Mum died of cancer when I was young. Until then, I was very close to my mother. When she was away in hospital having treatments I cried and cried for my mum, and I wasn't allowed to visit her. When she did come home I would cling to her skirt and stay close by. I was a real mummy's girl, and when she died I was alone in the world for a very long time".*

Right up until the time she got married, Margret lived with her mother and grandmother: *"I was very close to mum. As a child I spent a lot of time with my mother and grandmother, and when I was very good, I got to stay home from school and help out with bottling jam, helping mum around the house that kind of thing. In fact, sometimes I wouldn't want to go to school, because I just wanted to be with my mum, I'd get anxious without her".*

The only participant who did not report to have an anxious attachment style was Paul: *"My relationship with my parents was great. We didn't have a large family unit, because we immigrated from the other side of the world. But all my family relationships were sound, parents and grandparents. No relationship troubles, it was a good family.....I still live with them now".*

Reflexive note: *I wonder if Paul was the exception to the rule, with the participants. I wonder if it might have been an issue with my interviewing style. I would like to have followed up on this family comment, asked a few questions to clarify if we shared the same understanding on this, to ask if he had ever moved out of home (Paul is in his 30s), and if he lived at home due to his disability? In saying this, I am aware of my own bias and assumptions creeping in, as I think of clarifying these questions. It is good to note exceptions to the rule in this research, rather than ignore them as outliers, as in some quantitative statistics analysis.*

Childhood experiences with health:

Most participants reported having had either a personal experience of chronic illness when they were younger; or suffering the impact of chronic illness through a close family member. Often the impact of this was reported as being huge on participants, perhaps shaping childhood somatizing into adult high health anxiety/hypochondria. Often during these times, participants began their first relationships with medical doctors, and started forming views on them.

Experience with illness, both for herself and a close family member, dominated Jackie's childhood. Firstly, as reported, her mother died of cancer when Jackie was a pre-teen. For years before this, she had watched her mother being very sick with cancer, and experienced separation anxiety and loss when her mother was at hospital and Jackie was not able to visit her. Impacting this further, a family member who came to take care of her while her mother was in hospital began sexually abusing Jackie. Her mother's illness, and absence due to that illness, had wide implications for Jackie.

With regards to personal experience with illness, Jackie was often not believed, or was said to be making a fuss, when she was ill: *"I remember one day, a few months after mum had died, I woke up with a really sore throat. Each time I swallowed it felt like I had sharp glass in my throat. Dad didn't seem to care when I told him, thinking I was um, making a fuss. My throat got worse and worse, it was affecting my breathing, and eventually, maybe a week later, dad fetched the doctor. Our family doctor couldn't even see down my throat, it was that swollen. He threatened he'd have to take me to hospital if it didn't get better within a day or two; he gave me some antibiotics and told me to salt wash gargle. The salt gargle stung, but I was so frightened of going to hospital, and so I gargled with the salt over and over. When the doctor came back it was a little better, not much, and it turns out I had quinsy".* Jackie speaks here about her first interactions with the doctor, using the word *"threatened"*, and he seemed to be seen as colluding with her father, and unsympathetic, threatening hospital. Also, Jackie does not speak fondly of the doctor, or mention any care given. ***Note: Peritonsillar abscess (PTA) or "quinsy" is a complication of severe tonsillitis. It consists of a collection of pus beside the***

tonsil, and results from an untreated acute episode of tonsillitis, which can be life-threatening.

Eric's childhood was plagued by the personal experience of having chronic asthma, and frequently being rushed to hospital by his anxious parents in the middle of the night: *"I've had a lot of exposure to ER and hospitals and such, because I suffered from a pretty serious case of asthma. It wasn't allergy related, it was pretty hard-core asthma. So, a lot of times my parents would need to like rush me, in the middle of the night, to the emergency room, because I had trouble breathing. This went on for about five years".* Although he did not report having experienced the impact of other people's ill- health when he was a child, he did mention how his illness impacted on his family: *"There were at least several occasions where all parties were extremely nervous. There were times it was just really, really intense, it was emergency situations, and my parents didn't know what to do. I mean, my parents are divorced now....but that wasn't really the reason why".*

The impact that chronic illness had on Kay's childhood was also great. Kay herself had frequent times off school with 'nervous tummys', however most of her illness experience came from being a caregiver to her grandmother at a very early age, and watching her suffer vicariously: *"Nana, who lived with us, had rheumatoid arthritis, so she was completely crippled from the moment I was pretty much born".* I asked Kay what she meant by completely crippled: *"Like, she couldn't do very much, barely even lift her arms. That's the only thing that she could do, that and slightly move her neck. And then she had like 18 operations, to have like screws put in her. With the arthritis, it lead on to other problems, because she wasn't moving, like she had bad fluid on her ankles. She was always, always in hospital having operations. And then the last time she went in for normal procedures on her ankle, that's when she died in hospital (pause) an aneurysm in her heart. That's what ended up killing her in the end, but then mum was a nurse as well, she read over the notes and thought it didn't add up.... Government agency".* This last statement may have been where Kay started forming her mistrust of medical doctors, which she goes on to talk about a little later.

Kay talks about the social impact that her nana's illness had: *"I was so used to sickness, I didn't realize that it wasn't the norm. Since I was seven years old, I used to take my nana to the bathroom, because it was a lot of work for mum to look after me and nana. I'd take over, shower nana, and take nana to the bathroom. And I learned the proper ways to lift her. Anyhow, when I was 11 years old, I had my first crush on this guy. Nana had this whistle (whoohoo Kay) which meant that she wanted me. So I said to this guy, "Ok I gotta go, to take nana to the bathroom". And the guy was like, "What the hell?" (giggles...participant then me) and that finished that. And that was probably the first sickness thing which was in my life".*

Another chronic sickness that impacted on Kay's childhood was her mother's migraines. The impact on Kay was that she had to take on more adult responsibilities as the only other able body in the house: *"Mum has always had really bad migraines, so she always had to like take like a day off in bed. I had to completely look after nana cause mum couldn't move or anything".*

Paul had a mysterious sickness that affected him when he was young: *"I remember when I was in primary school; I got so worried about my health, that I ended up going to quite a few doctors, and they didn't know what was wrong with me. My stomach hurt all the time with cramping sensations and knots, I felt sick and lethargic. I constantly felt like I'd been kicked in the guts, it lasted all day, most days for many months. In the end I had to do some specialist tests that were very uncomfortable. The doctors still couldn't identify what it was, and over time the symptoms dissipated."* This is probably the stage that Paul began to form his impressions of doctors. In this case the doctors could not help him. He did not make comments on any family members being chronically ill during his childhood, but our interview was intentionally very open, and so this was not specifically asked about.

Although Eve did not suffer from a chronic illness in childhood, ill-health did personally impact on her forming beliefs about illness and doctors, and impact her catastrophic thinking: *"My first illness experience happened at a time when my mum was away, and my dad was looking after us. I had a genuine illness, like mumps or measles or something, and was put on antibiotics. When I was out walking with my dad at the shops I passed out, onto the concrete. When dad*

took me to the doctors they found out I was having an allergic reaction to penicillin. I fainted often during this time. For some reason, after that, I remember being very anxious about going to the doctors. So it didn't start off being about my health, it was more a fear of going to the doctors in the end. I felt really nervous and I fainted sometimes, at the doctor's, anticipating something bad happening. The smell of the doctor's room, and being touched by the doctor or medical equipment really panicked me, and still does. My mum just thought I had an over-active imagination".

Like many of the other participants, and in-line with research findings, Eve grew up with the experience of having a family member with chronic illness: *"Mum had lots of back pain, she has really bad arthritis and has had two hips replaced. During my childhood she also had frequent migraines and unexplained hearing loss".*

Trauma talk:

As with many mental illnesses, hypochondria and somatizing behaviours have been linked with childhood trauma and abuse. The disorders that share many overlapping symptoms with hypochondria include "Post Traumatic Stress Disorder" (PTSD) and Dissociative Identity Disorder (DID). Interestingly, these disorders have patients who report the highest number of cases of childhood abuse (sexual and/or physical). Many somatizing patients report childhood trauma and abuse. This may be linked again with attachment issues and caretaking relationships, so I was interested to note any talk on childhood trauma/abuse. Defining childhood trauma is personal in nature, I have listened for obvious talk of trauma, but, also what participants identified as traumatic, rather than myself as researcher adding a value judgment as to what counts as trauma and which narratives to outline.

As mentioned, Jackie had much childhood trauma. Her mother was very ill with cancer and died young, her own life-threatening illness was unattended to, and she was sexually abused repeatedly by a family member. She was also adopted as a baby, and this is a possible interesting link with the research on attachment. There is more... *"Dad was always worried*

about me making a fuss. When mum died, and this is what pushed me over the edge, I wasn't even allowed to attend her funeral. My own mother had died, and I wasn't allowed to attend and grieve! After that I was depressed, I spent a lot of time in bed. Dad called that same family doctor over (who had diagnosed her with quinsy, and threatened her with hospital). *He was moving, at that stage from being a general doctor to a psychiatrist, and dad asked him to look me over. Now, I don't know if it was because the doctor knew dad was an alcoholic and was not coping with me after mum's death, or whether it was his own interest, or even an "old boys' network- it was the late 60s", but he booked me into the local mental hospital. During my time there they were using electro-convulsive shock therapy treatment, which they performed on me, without my consent, many, many times".*

Jackie's trauma story includes her experiences with doctors as they were forming in childhood and adolescence. She eventually becomes positioned as a "docile body" (Foucault, 1980) that the medical profession had used without her informed consent. Again, she viewed her family doctor as colluding with her father, while her grief over her mother and consequent depression seem to have been ignored. Although this occurred in the 1960s, it shows a remarkable comparison with Charcot's patient who was locked up and straitjacketed after unresolved trauma of being raped at knifepoint. Jackie's story highlights the power of the medical profession above basic human rights.

Interestingly, like Jackie, Eve was also adopted as a young baby, linking in again with primary attachment theory, which will be revisited in this study's discussion section. She had on-again off-again experiences in her childhood when her sometimes unstable birth mother made contact with her. Apart from alluding to other significant trauma in her childhood, she added: *"We* (siblings) *had some physical punishment, just whipping with a long stick, whacking, and I had my mouth washed out with soap on occasions. I don't always remember these times being linked to us being naughty, they seemed to come out of the blue, but I do have memory gaps, and was an attention seeking child".* Eve also reported being *"devastated"* when her grandmother died of cancer when she was 10 years old, as they were very close.

Kay said that her grandmother dying was the most traumatic thing in her childhood: *"Nana was like my second mother, and then, just like that, she was gone"*. She jokingly added to a later conversation: *"being over-mothered was quite traumatic for me!"*

Paul identified his childhood trauma as moving across the world to immigrate and leaving his beloved dog behind.

Eric believed his greatest childhood trauma took place over a five year period, when he could not breathe from severe asthma attacks, and had to be taken repeatedly to hospital by very panicky parents: *"I was just a child, so I didn't know what to do, and um, when it comes to asthma, it's about whether your child can breathe or not. There were some things that my parents were instructed to do, but there wasn't a whole lot that they could do themselves, other than rush me into the hospital. Um, so I don't know, but I think you could call that a childhood trauma"*. Eric's parents also divorced.

Like both Kay and Eve, Margret was also adopted; her adoption was known to her as a child, however she never met her birthparents. She reported: *"I always felt different, like I didn't really belong anywhere"*.

Dave did not talk much about his childhood, other than to say: *"I grew up in um, what you might call an um, toxic environment. My parents were alcoholics"*.

Childhood functions of health anxiety:

Throughout the interview process, the participants talked about their health anxiety/ hypochondria in a way that looked like it had some kind of function. This was true for both childhood and adulthood health anxiety; however the types of functions that emerged from the data seemed to fall into two categories, for childhood and adulthood, with some overlap. Childhood functions are discussed here.

Eve speaks of selective caretaking: *"There was a lot of care given to me when I was sick. When I was well there wasn't as much, but when I was sick, even my dad came and sat next to me".* She went on to specify: *"When I was a young child, I thought of it like this- if I was sick, my dad would care for me and be nice to me, or at least exempt me from his grumpiness. Mum however would either be angry or attentive, like um, stroking my back. I'd never know which one it was going to be".* Selective caretaking occurs when parents selectively attend to their children with care and attention, and can possibly lead to children then realizing this, on some level, reinforcing certain behaviours: *"I did fake sick sometimes too, to stay home from school".*

When asked why, Eve spoke of being nervous going to school, having butterflies in her tummy. It seems that another function of her somatizing behaviour, besides eliciting selective attention, was avoidance. Avoiding school could function at many levels, for example, avoiding bullying, avoiding symptoms of learning disorders, avoiding dealing with other psychological disorders in the making, such as social phobia, agoraphobia and separation anxiety. Eve also mentioned in her above statement that she was "exempt", if ill, from her father's grumpiness. The function of avoidance here might have been to also be exempt from the physical punishments that she had mentioned before.

Making *"a fuss"* gave Eve a small sense of control as a child in the doctor visits that made her so anxious: *"I had a genuine illness, tonsillitis, which I had a lot as a child. One day the doctor said that I had had it recurred too many times, and that I needed to go to hospital to have my tonsils removed. I made such a fuss about going, both to my parents and the doctor, that the doctor gave in and so did my parents and I continued having less drastic treatment".* The function of fuss-making high heath anxiety may have been very adaptive for Eve at the time, considering her past allergic reaction to penicillin.

Paul discusses his childhood illness in terms of turning worry into physical symptoms: *"It wasn't to avoid school, but I was just so worried about a lot of things, like, we had just immigrated, and there was the transition from primary school to intermediate school".* So the function of Paul's childhood health anxiety and illness behaviour was to avoid conscious worry, which may have then been converted into physical symptoms.

Kay's mother was often busy looking after her crippled grandmother. Kay spoke of wanting her mother's attention: *"When I was younger I used to pretend to be sick a lot so mum would look after me too"*. Here is another example of a child trying to elicit selective care taking from their parent. The function here is not so much of health anxiety, as Kay specified that in this example she is talking about faking. However it is interesting to note here.

She continued: *"I cried at school heaps when I got dropped off"*, highlighting separation and attachment issues. *"When I was about eight, I didn't want to go to school, because, um, I was really badly teased at school"*. Here the function appears to be avoidance. Kay talks again about eliciting selective attention another way as well: *"When I was 10 years old I used to pretend to faint. I'd go to bed, and at 8.30pm I'd come out to the hallway and pretend to faint. I'd get mum all worried, but then she knew I was just being silly, so I stopped"*. This example perhaps includes two functions of Kay's behaviour. The first may be to get attention from her mother. However the other part might be more related to attachment and separation anxiety, as she specifies the time that it had happened each night, and corresponds to some of the other attachments comments that Kay makes through-out her interview, such as her mother being the only one who could calm her down and make her feel safe. When her health behaviour no longer served its intended function, she *"stopped"*.

The functions of Jackie's childhood health anxieties were possibly due to selective attention. Her story brings to mind a very lonely, ignored grieving girl. Her outbursts, or "fuss" as her father used to call them, may have been Jackie's unconscious childhood means of seeking help and attention. The function of her high health anxiety may have been very adaptive, considering previous life-threatening times when her symptoms had been ignored. Jackie may have also converted her unexpressed feelings of grief into physical symptoms.

In fact, this can be said for Eric too with his asthma. It may be that, after the experience of a life-threatening illness or experience, the excessive health anxiety serves the function of making sure participants could get enough attention to elicit help again should they need it.

11.2 Health anxiety progressing into adulthood:

Participants have all reported having experiences of somatizing their distress as children. Many participants discussed this in terms of responses to stress and trauma, and also discussed adaptive functions that such behaviours served. However, as participants developed from childhood into adulthood, most had their childhood health anxieties lie semi-dormant until they experienced a major life stressor.

Experience of a major life event/stressor:

Eve had a resurgence of hypochondriacal concerns when she was a young adult. She was living on her own with her young child, studying at university, when a family member who was in prison escaped, along with a high profile criminal that was said to be armed and dangerous. Similar to the time of her childhood allergic reaction, Eve's mother was away, and her social support network was very limited. This is when Eve's adult experience with hypochondria began: *"Instead of acknowledging the very stressful situation at that time, I got health anxiety...you could probably even say it was hypochondria. It started with tightness in my throat, and from there I ended up at the university doctors all the time of that prison escape. In the end, my health worries were so bad that I wanted to stay there* (at the doctor's office) *and the nurse organized a little room for me, for when I was too stressed about my symptoms. I would turn up at the university doctors often, thinking I had heart problems, appendicitis, sore tight throat, high blood pressure worries, and all those kinds of things".*

Eve makes statements that show she has good insight that her hypochondriacal concerns were related to her stressful life event, in hindsight. She saw her stress at the time being converted into bodily symptoms that she became obsessive about.

Paul also noticed that his health anxiety started up again when he was an adult starting university. Starting university may have been an especially big life event, as he has a disability and uses a wheelchair, so there would have been many things to organize for attending lectures: *"When I started university study it was really stressful. I'm usually pretty good, I used*

to thrive on study stress, it made me work harder, made me more focused. But now that I've started university study, well...lately everything's stressful, and it's slowing me down, it's getting the best of me, I'm not handling it. I come here (university), *I get all this stress, and now I have my old health anxiety back! Everything just snowballed, like a minor ache in the legs, I'll just try and sleep well, then its doctors, and painkillers, it seems worse, because you don't have time to go to the doctor's cause you're working on assignments. So you can't get it checked out early to get peace of mind, so it builds up until you get the time to go to the doctor's".*

Paul's narrative brings up several points. First, Like Eve, he shows good hindsight into how the major life event of starting university impacted on the resurgence of his health anxiety as an adult. He also talks about his studies preventing him from going to the doctor as much, and implies that earlier reassurance from his doctor would lessen his health anxiety response to his stressor. Paul's perspective here seems to be that starting university study not only related to the beginning of his adult health anxiety, but that it also perpetuated his anxiety by preventing him from going for regular check-ups that, he implies, maintains reassurance.

Kay identified that the time when she started experiencing adult health anxiety correlated to starting university too. Like Eve (with the prison break experience) and Paul (with disability issues involved with starting study), Kay also identified having a stressor that made university life more difficult: *"I moved out of home, to live in Auckland city, to attend university. But no one was there to catch me and hold me when I don't live at home; I'd always lived at home before then. Mum is the only one who can calm me down if I'm in pain. I was terribly homesick, failed my university papers, and moved back home".*

I asked Kay specifically about the health anxiety experience that began at this time in her life: *"The whole smoking thing...my mum knew, but never said, about me smoking when I was younger. I never told her* (that Kay smoked) *because she's anti-smoking. So I can't say that I might have cancer because I used to smoke, I don't want to confirm to her that I smoked, so I talk about it in terms of asthma. But, yeh, I went to the doctor's when I moved out of home, because of a sore throat".*

Reflexive note: *It was interesting that when asked about her initial adult health anxiety symptoms, Kay started talking about her mother and the smoking/cancer anxiety. I wonder if her statement could be used to interpret her adult health anxiety and life stressor as an attachment act, triggered, by leaving home.*

Margaret's adult hypochondriacal worries began when her mother, whom she was very close to, was diagnosed with an inoperable brain tumour. Margaret reported being grief-stricken, and she took over all care for her mother who lived just down the road. Around this time, she became not only concerned with her own health, but also worried about her children's health: *"I was fixated on making sure that my children had had all their immunizations and I wanted them to get the 'flu injection. I also worried that we may all have had tape worms".* Margaret's attachment with her children, and worry about their health seemed to coincide with her own mother's illness, perhaps again attachment related.

Dave talked about his adult health anxiety starting when he first began working in a highly stressful job, when he was in his early twenties: *"Difficulty sleeping was the first symptom that I noticed, and um, this quickly deteriorated into a raft of other symptoms".*

Jackie was the exception to the other participants. She did not have a period of time distinguishing childhood somatizing behaviours, and adult health anxiety, marked by a major life event. Jackie reported having both somatizing behaviours and high health anxiety that waxed and waned throughout her life. In her mid- sixties, Jackie still struggles with health anxiety from time to time. One possible reason for this may be the extent of her childhood trauma, and ongoing stressful life events such as living in the mental hospital for some time and enduring the electro-convulsive-shock therapy treatment.

To summarize, nearly all participants identified experiencing a stressful life event that occurred at the time in their life as their adult health anxiety. There seems to be some similar links with attachment in the above narratives. Woven into some of the narratives on major life events are snippets of information alluding to some adult functions of health anxiety. For example,

Kay, after becoming health anxious away from home, got to move back in with her mother. The next theme discussed is adult functions of health anxiety and hypochondria.

Adult functions of health anxiety and hypochondria:

From listening to the interviews with participants it became clear that talk of the functions of health anxiety were consistent from childhood and adulthood. Some of the functions served the same purposes in childhood and adulthood, for example, avoidance and care seeking. Although having the same purpose, some of these functions were refined in adulthood. For example, in childhood, somatizing behaviours were often reported to be aimed at care seeking from parents. As the narratives in this category will show, this same care seeking behaviour is directed towards doctors and partners by participants in adulthood. Some functions are modified, other functions are dropped from childhood to adulthood, and sometimes new functions were reported.

As mentioned, Kay's initial adult health anxiety resulted in her moving back home with her mother and dropping out of university. In some ways the functions of her health anxiety can be based on the situation outcome. Her health anxiety appeared when she was separated from her mother, and as a result of her health anxiety, she moved back home again. One main function of Kay's health anxiety may be to avoid separation from her mother: *"If I feel a pain in my chest then I get chronic butterflies in my stomach. I get that when I'm driving away from home, separation from my mum".* Kay's health anxiety and consequent separation anxiety with her mother is impacting on her life severely: *"I had no control; I missed my mum, mum being close means everything's ok, and going to be fine. I'm really worried about travelling; I worry about my health issues stopping me in the future".* What was once functional in childhood, such as faking illness to be close to her mother, had become maladaptive in adulthood, as expressed by Kay. That initial function of Kay's health anxiety is the same as reported in her childhood narrative of this category. Kay is however, only 18 years old, so her health anxiety may evolve into other areas later in her life.

Jackie reported having a frequent need to seek reassurance about her health in times of stress, by visiting both her doctor and her physiotherapist. She noticed that when she has a lot of work to do, or has an assignment to hand in at bible college, that one of her illnesses will *"crop up"*. Often her muscles will seize up, or, if writing, she will develop sore arms instantly: *"Just when I am about to accomplish something, or I need to gather up my resources...something goes wrong with me!"* The function of Jackie's adult health anxiety could be seen in terms of attachment style (visiting the doctor/physiotherapist for reassurance), avoidance (of the stress of her assignments) and self-sabotage.

Eve identifies with the element of self-sabotage in her narrative: *"I would split from a situation where I needed to concentrate on something, or get something done, into health anxiety mode. Like, um, I might be having to clean the house for a visitor, and it's nearly finished, then I'll get a chest pain, and everything's off"*. There seems to be a fine line between the function of avoidance, and one of self-sabotage here. The self-sabotaging seems to be distinguished from avoidance when the function has a negative impact on the participant. This self-sabotage is reported from both Jackie and Eve as new, adult functions, whereas the avoidance is the same as in childhood, for example, avoidance of school, and school work.

Margaret's health anxiety function seems to be that of control: *"I have to make sure that if my children stay overnight anywhere, that the house in question has smoke alarms that have been checked. Also, and I get a lot of flak for this, I do not allow cell phones in my home, in case of brain tumours"*. These behaviours started when Margret's mother was diagnosed with a brain tumour.

Paul and Dave briefly reported avoidance of work and school as a result of their adult health anxiety, although Eric did not mention any adult functions of his health anxiety. There was mention of how participants' health anxieties impacted on other people. For example Margaret's children were impacted by their mother's health anxiety by having to be regularly wormed.

Impact of health anxiety on others:

Margaret's children were not the only ones who were impacted by her health anxiety. As stated, no one was permitted to bring cell phones into the house, for example. This must have impacted on her husband, and children when considering bringing friends over to the house. Margaret mentions her latest health fixation: *"With the swine flu possible epidemic, I decided to keep the children at home with me. Now, every time my mother-in-law phones the house, she asks if the children are back at school yet, it's really frustrating having to justify my actions to everyone".* Margret's relationship with her mother-in-law has reportedly deteriorated because of this, the cell phone issue, and her smoke alarm issues: *"My mother-in-law was really offended when I asked my husband to check her smoke alarms the other week before the children stayed overnight with her. My worry is about the radiation from the batteries if they are old, and the kids getting sick, but no one gets that. I wrote her a letter in the end, to tell her to back off".* It seems Margret's health anxious behaviour has impacted on her relationships with her immediate family and mother-in-law.

In contrast, Eric talks about being very careful and selective about whom he discusses his health anxiety with: *"Um, I think I'm a little more hesitant in being completely um, in taking full initiative in opening up a dialogue. Because a lot of the times I would suspect myself of being a hypochondriac. It is probably not that serious, I say to myself, and I prevent myself from telling family and friends what I am going through on the inside".* I asked Eric if there was anyone at all that he talked to, or that he might impact on with his health anxiety: *"We are different with different people. I think I'm probably the most open with my partner, so I filter a lot less when I am talking to him, than to anyone else. So, whatever is on my mind, I tell him, and so he gets the brunt of it (laughs). Even though, sometimes I think I'm kind of facetious, desperately trying to tick him off because it does kind of irritate him. That's what partners are for".* So Eric's health anxiety has minimal impact on others since he chooses not to mention his anxieties to anyone except his partner.

Eve's hypochondriacal fears have had an impact on her child: *"I used to talk to my child like he was a little adult, and, at times this meant I discussed my health anxiety with him. However,*

much of my anxiety infected him vicariously, like, if he witnessed me panicking, or seeking reassurance from others. I wish I had known that it was infecting him back then, but I was such a young, introverted mother".

Kay's mother used to be the first to rush her off to the doctor, and over-react, when Kay was younger. However now Kay's mother recognizes that Kay has a health anxiety problem: *"She used to make me go to the doctor's heaps, but she knows now that I take all the symptoms to the extreme, so she doesn't encourage me anymore".* Kay's anxiety must have impacted on her mother. She also talks of her anxiety affecting her relationship with her boyfriend and friends: *"My health anxious behaviour can annoy people, for example; I do not risk going out in the sun at peak times. I won't go out in it for more than five minutes. That really disrupts the summer, if you know what I mean, my boyfriend gets upset, and my friends stop inviting me to things".*

Participants' friends and family were impacted in a variety of ways. Some families were impacted significantly by the participant's health anxiety; such is the case with Margaret. On the other end of the continuum, Eric's health anxiety had minimum impact on anybody except himself. There is variation in impact of health anxiety on others.

11.3 Positioning of Self

The terms health anxiety, hypochondria and somatizing have been used interchangeably, but they also represent a spectrum of health anxiety. Within that spectrum, there seems to be more stigmas towards the hypochondria side of the spectrum. This stigma, however, is not only from the medical profession and the wider society. Participants position themselves on the spectrum. Much of the stigma seems to be internalized, which is demonstrated by the participants positioning of themselves and others on the spectrum. It can also be seen in participants' talk of genuine illness compared to hypochondria, and how they can see themselves as separate from others on this.

Positioning of self and stigma:

The participants' positioning of themselves in hypochondria is interesting, because it may be a lens into how much people introject their cultural biases into themselves, and self stigmatize. The extent to which people differentiate themselves from other sufferers, or from the severity of something they themselves suffer from may reflect such introjections through the discourse.

Eric speaks about his position on the health anxiety scale: *"I think I am on the lower end of high health anxiety".* He separates himself from others who are on the higher end of the spectrum, and the way he speaks of hypochondria and higher health anxiety shows some absorption from our culture: *"Us males, we cannot be this panicky victim, we have been constructed not to vent ourselves that way, we hold back a lot more".* Here Eric distinguishes males and females with health anxiety, much in the way hysteria was distinguished from hypochondriasis in early times. He talks about doctors during the time of September 11th (Eric is American): *"I guess they* (doctors) *would easily get overwhelmed, if you were like, too much of a hypochondriac".* The degree of health anxiety is the focus, and he speaks of a really important observation, that society can tolerate a bit of health anxiety, but when it is persistent or consistent, that it wears this tolerance out. This may be why many people suffering with hypochondria are often reluctant to share their health concerns with others.

Eric talks about the hypochondriac from his perception of the doctors' view of himself and other health anxious people: *"It's like, you're taking the kitchen away from the chef, and doctors like to investigate illnesses themselves, not be presented with prearranged ideas*". He positions himself on two different ends of the spectrum, first as low health anxiety, and then he says: *"I would suspect myself of being a hypochondriac. I can do the stupid thing and research online and see if I could find anything to diagnose myself of illnesses".* Eric's distinguishes himself from the stereotyped hypochondriac that the media plays up on: *"I'm a little more reserved, I am not just babbling away with what my worries and concerns are".* Eric reports that he does not feel stigma: *"I don't think I have the stigma, because I hide it well, so no one knows I'm worried. If I do mention my health anxiety, it's not enough for them to put that stigma on*

me, but I know that this stigma does exist". Showing his uniqueness, as a tentative self-identified hypochondriac, lifts some stigma and stereotyping, which is invaluable to this study.

Dave mentioned experiencing stigma: *"I was known as a hypochondriac and I didn't enjoy it. There was a feeling of helplessness, as I felt unable to do anything about it. I described my symptoms, but my doctor kept writing me out prescriptions for tranquilizers and anti-depressants. Even when I said that I was beginning to feel addicted to the pills, the doctor didn't believe me, and stigmatized me as a hypochondriac even further! I was told that addiction to tranquilizers was impossible. My wife at the time was sympathetic, but she didn't really believe that there was anything wrong with me".*

Kay separates herself, as a self-identified hypochondriac, from others: *"If mum gets a sore throat, it's just a sore throat. If I get a sore throat, it's like, well I used to smoke, maybe its lung cancer".* She differentiates herself by her catastrophic interpretations, not by the symptoms experienced, which shows very clear insight into the nature of her somatizing. Kay talks about her perceptions of the danger of admitting she has hypochondria to herself: *"Even to the self, to call myself a hypochondriac might mean that I don't get help for myself by going to the doctor, because I might tell myself that the pains mean nothing, I'm just being a hypochondriac".* Kay worries about the dangers of the doctor identifying her as a hypochondriac: *"I don't want the doctor to label me a hypochondriac in case something does go wrong. And then it could result in the boy who cried wolf. Then you actually do have something wrong, and it's not acted on*".

In contrast, Kay finds comfort in her friends labelling her: *"All my friends do call me a hypochondriac. They say, 'Look, you're 18, you're not getting lung cancer'. It's in a kind, loving, reassuring way".* Sometimes health anxious people need to decide when to stick to their convictions or whether to back down, and this can be very difficult. Kay positions herself very harshly when she feels forced to stick to her health anxious concerns, knowing that others are not pleased: *"I have had to be a real anal bitch about not going in the sun".*

Paul also discusses times when he feels forced to face stigma by sticking to his health anxious concerns: *"I do it* (have more doctor's visits than normal) *because it's a preventative thing more*

than anything. I don't need more health issues effecting my life, (with regards to his disability) *so if I go to the doctors once or twice more than the average person, and it prevents me from being ill more often, then I don't mind people making fun of me. If I'm well and happy it's all good".* To stick with health anxiety beliefs and behaviours sometimes comes with a risk. Ironically most participants are highly insightful and introspective, and express being aware of the cost of sticking to their hypochondriacal guns, so to speak. Like Kay, Paul is more relaxed about stigma from his friends and family: *"My friends and family do call me a hypochondriac, but it's in a joking, loving way".* Perhaps being labelled as a hypochondriac from friends and family holds a comfort of reassurance that the person is probably well, when they become health anxious. He identifies quite clearly on the health anxiety spectrum as hypochondriacal, this is evident by the amount of times that he refers to himself as a hypochondriac.

Eve has a good understanding of her health anxieties being irrational, after they have occurred, and classes herself as a hypochondriac: *"Quite often I would have good insight into it* (excessiveness of her health anxiety). *I'd have a laugh at myself, and think, oh gosh, I am such a hypochondriac! And it was embarrassing at times, going back to the doctors and nurse frequently. I knew they were just humouring me!"* She talks about her friends and families judgments: *"If they see me watching something on the news about health, they will warn me not to think I have that same illness later. My family do call me a hypochondriac, but I find it reassuring that they don't take me seriously".*

The participants offered a great deal of insight into their views on hypochondria and health anxiety. They also discussed how they separated themselves from others, and where they saw themselves and others on the health anxiety spectrum. Interestingly, there was a theme being reported when participants positioned themselves harshly. If they stuck to their health anxious convictions, they would be judged negatively (for example Kay calls herself an "anal bitch"). They viewed stigma from family and friends, on the whole, as comforting and reassuring. The next topic focuses on participants' views of their doctors.

11.4 Doctor/ Patient variables

In this category, the themes discussed were positive and negative descriptions of participants' views on their doctors, the doctors' power to entitle some to the sick role, variables surrounding doctor shopping and issues that occurred when doctors did take participants seriously.

Positive and negative perceptions of doctors and doctor shopping:

There has been much research on doctors' perceptions of health anxious and hypochondriacal patients, but, not many studies have focused on this the opposite way around. Therefore I was very interested to hear what the participants had to say about their doctors.

At the centre of Kay's descriptions of doctors are the themes of mistrust and worries about doctor incompetence: *"The more you know (pause)... the doctor can fool a patient who doesn't know, but the more I know, the more I discount it. Like the whole stress thing. Just excuses, wasting my money telling me I'm stressed".* She contrasts this statement by saying: *"I wind myself up chronically".*

Kay gives a good description of both her mistrust of doctors, and doctor shopping: *"Last year I had a lump in my throat. It turned out to just be a virus, but I honestly thought it was a tumour. It wasn't like a sore throat, like I normally get. I went to the university doctor; I felt she was not good, like not thorough. She gave me antibiotics, and it didn't go away. So I kept complaining to my family, and I went to another doctor. He said the same thing, but also, if it's still there, that they could get a camera and stick it down my throat. And then I think after that it went away. But it did come back. I went back to the university doctor. But I came to the conclusion that she can't be a very good doctor. Because if she was a good doctor, she wouldn't be working at the university clinic, getting shit* money". I wanted to check my understanding of what she was saying, so I said *"so she wasn't a proper doctor*?" Kay responded: *"Yeh, the drop out doctors, she's not in a private clinic, she must be a shit doctor. So after that I went to two*

other doctors. They all just kind of felt it and said that my glands were up, or that they couldn't feel the lump. I don't trust doctors, the lump was right there!"

Kay's deep mistrust of doctors seems to be related to the perceived quality of the doctor that she is consulting with. Therefore, she seems to get more reassurance from doctors who are in private clinics. The doctor, who suggested following the consultation with putting a camera down her throat to look, was valued more than the other doctors, and the symptoms dissipated after Kay saw this doctor. The reassurance given by the doctor then must be from a doctor who is perceived as a good doctor.

Paul has had different experiences with different doctors over the years, and notices a difference in quality between his general doctor, and emergency room doctors: "*I know when I go to an emergency doctor for stuff, and ask for various painkillers or antibiotics for things like urinary tract infection* (UTI)*...when they suddenly come on, and you can't get to the doctors before the weekend... and its painful, you've got to go to accident and emergency (A & E), and those doctors say that you've got to put a sample in first. I know what it is (UTI), because I've dealt with it a lot, which gets me frustrated. They're like 'oh no we want to do tests to know what we are giving you this for'. But I know what it is, been there, done that, but it's because I'm not a doctor I guess. They sort of cast that doubting eye over you, 'what are you on about', you know, 'you're not a doctor, you can't tell me what you need".* Paul's perception here is that these doctors do not like to be told what to administer or diagnose, and that they look down on him, for even trying to suggest what is wrong with him.

In contrast to emergency room doctors, Paul had positive things to say about his family doctor. The other participants did not mention many positive things about their doctors and no one else apart from Paul talked about having one family doctor, so his views are particularly important on this matter: "*My doctor is ready to help me. I had just the one doctor mostly, but I had to change my doctor recently because the doctor we've had since we came to New Zealand has retired. I had him since I was eight years old. This new one is ok though, he's good. Every time I go in I get my blood pressure checked. Sometimes he will give a chuckle when I say, do*

you mind testing my blood pressure, and he'll say, well you were here just the other week. He does it happily though; I pay $50.00 for the visit, so I might as well get checked".

Dave's struggle with doctors started in the 1970s: *"I was health anxious in the late 70s, when there was perceived to be a pill to cure every ailment. The relationship with the doctor was very superficial. I described my symptoms, he wrote out a prescription for tranquilizers and antidepressants. With regards to my addiction with the pills, no real effort was made to get to the cause of the anxiety; I was just given more prescriptions on doctor's visits".* I followed up by asking Dave if he experienced any difference between emergency doctors and his general doctors, and if there was anything more he could add: *"Remember, this is over a 20 year period, so there were several doctors, in both New Zealand and the UK. Communication was frustrating, in that there was never a plan B with doctors. I don't think that I ever went to an emergency doctor, just general practitioners. I never got anything other than the offer of drugs, until I started seeing 'alternative practitioners', who were a lot more helpful".* Dave sees traditional doctors as uncaring, superficial and unhelpful.

Entitlement to the sick role:

Another theme was that of the doctor holding the entitlement to the sick role card. The doctor's opinion can have a powerful effect on health anxious patients and impact directly on the amount of stigma allocated to the sufferer. This is true in the case of Jackie, who has struggled with health anxiety, on and off, for all of her life: *"I was always going to the doctors with aches and pains, and stiffness in my body, and often they gave me drugs, and tried to end my appointment as soon as possible. Three years ago, I went to a doctor who finally gave me a diagnosis. He diagnosed me with fibromyalgia. This gave me some understanding of why I had aches and pains. I have to manage the pains, by exercise, antidepressants for the pain, exercise, and regular massage with the physiotherapist. Finally I have a diagnosis, and I can tell people why I can't do certain things now".* This diagnosis has given Jackie a sense of entitlement to the sick role. It also gives her regular appointments for the physiotherapist. To look at this in terms of attachment theory, there is always a caregiver available to her, regardless of the degree of

her somatizing. Even taking antidepressants is less stigmatized for Jackie now, as they have been prescribed for pain, rather than psychological factors.

Paul's disability means that he has to take extra precautions with his health. He explains: *"I worry about my health more, because I figure that any activity can lead to health troubles, you know. Um, I don't want anything that could put me in the higher risk category for things like diabetes, because I cannot exercise with my legs. Hypertension and stuff like that...Cardiac, heart stuff... If I maintained an unhealthy, unregulated diet, those kinds of issues I'm always aware of. General health practices I keep on top of. I drink plenty of fluids, eat well, exercise".* As mentioned on previous discussions of entitlement to the sick role, part of the reason why hypochondriacs do not fit this role is because they appear to be non-compliant with the doctor's advice (for example coming back for reassurance when the doctor has already given some). Due to Paul's disability, he is vigilant about following health practices, so he may be more easily accepted into the sick role because of this. The next theme that came up was how participants responded, when their doctors did take their health concerns seriously. Paul, Kay and Eve reported specifically on this.

When doctors take you seriously:

When Paul was sick as a child, he told his parents that he was really sick and they took him to the doctor. When the doctors decided to take action and run some tests, Paul became really worried: *"Worrying about that, and what was going on with me, made me feel even worse. Because the doctor was concerned, it was almost like a mental stress from thinking about it too much, I was making myself sicker".*

Kay reported a similar experience: *"When I was 16 years old I had real bad chest/ heart pain. I kept going back to hospital with it. And then finally they put me in for a CAT scan and ECG. They put iodine in my blood. It was 4am in the morning; that increased my fear. I wanted the reassurance that it was all in my head, I got very scared when they came down at 4am to do the CAT scan. I thought, shit, they're taking me seriously, there really is something terribly wrong!"*

Eve went through a period of time when she would regularly go to the university nurse to have her blood pressure taken: *"One day I was particularly anxious about my pulse rate. I went to see my nurse, and when I got there, I was told that she was sick, and there was another nurse filling in for her. I felt disappointed, and also a little worried about how competent this new nurse might be. Worry always puts my blood pressure up, and by the time the nurse had taken my blood pressure, it was elevated. She took this seriously, and requested that I wait to see the doctor. I was terrified".*

These examples illustrate poor communication between doctor and patient about the purpose of the visit (such as for reassurance). Some interesting discussions took place about doctor/ patient communication. Paul and Eric give some very insightful perspectives into this, and outline some coping techniques that they use when consulting with their doctors.

Doctor/ Patient communication and coping techniques:

Paul talks about his communication style with his family doctor: *"Due to my disability I've dealt with a lot of doctors and specialists. So, when I go in and explain why I'd like to try some pills, or why I'm feeling this way, or can I have this and that...I've tried all sorts of different kinds of painkillers, so when I go in and ask for one again, they know that I know, I've already explained at some time before why I need something. So they are usually more than happy to say alright".*

Eric offers some excellent advice for managing doctors' consultations: *"I prevent myself from asking a multitude of questions. I just kind of filter them out. I anticipate the doctor's reaction to a question before I ask it. If I am really worried about symptoms, first I talk to my partner then, if I am still worried, I look on the internet; look for some kind of conclusion first. And then I would maybe present my case to the doctor. You need a balance, like to prep yourself beforehand real quick. The most important thing though, is that I talk to my partner and filter some of my anxiety out before I see the doctor".*

One coping strategy Paul has is that he visits the doctor regularly to have his blood pressure taken. This means that he has regular times that he visits the doctor when he is not highly anxious which may counter balance the other times when he is very anxious. In some ways it may be possible that having Paul's doctor seeing him when he is calm could reduce any stigma since often the doctors of health anxious people only ever see them when they are panicking. In turn, Paul gets to see his doctor when he is feeling well, perhaps aiding in doctor/patient rapport.

12. Discussion

By taking a narrative approach to understanding health anxiety and hypochondria, I have not attempted to discover certainties or truths about the disorders themselves. Instead I have wanted to explore participants' experiences of health anxiety and hypochondria. The epistemology and theories that frame these understandings suggest that hypochondria has been constructed by cultural discourses and power relations. Therefore it has been useful to hear the voices of sufferers as the focus of this research. The main aim of this study was to start to close the gap in doctor/patient research on health anxiety and hypochondria, by focusing on the patients' perspectives. Although the study was exploratory in nature, there were areas of interest outlined in the study aims section of this thesis that related to findings in the literature review. Such areas of interest were; childhood attachments, possible participant identification of anxious/ambivalent attachment styles, doctor/patient experiences and relationships from each participant's perspective and perceptions on the stigma of being labelled as a hypochondriac.

The other aim of this study was to work under the umbrella of social constructionist epistemology. Therefore it was important, when listening to participants' narratives, to be open to anything that they had to say, to allow them to lead their story as much as possible, and to see how their meaning-making is socially constructed. The following section first highlights some practical interviewing issues, before leading on to a discussion of the main findings. Validity, practical implications and conclusions for this study will follow.

Interviewing Methods:

At the beginning of the present study, it was thought that flyers might attract a small number of people to come forward to be interviewed about their experiences with health anxiety and hypochondria. A room at the School of Psychology was organized for these interviews to take

place. However, only two interviews were conducted at the School of Psychology. The first interview used video conferencing technology from Massey University Albany, to Massey University, Wellington Campus. The information sheet and consent forms were organized via post and the consent form was reviewed at the beginning of the interview. Some of that interview data was lost, as the recording device picked up more of the researcher's questions than the participant's answers. A follow-up was arranged over the phone, to make note of, clarify and check the validity of this participant's interview narrative.

One interview used Skype, which is a computer program, where both the participant and I could see each other and hear each other's voices. This was very similar to the school of psychology's video conferencing, except that it could be recorded from home. In this case, consent was given by email, and initial rapport building and information giving was attended to by email.

One local participant could not come in to the school of psychology due to a disability, and so we met in person elsewhere. In this interview, I sat on the ground next to him in his wheelchair, and we used the recording device to record our talk outside.

The other two interviews were hard to organize. One of the participants had an extremely busy work schedule, but was keen to talk with me. However on the first day we had arranged to meet, he had come down with 'flu, and was bed-ridden. The second time we had decided to meet did not go to plan either; as the participant lived some distance away, it was decided in the end that we would do the interview over speaker phone, and that I would record this. This process worked very well, however it is worth noting that I had met this participant in person before, and so that may have made the interview run smoothly despite not having face-to-face contact throughout the interview. In this situation I took extra care, when transcribing the interview, to note down any pauses and laugh times, as I could not include body language. After this, a woman from Tokoroa had left messages on the study's answer-phone. She was keen for information, so I sent her an information sheet and consent form. I then rang her, and we discussed the possibility of interviewing her over speaker phone too. She was happy to do this, and posted back the consent form.

So the interviews were not all conducted in the same environment which may have impacted on the interviews in several ways, for example, I noticed that, in the three interviews where I met with the participant in person, a larger quantity of data was generated. This is also true of the video conferencing interview, except that I had much less recorded data in the end, because of the poor sound quality of that interview. The interviews over the phone were shorter, and the Skype interview was quite brief, and had time distortion.

Shared Awareness:

The discussion of analysis will be reported in the same order and categories as the findings were. The analysis section starts with an excerpt from each participant's interview which gives a clear example of their shared experience of health anxiety. Each of these experiences involved participants having an amplified bodily symptom, followed by catastrophic meaning-making of that symptom. For example, Dave's headache pain that he automatically attributed to a brain tumour highlights this. The examples given can all be seen to reflect the cognitive thinking errors that have been previously outlined, the most common being catastrophic thinking. Much like the Clark Hook Panic Diagram, participants reported noticing a physical symptom before engaging in catastrophic thinking. Selective attention was reported when focusing on these symptoms. For example Margaret had her focus on the spot on her arm, and Kay had her focus on taking her pulse, after feeling a palpitation. This finding of such common shared experience relates back to the study's general aim of exploring the typical experiences of health anxious/hypochondriacal people, and is congruent with the literature on cognitive thinking errors.

Most participants reported that looking back, they understood that their health anxiety had been excessive, some even reported being embarrassed by the experience, and other participants' giggled. The DSM-IV specifies at the end of the diagnostic criteria for hypochondriasis, about whether or not the sufferer has insight into their hypochondriacal beliefs: "Poor insight: if, for most of the time during the current episode, the person does not recognise that the concern about having a serious illness is excessive or unreasonable" (APA,

2000, p.507). It may be that the types of people who would respond to the study's flyers and newspaper article are people with a higher degree of insight about health anxiety, than other sufferers. People who have hypochondria and/or health anxiety have been reported to typically consult with doctors rather than psychologists, and to ignore and resent the implication that their symptoms involve both psychological and physiological components.

A contrasting view, which may explain participants' unexpectedly high insight, is a hypothesis that Kleinman (2002) holds. This is that people are forced to hold on to their hypochondriacal beliefs at the time of panic, or they will not be taken seriously. Kleinman (2002) argues that many health anxious and hypochondriacal people do notice this irony. So perhaps many sufferers do have good insight, like all of the participants in the current study, but have not been given the opportunity to express this except for at times when they cannot do so well (for example in panic mode). This finding highlights the need for more research, as it is not clear whether the participants for this study are the exception to previous literature, or not. It raises the question- have hypochondriacal people been stereotyped and socially constructed as having low insight, when in fact they understand the irony.

Childhood Attachment:

The analysis on childhood showed that many parts of the participants' narratives reflected congruency with previous research on attachment by Stuart and Noyes (1999). For first example, these researchers hypothesized, and found in their study, that people who somatise tended to fit into the category of having an anxious/ambivalent attachment style. Their study of this took records from other research on hypochondria and somatizing, rather than self-reports of attachment style. Some of the studies used inference and answers about attachment and abuse from questionnaires. Some used specific attachment questionnaire such as the 'Adult Attachment Interview' (Steele & Steele, 2008). Whilst it was beyond the scope of this study to conduct such an interview, and also out of the context of the aims and methodology of this study, attachment language was listened to. All participants talked of being very clingy with their mothers in childhood. The extent to which this reported 'clingy'

behaviour varied across participants seemed small when discussing childhood attachment, and changed for most participants when talking later about adulthood experiences. Being clingy with mothers is a key component of anxious/ambivalent attachment style, as in the Ainsworth (1976) stranger studies. This theme came up repeatedly for most participants. Interestingly, four out of seven participants indentified having a close secondary attachment figure, in all cases being their grandmother.

Anxious ambivalent attachments were said to be, in part, affected by the mother's care-giving style. That is, that the care-giving that these anxiously attached children receive, is selective attention, e.g. only when the child behaves a certain way, or gets incredibly upset, would they then be attended to (Ainsworth, 1976). Stuart and Noyes (1999) then add to this that somatizing and hypochondrical behaviours, is one way in which these anxious children can initiate attention. Some participants reported that this was the case for them. For example, Eve would receive attention from her father when she was sick, and Kay would receive her mother's attention when somatizing, as otherwise that attention went to caring for her grandmother. These findings answered the study question- would, like in Stuart and Noyes (1999) study, participants identify with having an anxious/ambivalent attachment style. The participants all identified with the thoughts and behaviours implicated in the anxious/ambivalent attachment style. The many reports of participants being *clingy* with their mothers and receiving selective attention supported this literature.

Childhood Illness Exposure:

Adult health anxiety and hypochondria has been linked with childhood exposure to an environment where there has been illness, both in the previous literature, and also in the findings of this study. Some studies suggested that this illness needed to be experienced by the hypochondriacal sufferer (Stuart & Noyes, 1999), while others hypothesized that this childhood experience of illness could involve experiences of the person's family members (Maj et al, 2005). The majority of participants reported the vicarious experience of watching a close family member struggle with a chronic illness, rather than themselves having one. The exception to this was Eric, who suffered from severe asthma.

The experience of chronic illness, whether of family or self, is a theme that runs through this study and previous studies. Other research has offered explanations for this correlation however the present study was interested in the meaning sufferers themselves made of this. Their interpretations are outlined in their narratives. For example, Eric believes that his childhood asthma experience played a part in his adult health anxiety. Kay believes that she faked illness to get her mother's attention initially, and that this shaped her later health anxiety. Regardless of explanation theories, it was the meaning that each participant ascribed to their childhood experiences that mattered to them and shapes their understanding of hypochondria. Their meaning-making links in with this study's aim to look at each participant's narrative through a social constructionist's lens. Participant's views on how their adult health anxiety has been shaped by childhood experiences with illness and social interactions with sick family members, highlight how hypochondria and health anxiety have been socially constructed by participant's experiences.

Childhood experience of illness often involves contact with a doctor(s) for the first time. Examples of this contact are Jackie's experience with her family doctor as threatening or colluding with her father, Kay listening to her mother's suspicions of the medical interventions at work when Kay's nana died during a routine operation and Paul's doctors not being able to figure out his mysterious illness and saying that it was all in his head. Perhaps these two aspects of childhood illness experiences work together towards hypochondriacal tendencies. That is, perhaps these children put illness and doctor care together vicariously in a manner different than most people. They may watch their family member with the chronic illness, and see the unintended secondary gain surrounding their illness environment however they may also see the doctors who are unable to help, in a negative view. This learning experience could be simmering way in the back of the child's mind as they further encounter chronic illness and have their own experiences with doctors. This finding adds to the study's aim to begin to explore doctor and patient experiences and relationships, and how they are socially constructed for and by the participants.

Reports of these vicarious experiences of chronic illness and impact on future health anxiety/hypochondria can have direct practical and clinical relevance. When working with adults who are chronically ill, health psychologists and other professionals should keep in mind early intervention practices for any children. Children of the chronically ill, or who have illness themselves in childhood could be identified as high risk, if they show signs of anxious/ambivalent attachment styles. This could be identified in a quick checklist for parents on clingy behaviour, for one example. Although explanation theory only moderately improved adult hypochondriacal symptoms in the Giovanni et al (2000) study, a brief psycho-education/explanatory session, for parents and children with these risk factors, may possibly reduce later development of hypochondria. This could include handouts for parents and children about such related issues of selective care-giving, correcting thinking errors early on, and exposure to illness environment information.

Childhood Trauma:

The third point that Stuart and Noyes (1999) argued, was that many hypochondriacal and health anxious people have experienced some form of trauma in their childhood, and that this has exacerbated anxious/ambivalent attachment styles, and increased somatizing behaviours. Participants discussed trauma, and some of their trauma stories seemed to have a very high level of trauma reported. Four out of seven participants reported the death or loss of a loved one. This is especially true for Jackie, and, interestingly, Jackie was the only participant who experienced a high degree of health anxiety right through her life rather than having it re-emerge in early adulthood. This finding reflects other literature on this topic, and addresses the general study aim of exploring health anxious participant's childhood experiences.

It was unexpectedly noted that Four out of seven participants were adopted as babies. It makes sense that this experience would have some kind of impact on attachment, and I was interested to know if this had been noted before in either hypochondria or adoption research. From an attachment perspective, bonding has been said to begin in uterus, and continues through-out the postnatal bonding period. When this natural evolution of bonding process is interrupted, the child is said to experience separation as abandonment, and an attachment

wound begins (Chamberlain, 1988). According to Verrier, this then "affects the adoptee's sense of self and often manifests in a sense of loss, basic mistrust, and anxiety (Verrier, 2000, p.21). Dr Maduro expanded the early separation from mother research to include studying these effects on incubator babies as well as adoptees. He concluded that these babies would later, as children, react with bodily feelings to mental pain (Maduro, 1985).

Verrier found that separation anxiety from an attachment figure was common amongst the participants in her research. Some participants had reported being physically and mentally sick when separated from their parents in younger years, and often, their partners in adulthood (Verrier, 2000). Verrier's adoption participants' experiences linked in with some of the stories shared by the adopted participants of this current study. For example, Eve crying at night about the possibility of her mother being killed on a plane while away, and Jackie, clinging desperately to her mother's skirt when she arrived home. However, these experiences were also shared with non-adopted participants in this study. An example of this is Kay feeling butterflies when driving away from her home and her mother.

Verrier (2002) talks of psychosomatic responses to loss. In her interviews with adopted people it was indicated that many participants mentioned having stomach aches, chronic headaches, migraines, allergies, asthma, chronic fatigue, eczema and irritable bowel syndrome. Verrier (2000) concludes that early experiences of loss may leave some people with somatic (bodily or physical) memory traces, which get triggered by later experiences (such as separation from attachment figures perhaps). It seems to make sense then, that the adoption correlation can be seen as significant, in terms of the experience of early loss and trauma, rather than adoption. More research into this area would be of value.

The main function of childhood somatizing behaviour was reported by the participants to be to initiate attention from their parents, most often. In relation to this, some participants did identify with parents who engaged in selective caretaking behaviours. Other functions, such as avoidance, tended to continue into adulthood.

A major life event coincided with the time that all but one participant experienced their first bout of adult health anxiety. These factors were separation from a parent through moving or parent illness, starting university, starting a stressful job. Again with a high degree of insight, participants described their major life stress and then the following health anxiety symptoms that almost completely distracted them from their major life event/stressor. This was certainly the case for Eve, who had the experience of having an armed and dangerous person on the loose. All that she could think of was having a sore throat and possible appendicitis pains. The function of adult hypochondria and health anxiety included avoidance, and as discussed, possibly involved re-enacting attachment seeking behaviours. These are powerful reinforcers of such behaviours.

Doctor/Patient Variables:

Doctor/patient variables have definitely perpetuated the participant's health anxious behaviours. If the doctors are dismissive of the participants, then they do not feel that they are getting the appropriate medical care, and participants have then reported viewing their doctors negatively, as incompetent. This then perpetuates doctor shopping and the participants paying more attention to their symptoms. Unnecessary tests are then often given, using up resources, pressuring the health care system and adding stress to the patient, their families, and the person's employer with time off work. In contrast, some participants reported feeling very scared if the doctors did take them too seriously, however this was only the case where the participants had felt the need to doctor shop in the first place. As reported, it was more likely to be new doctors, such as afterhour's doctors, that did not know these participants well, that insisted on full tests, such as Kay's CAT scan. Therefore the heart of resolving the doctor and patient consultation misunderstandings and biases is then communication between the primary care doctor and patient.

The clinical implications here then involve both doctor and patient. From participants' reports and literature review, it seems that doctor shopping can cause much in the way of damage and distress to the health anxious/hypochondriacal patient. One initial goal of treatment then could be to assist the patient to find one, good, readily available doctor to see as a primary care

provider. The patient may like to write down a list of what they would like in a doctor and then refine that list with their therapist, if they have one. Also, although the participants from this study show great insight into their health anxiety being excessive after each episode, only one participant talked of seeing things from the doctor's point of view. The majority of participants reported negative views of most doctors. Perhaps along with making a list to find the one, good enough, primary care-giver, patients could also have a reading or do some specific work on seeing themselves and the situation from the doctor's point of view. The therapist writing a letter to the patient's doctor or organising a group meeting, with the purpose of working together, may also be of benefit. Further research in this area could be useful.

Overall, participants' narratives had many examples of excellent insight into the psychological component of hypochondria. The literature, and indeed media hype of people with hypochondria and health anxiety seem to portray them as if they have no insight or hindsight. This may be due to the places where such research takes place. For example, this could have taken place in the doctor's office, or in the middle of a health anxious time. It has been interesting to ask sufferers when they are not anxious, about these experiences, because it seems like a different story is coming through here, one of much hindsight, humour and self-awareness.

Protective factors in the doctor/patient relationship could involve scheduling in regular maintenance appointments, and educating doctors about how best to manage health anxious patients. Paul, who did have the one primary care-giver said that he went in for regular appointments, that did not involve his health anxieties. This repeated experience may have lessened doctor and patient stigmatized views of each other. Eric suggested that patients could prepare themselves before the appointment. Using other support people to filter out some of the health anxieties has also been beneficial for participants.

Validity:

This research is tested for validity by checking with the participants, about the meanings of their narratives. That is, that the information is valid to them; that it has this particular meaning for that person in that context. If this is so, then it is valid, and not up for discussion (Denzin & Lincoln, 2003; Emerson &Frosh, 2004). To check for validity I questioned the participants to see if we shared the same understandings. In the time of the interviews this meant repeating information back, using the participants' own words, so that the meaning did not change by using alternative language. It also involved reflecting, paraphrasing and clarifying information. Follow-up phone calls were made, the purpose of these calls were either to clarify a point, or because the participants voice had not been picked up for a segment of the interview. According to the participants, we *did* share (as much as possible) the same meanings, and changes were made where we did not. Participants were happy with the information that they gave me, and pleased to have their stories retold.

Practical/Clinical Implications:

Although these findings cannot be generalized to everyone with health anxiety and hypochondriasis, the practical implications that could be useful include guidelines for both doctors and health anxious patients. For work with health anxious/hypochondriacal patients there are several factors to consider; first, psychologists need to be actively working to fight stigma on mental health. This stigma, in the current study, has been shown to be part of the health anxiety sufferers themselves, through introjections of society's stigma, with the medical profession, and with friends and family. Psycho-education may be useful here, and especially for stigma it is important to discuss the diagnosis in terms of it not being a malingering or factitious disorder. It would be valuable for psychologists and other professionals to remember that they are not working with 'health anxiety' or 'hypochondria'; they are actually working with the people who have had these constructs put upon them. The work then is to alleviate the suffering that many patients share. Also, when working with health anxious patients,

having a good working relationship with their doctors would be of value. This may mean organizing how to work together to help the patient manage their symptoms both physically and psychologically, and sharing understandings of health anxiety with the doctor to aid communication.

In summary, when working directly with the health anxious client, it would be relevant to encourage patients to choose one doctor and schedule regular appointments with them, and also to integrate attachment work and communication skills training into existing therapy. Perhaps the development of a patient form would be useful, where the health anxious person could get into the habit of doing a check list before consulting with the doctors, and also for them to identify what they would like out of each consultation (such as reassurance or medication).

Future recommendations:

The other part of this though, is that research in this area has often focused on the doctor's view, and perhaps the doctor's views are tainted by only seeing such patients at their worse anxious moments. Paul's doctor has regular consultations with Paul, for repeat prescriptions due to his disability, and for regularly scheduled blood pressure check. If research was to ask for Paul's doctor's perspectives on him as a hypochondriac, the report may be different. For example, Paul noted that his doctor does chuckle sometimes, and humours him. There seems to be a degree of empathy on the doctor's part, which is often not reported during typical doctor/patient consultations so timing and perspective would be important considerations for future study in this area. Much more research needs to focus on the patient's perspective.

Personal Reflections and Conclusion:

During the process of writing this thesis I have been made aware of my own bias and assumptions. An example of this was my assumption that participants responding to my advertising would all be female. When the first participant to volunteer was male, I was unsure

as to whether to count him as a pilot study or not. I had an idea in my mind about how the interviews would take place, and then I became more flexible with this, as the participants mostly lived at a distance. Looking back at my experiences with managing an anxiety crisis-line service, my initial aim for this research was to address the fact that health anxious/hypochondriacal people were falling through the cracks of the mental health service, not getting their needs met through their doctor consultations, or general anxiety phone-calls. From my experience interviewing, transcribing and coding the participants' narratives in this study, I feel I have gotten to know their stories very well! The common experiences of health anxious people's stories could be shared in much the same way as people's stories of panic disorder, for example, to bring sufferers together and offer some understanding. Although findings cannot be generalised to all other health anxiety/hypochondriacal people, I feel better equipped to work with these people, as a result of the process of this research.

In a field dominated by objectivist assumptions, I wonder what my research can achieve in telling the narratives of health anxious people, and people who are stigmatized as hypochondriacs. At the very least I hope that this research will develop an awareness of how meaning has been constructed through discourse and power relations and how these meanings impact the lives of health anxious people. In turn we must acknowledge how we as psychologists and medical doctors working with these people have had our stereotypical views of hypochondriacs strengthened, and how those of us in positions of power must work towards a more empathetic understanding of this ancient malady.

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Appendices

Appendix A – Flyer

Appendix B – Ethics Approval

Appendix C – News Paper Advertisement

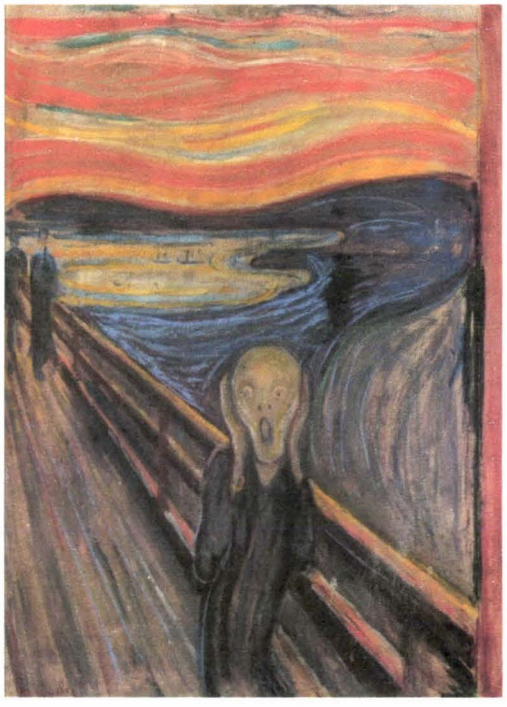
Appendix D – Information Sheet

Appendix E – Consent Form

Appendix F – Probe Questionnaire

Appendix A - Flyer

Do you worry about your health?



Do you monitor your body symptoms?

Seek reassurance from G.P's, but worry later that something may have been missed?

Worry that your doctor doesn't take you seriously?

Hear about an illness, and later worry that you are getting that illness yourself?

Have you ever been told that your symptoms are "all in your head"?

Have you ever been told that you are a hypochondriac?

I am writing a master's thesis about the experience of health anxiety, stigma of being labeled a hypochondriac, and doctor/patient care. I am looking at this from the patient's perspective, and want to hear about peoples struggles with health anxiety. If some statements above apply to you, please consider participating in this Massey University study, which is asking people to tell their story about health anxiety in a private supportive interview with the researcher.

Please leave your details for Jenni [redacted] to send an information sheet.

"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor Sylvia Rumball, Ph 06 3505249, email humanethics@massey.ac.nz". Picture by E.Munch, from www.thescream.com

Appendix B – Ethics Approval

Massey University

OFFICE OF THE ASSISTANT
TO THE VICE-CHANCELLOR
(Research Ethics)
Private Bag 11 222
Palmerston North 4442
New Zealand
T 64 6 350 5573/350 5575
F 64 6 350 5622
humanethics@massey.ac.nz
animalethics@massey.ac.nz
gtc@massey.ac.nz
www.massey.ac.nz

14 October 2008

Jennifer Beckett
[redacted]

Dear Jennifer

Re: An Investigation into the Experience of Hypochondriasis: The Patient's Perspective

Thank you for your Low Risk Notification which was received on 14 October 2008.

Your project has been recorded on the Low Risk Database which is reported in the Annual Report of the Massey University Human Ethics Committees.

The low risk notification for this project is valid for a maximum of three years.

Please notify me if situations subsequently occur which cause you to reconsider your initial ethical analysis that it is safe to proceed without approval by one of the University's Human Ethics Committees.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:

> *"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.*
>
> *If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor Sylvia Rumball, Assistant to the Vice-Chancellor (Research Ethics), telephone 06 350 5249, e-mail humanethics@massey.ac.nz".*

Please note that if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to provide a full application to one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

Sylvia Rumball

Sylvia V Rumball (Professor)
Chair, Human Ethics Chairs' Committee and
Assistant to the Vice-Chancellor (Research Ethics)

cc Dr Linda Jones
School of Psychology
Wellington

Assoc Prof Mandy Morgan, HoS
School of Psychology
PN320

Appendix D – Information Sheet

Massey University
WELLINGTON

Private Box 756
Wellington
New Zealand
T 64 4 801 5799
F 64 4 801 2692
www.massey.ac.nz

Health Anxiety Stories: *The Patient's Perspective*

Information Sheet

Researcher:

This research is being conducted by me, Jenni Beckett, and I sincerely invite you to participate. The aim of this study is to explore the experience of health anxiety and the stigma of being thought of as a hypochondriac. I hope to offer an understanding of high health anxiety and hypochondria, from the perspective of those whose lives have been affected through such experiences. This project is being undertaken to fulfill the requirements for a Masters Degree in Psychology, and will be supervised by Dr Linda Jones. Our contact details are below:

Jenni Beckett

[redacted]

jennijean@orcon.net.nz

Dr Linda Jones, Senior Lecturer

(09) 414 0800 extn 6530 (Massey University number)

L.M.Jones@massey.ac.nz

What is this study about?

The aim of this study is to explore life stories told by people with high health anxiety and/or hypochondria. The intention is to gain an understanding of the development of high health anxiety, the effects of stigma, if any, currently, and to explore doctor/ patient relationships from the patient's perspective. The focus will be on the patient's perspective and history, as often it has been the medical profession and society who have constructed a stereotype of health anxious people. Attention will be paid to the health anxiety sufferer's voice, as it is often unheard, and missing from theories on health anxiety.

What would I have to do?

If you agree to participate in this study you would need to be available for a confidential interview with the researcher, to share your experiences of health anxiety and the impact is has on your life. The interview will take place at the School of Psychology, at a time convenient to you, and would last around an hour. You will receive a voucher towards your petrol costs/ or a Westfield voucher. The interview will be digitally recorded and transcribed by the researcher. No identifying information will appear on the transcript as pseudonyms will be used. The digital file will be deleted after the study, but you may have a copy of the transcript if you wish.

What can I expect?

If you choose to take part in the research, you have the right to:

- Decline to answer a question
- Turn off the recorder at any time during the interview
- Withdraw from the study at any time before the transcript is used in the project
- Ask any questions about the study that occur at any stage in your participation
- Have the information that you provide kept completely confidential. If excerpts from your interview are included in the thesis, you will not be indentified, as pseudonyms will be used.

If, after reading this information sheet, you agree to participate, that would be appreciated. Your experience with high health anxiety is valuable to this study. Please phone the answer phone number for the study. Leave your name and phone number and best time to call, and I will call to arrange an interview time that suits you, or if you want more information at that stage, I am happy to call and answer your questions.

Sincerely

Jenni Beckett B.A. (Hons.) in psychology.

Appendix E– Consent Form

Health Anxiety Stories: The Patient's Perspective

PARTICIPANT CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to my interview being sound recorded, and understand that any audio-recordings and transcriptions will be kept in a safe location by the researcher, and deleted after the study.

I agree/do not agree to participate in this study under the conditions set out in the Information Sheet.

I understand that parts of my interview may be used either as direct quotes and/ or summed information, and I would like to use the pseudonym

.....

to protect my identity.

Signature: ..... **Date:** .....

Full Name - printed .....

Appendix F – Probe Questions

Interview Probe Questions

In this interview I would like to hear about your experiences of living with high health anxiety. I am interested in 3 main areas, (your childhood experiences, experiences with doctors, and experiences if any of being stigmatized. However anything you have to talk about is fine.

Childhood/attachment:

Doctor/Patient relationships:

Hypochondria Stigma: