Psikoloji Çalışmaları
Studies in Psychology

İSTANBUL UNIVERSITY PRESS

Psikoloji Çalışmaları - Studies in Psychology Cilt/Volume: 42, Sayı/Issue: 1, 2022
DOI: 10.26650/SP2021-935379 Research Article/Araştırma Makalesi

A Helix of Anxiety: A Qualitative Analysis of the Personal Experiences of Individuals with Health Anxiety

Kaygı Sarmalı: Sağlık Kaygısı Olan Bireylerin Kişisel Deneyimlerinin Nitel Bir İncelemesi

Burcu Pınar Bulut[1], Özlem Bozo[2]

[1]Dr, Ankara Hacı Bayram Veli University, Faculty of Letters, Department of Psychology, Ankara-Turkiye
[2]Prof. Dr., Middle East Technical University, Faculty of Arts and Sciences, Department of Psychology, Ankara-Turkiye

ORCID: B.P.B. 0000-0001-8168-0068; Ö.B. 0000-0002-4480-1876

Corresponding author/Sorumlu yazar:
Burcu Pınar Bulut,
Ankara Hacı Bayram Veli Üniversitesi, Edebiyat Fakültesi Psikoloji Bölümü, Emniyet Mahallesi Abant 1.cad. No:10 06560 Yenimahalle, Ankara-Türkiye
E-mail/E-posta:
burcupinarbulut@gmail.com

Submitted/Başvuru: 09.05.2021
Revision Requested/Revizyon Talebi: 03.12.2021
Last Revision Received/Son Revizyon: 24.02.2022
Accepted/Kabul: 24.02.2022
Published Online/Online Yayın: 04.04.2022

Atıf/Citation: Bulut, B.P., & Bozo, Ö. A helix of anxiety: A qualitative analysis of the personal experiences of individuals with health anxiety. *Psikoloji Çalışmaları - Studies in Psychology,* 42(1): 165–198. https://doi.org/10.26650/SP2021-935379

ABSTRACT
Hypochondria is at the center of debates about the mind-body problem in that those individuals with this symptom experience physical complaints in the absence of 'real' illness. The study examined how individuals with hypochondriac complaints experience their 'illnesses' or anxiety about it. Also, how they establish their interpersonal relationships with the people they get reassurance, especially with physicians, was understood. The sample consisted of 14 individuals with high health anxiety, and their ages were between 19-55 years old. The data were collected through face-to-face semi-structured interviews. The Interpretative Phenomenological Analysis method, which offers a systematic approach to study participants' subjective experiences, was used. As a result, four superordinate themes emerged: 'Causal attributions of health anxiety: Loss at the core as unfinished business,' 'Being drawn into a vortex of symptoms,' 'Endless calls to experts for naming own experiences and eliminating uncertainty,' and 'Every cloud has a silver lining: Benefits of being/feeling ill.' The findings are important for both mental and physical health professionals working with these individuals since the experts' physical-psychological distinction does not correspond with the reality of those people. The prominence of a loss experience that these people associate with the onset of their symptoms also points to the importance of dwelling on the issue of loss while working with these people. In addition, it was observed that the information given to the participants about their health status had a short-term relaxing effect, and they had an ongoing search for "what their illnesses are." For this reason, it was thought that providing information that the physical symptoms do not indicate a serious situation at the focus of the treatments applied would not work. In conclusion, it is possible to say that therapists working with patients with hypochondria should help them understand the continuity of their desire to know what is happening in them after establishing a therapeutic alliance with the patient.

Keywords: Hypochondriasis, health anxiety, somatization, interpretative phenomenological analysis

ÖZ

Hipokondriya bu semptoma sahip bireylerin 'gerçek' bir hastalığın yokluğunda fiziksel şikayetler yaşamaları bakımından beden-zihin problemine dair tartışmaların merkezinde yer almaktadır. Bu çalışmanın amacı da hipokondriyak şikayetleri olan bireylerin 'hastalıklarını' ya da bu konudaki kaygılarını nasıl deneyimlediklerini araştırmaktır. Ayrıca, bu kişilerin özellikle doktorlarla olmak üzere onay arayışında oldukları kişilerle ilişki kurma biçimleri anlaşılmaya çalışılmıştır. Araştırmanın katılımcıları, 19-55 yaşları arasındaki sağlık kaygıları yüksek olan 14 kişiden oluşmaktadır. Çalışmanın verisi yüz yüze yapılan yarı-yapılandırılmış görüşmeler aracılığıyla toplanmıştır. Katılımcıların öznel deneyimlerini çalışmak için sistematik bir yaklaşım sunan Yorumlayıcı Fenomenolojik Analiz yöntemi kullanılmıştır. Sonuç olarak dört üst tema ortaya çıkmıştır ve bu temalar 'sağlık kaygısına yapılan nedensel atıflar: 'halledilmemiş bir mesele olarak kayıp', 'semptomun girbadına sürüklenmek', 'deneyimlerini adlandırması ve belirsizliği ortadan kaldırması için bir uzmana yapılan sonsuz çağrı' ve 'her şerde bir hayır vardır: hasta olmanın/hasta hissetmenin faydaları' şeklindedir. Bu çalışmanın sonuçları hem ruh sağlığı çalışanları hem de diğer sağlık çalışanları için önemlidir çünkü uzmanlar tarafından yapılan fiziksel-psikolojik bozukluk ayrımının sağlık kaygısı olan kişilerin gerçekleriyle uyuşmadığı görülmektedir. Bu kişilerin semptomlarının başlangıcıyla ilişkilendirdikleri bir kayıp deneyiminin ön plana çıkması da bu kişilerle çalışırken kayıp konusu üzerinde durmanın önemine işaret etmektedir. Ayrıca katılımcıların sağlık durumları ile ilgili kendilerine verilen bilgilerin rahatlatıcı etkisinin kısa vadeli olduğu ve "hastalıklarının ne olduğuna" dair süregiden bir arayışları olduğu gözlemlenmiştir. Bu nedenle de uygulanan tedavilerin odağında bedensel belirtilerin ciddi bir duruma işaret etmediği bilgisinin kişilere verilmesinin işe yaramayacağı düşünülmüştür. Sonuç olarak hipokondri hastaları ile çalışan terapistlerin, hasta ile terapötik bir ittifak kurduktan sonra, bu kişilerin kendilerinde ne olduğunu bilme isteklerinin sürekliliğini anlamalarına yardımcı olmaları gerektiğini söylemek mümkündür.

Anahtar Kelimeler: Hipokondriya, sağlık kaygısı, somatizasyon, yorumlayıcı fenomenolojik analiz

The mind-body problem dates to ancient times, and it remains in the scope of both philosophy and modern science. The nature of mental processes and their relations with the body are the main focus of the problem. Psychology as a discipline must also deal with the mind-body problem. In the historical development of psychology, ideas about this problem have changed and become varied. According to the current view, it has been argued that mind and body constitute one unity (See Barrett, 2011; Bishop, 1994). Nevertheless, the attempts to name this unity as 'psychophysics' do not meet the needs of a comprehensive construct (Kreitler, 2018). Although the interaction between mind and body has been accepted over time, mental and physical disorders are still differentiated in current classification systems. This kind of differentiation implies that physical illnesses have a different status from mental illnesses, and the emphasis has been made on the presence of 'real' illness (Kendell, 2001). At this point, hypochondria challenges this classification system since it appears that individuals with hypochondria have physical complaints in the absence of a 'real' illness, and it settles down at the center of the discussions about the psyche-soma relationship (Wintrebert, 2009).

Hypochondria, as a term, came ultimately from the Ancient Greeks. A real and painful disorder of the 'hypochondrium' was named hypochondria by one of the students of Hippocrates (Berrios, 2001; Brown, 1936; Grinnell, 2010; Taylor, 2016; Wintrebert, 2009). As a diagnostic category, it has been a long-debated issue. One dimension of this discussion is whether it should be included in somatoform disorders or anxiety disorders (Scarella et al., 2016). The DSM-IV classified hypochondriasis in the first category, but this was omitted from the DSM-5 since it has an old and misleading etymology (Starcevic & Noyes, 2014). In the DSM-5, two categories were added instead: Somatic symptom disorder, which refers to having excessive bodily symptoms, and illness anxiety disorder, for being excessively anxious about the illness without having any significant somatic symptoms (American Psychiatric Association [APA], 2013). Some researchers have also criticized such a distinction for its uncertainty regarding both diagnosis and treatment (Brakoulias, 2014; Ghanizadeh & Firoozabadi, 2012). These new categories are unfamiliar to most clinicians; therefore, the terms 'hypochondriasis' and 'health anxiety' are used more widely in the literature (Starcevic & Noyes, 2014).

According to the results of the qualitative studies about hypochondriasis, reassurance-seeking emerged as an important feature. In the study about the relation between internet use and health anxiety done by Singh et al. (2016), intolerance for uncertainty

was crucial for health-related web searches. By searching, those individuals felt a sense of control and reassurance. However, short-lived reassurance in those individuals led to further research. Beckett (2009) found that most of the participants had negative ideas about doctors, and if the doctors could not make patients feel that they cared enough, patients considered them incompetent. She also discussed that contrary to the opinion that these individuals have poor insight, hypochondriac individuals accept their excessive health anxiety. Moreover, they had anxious/ambivalent attachment styles in their childhood and they were exposed to an environment in which a family member had an illness, or they lost a loved one. Papis (2015) examined emotional skills and interpersonal tendencies in hypochondriasis. According to the findings, the emotional needs of hypochondriac individuals were not met. Hence, Papis advised therapists working with these individuals to intervene in their emotional and interpersonal insufficiency by developing trust-based therapeutic relationships.

Individuals with hypochondriac symptoms specifically got the attention of researchers of the current study with characteristics like their fixation on their bodily symptoms and their difficulties in being persuaded not to worry about their health (Barsky & Klerman, 1983). Hypochondriac individuals have been well known for their disposition to get reassurance from significant others and health care professionals, and at the same time, for their refusal of the reassurance that they receive (Wearden et al., 2006). Hence, in the current study, the researchers suggested that understanding the transference established with hypochondriac individuals might help psychotherapies in which the relationship between the patient and the therapist occupies a more vital position than all other techniques.

As explained above, hypochondria is a complex issue in terms of its definition and categorization and the mixed emotions that arise in both the sufferer and the observer, such as grandiosity, resentment, irritation, and guilt (Comay, n.d.). Although there have been many quantitative and qualitative studies on health anxiety, the majority of these studies focused on one aspect of health anxiety; for example, searching for physical symptoms on the internet (e.g., te Poel et al., 2016; Singh et al., 2016), reassurance seeking (e.g., Okita et al., 2016; Jones et al., 2020), or the clinical efficacy of one type of treatment (e.g., Hedman et al., 2011; Tyrer et al., 2020). However, through the current qualitative study, hypochondriac individuals' feelings, perceptions, and actions regarding their somatic complaints and the way they interact with health care professionals

were investigated with a more holistic view. Also, qualitative research's person-centered nature enabled the researchers to approach the participants as human beings (Holloway, 2005). Overall, the researchers' interest was an in-depth understanding of those individuals' interpretations of their complaints, their emotions, thoughts, how their symptoms influence them, and how they express themselves. The present researchers also focused on how the participants explained their situation in their own words, which enabled them to elaborate on cultural factors. Before giving more information about the current study, the following section explains how different theories conceptualize hypochondriasis as they would be used as a resource for evaluating the results of the current study.

Conceptualization of Hypochondriasis by Various Theoretical Approaches

The meaning of hypochondria has changed in its historical development. This old dynamic concept does not refer to a particular meaning even today. Each theoretical approach attempts to explain the concept of hypochondriasis and its related qualities from its perspective.

Cognitive-Behavioral Approach

As one of those theoretical approaches, cognitive-behavioral theory explains that hypochondriac individuals regularly misinterpret harmless physical sensations as symptoms of physical disease. Although the physical illnesses that individuals fear vary, they are usually chronic diseases such as cancer or multiple sclerosis (Warwick, 1989). Moreover, from the behavioral point of view, the patient's sick role can provide advantages to the individual (Craig et al., 1994). For example, an individual may get more care and help from their loved ones because they are sick or exempt from some of their responsibilities. Such benefits are called "secondary gain" (Sata & Munday, 2017). Therefore, this approach emphasizes the role of physicians and family members in the persistence of physical complaints and emphasizes the importance of strengthening individuals' independence with positive reinforcement (Barsky & Klerman, 1983).

Attachment Theory

Unlike cognitive-behavioral theory, which emphasizes the importance of how the person with a diagnosis of hypochondria interprets physical symptoms and the effects of behavioral elements on the continuity of these symptoms, attachment theory emphasizes the role of interpersonal relationships in how health behaviors are developed and maintained. According to this theory, childhood experiences with parents (or caregivers)

lead to a set of internalized representations of relationships that persist into adulthood (Bowlby, 1969; Hazan & Shaver, 1987; Wearden et al., 2006). According to Hunter and Maunder (2001), people with an anxious attachment style believe less in their ability to cope with diseases, seek more care and assurance, and tend to be less satisfied with the assurance they receive. Stuart and Noyes (1999) linked bodily complaints and somatization with that attachment style in childhood. According to this view, when the child becomes ill repeatedly and the caregiver does not respond to the child's needs, this may have a consequence of symptom experience and health behaviors in adulthood. That is, in adulthood, somatization could be used to evoke others to receive care indirectly from them as a part of restoring a sense of security.

Psychoanalytic Theory

The psychoanalytic theory is another theory that contributes to the hypochondriasis literature by trying to explain its origin rather than describing its clinical appearance. The 'body' has an essential role in understanding hypochondriasis in this theory. Its importance comes from Freud's encounter with hysteric patients' symptoms and their bodies during his studies with Charcot (Breuer & Freud, 1893-1895; Canellopoulos, 2010). Those studies indicated that biological reasons are not obligatory for physiological symptoms (Burgoyne, 2004), which is different from the medical approach that considers the symptomatic body the biological body (Gessert, 2004). According to Freud, the human has two bodies, one is physiological and the other one is erotogenic, and the latter plays an essential role in hysteria (Freud, 1953; Chapman, 1999).

Freud argued that the anxiety in hypochondriasis originates from the ego libido; a hypochondriac individual withdraws his/her libido investment from external objects and invests it into his/her bodily organs; that is, the erotization of body organs (Freud, 1914; Christogiorgos et al., 2013). It is a narcissistic investment, and paradoxically, it includes pleasure and pain simultaneously (Starcevic & Lipsitt, 2001). The reluctance of those patients to part from their symptoms and the physicians' frustration stemming from an attempt to emancipate patients from their suffering has been associated with this contradictory position (Lipsitt, 2014). Freud also explained that the pleasure experienced by a hypochondriac individual is unconscious. At the conscious level, the subject experiences too much anxiety due to the excitation of a particular organ since there is tension emerging from the ego's effort to get libido under control (Freud, 1914; Chapman, 1999). Despite categorizing hypochondriasis as an 'actual neurosis' and emphasizing its

traumatic and somatic origins, there has been an argument that Freud had difficulty choosing a somatic rather than psychogenic etiology (Jones, 1955 as cited in Richards, 1981).

Klein (1935) tried to broaden the instinctual conflict model with an internal object relations viewpoint using Freud's perspective as a base. Applying this perspective to hypochondriasis, Klein argued that the internal object has been able to turn into an aggressive one by itself, leading to the feeling of being intimidated by the internal body. Also, the target of ambivalence was chosen as the body ego rather than the psychic ego, which is a defense. Thus, hypochondria can be conceptualized both as an increase in narcissistic libido and a struggle against it. The child's early stages of development and aggressive impulses are central in her approach (Klein, 1935). Rosenfeld (1958) agreed with Freud and Klein that there is a regression to the early narcissistic phase. On the other hand, he did not hypothesize it as a pure regressive state since there is no one type of hypochondriasis. Rosenfeld added that hypochondria should be differentiated according to its temporary or chronic characteristics. When early infantile paranoid anxieties are stimulated, temporal hypochondriac anxiety could appear, which may be the reason for the increase of these kinds of anxieties in readjustment phases such as puberty or middle age. However, chronic hypochondriasis is associated with a poor prognosis, and rather than regression, it was thought of as a defense against the confusional state having a schizophrenic nature (Rosenfeld, 1958).

To sum up, considering the place of hypochondriasis in the psychoanalytic literature, it is hard to say that 'hypochondriasis' was placed in the psychoanalytic literature as a 'clear' entity; there is still ambiguity about it.

Method

Participants

A homogeneous sample was established in line with the IPA's purposive sampling method (Smith & Osborn, 2003). Accordingly, participants consisted of 14 individuals (two men and twelve women) between the ages of 19-55, living in Ankara, and having high health concerns based on their scores on the Turkish version of the Short Health Anxiety Inventory (SHAI), and also reporting high health concerns by themselves. Detailed information about the demographic characteristics of participants, current complaints, and event/s associated with the onset of anxiety is given in Table 1.

Table 1.

Demographic Characteristics of the Participants (Contd)

Participant (Gender)	Age	Marital Status	Education	Department of Education, Occupation or Job	Current complaints	Event/s associated with the onset of anxiety
1 (M)	44	Married (having 2 children)	Associate degree	Health technician (Works in the operating room)	Panic attack (diagnosed) Excessive asthenia, headache, stomach-ache	Stomach bleeding (at age 27)
2 (F)	19	Single	Undergraduate student	Faculty of arts and sciences	Anxiety disorder (diagnosed) Fear of cancer (breast and lymph), diseases that can infect him from the outside, insect bites, diseases that will cause disability or deformation, cysts in the ovaries	Aunt's husband died from lung cancer (when she was in 8th grade) Her mother's surgery due to a cyst exploding in her ovaries and her parents' move to another city due to her father's job change
3 (F)	55	Married (having 2 children)	Primary school graduate	Nursing someone with Alzheimer's disease	Varicose veins, restless leg syndrome, migraine, hernia in the waist and neck, muscle tears in the shoulder, arthritis of the knee joint (diagnosed) Unaccountable headache and dizziness, and panic attack	In 2000, problems with her husband and the start of dizziness
4 (M)	20	Single	Undergraduate student	Faculty of arts and sciences	Abnormalities in the number of neutrophils in his blood value	Physicians suspicion that he has a serious illness due to an abnormality in neutropenia (when he was in 11th grade)

Table 1.

Demographic Characteristics of the Participants (Contd)

Participant (Gender)	Age	Marital Status	Education	Department of Education, Occupation or Job	Current complaints	Event/s associated with the onset of anxiety
5 (F)	45	Married (having 2 children)	Primary school graduate	Housewife (but helping her husband who was a hawker)	Anxiety disorder (diagnosed), Panic attack, the wound on her leg that she thought is cancerous, tingling in her hands	Five years ago, a physician said to her that the pimple on her leg should be removed in a big hospital. Also, after the removal, she could not get a straight answer from physicians in terms of whether there is a risk of cancer or not.
6 (F)	20	Single	Undergraduate student	Faculty of management	Generalized anxiety disorder, post-herpetic neuralgia (diagnosed) Panic attack	Being diagnosed as genital herpes (one year ago)
7 (F)	29	Single	Bachelor's degree	Teacher of mentally handicapped	Throat ache (thought that she has throat cancer)	Facial paralysis in 2008
8 (F)	21	Single	Undergraduate student	Faculty of arts and science	Anxiety disorder, obsessive-compulsive disorder, depression (diagnosed) Fear of getting cancer and losing individuals close to her	Death of her cousin (for death anxiety) Recurrent cancer of her aunt (for health anxiety)
9 (F)	21	Single	Undergraduate student	Faculty of management	Anxiety disorder (diagnosed) Fear of cancer	No specific event
10 (F)	28	Single	Graduate student	Faculty of architecture	Hip fracture, femoroacetabular impingement syndrome, varicose veins, kidney gravel, hyperlaxity, Morton's neuroma, uterine fibroids	Health problems after a traffic accident
11 (F)	27	Single	Ph.D. Student	Research Assistant	Panic	Misdiagnosed malignant melanoma in 2015

Table 1.

Demographic Characteristics of the Participants (Contd)

Participant (Gender)	Age	Marital Status	Education	Department of Education, Occupation or Job	Current complaints	Event/s associated with the onset of anxiety
12 (F)	28	Single	Ph.D. Student	Research Assistant	Illness anxiety disorder, various infections (diagnosed) Panic attack	Minor health problems but "traumatic experiences" such as entering the operating room without sedation
13 (F)	31	Married	Graduate	Instructor	The health obsession, Anxiety Disorder (diagnosed) Fear of cancer, panic, worries about persistent pain, chronic wounds, or menstrual irregularities	Expelling kidney stones and a cyst found in her breast
14 (F)	22	Single	Undergraduate Student	Medical Faculty	Anxiety disorder (diagnosed) Thinking she had a mass in her spinal cord, fear of cancer	Her mother's difficult pregnancy and the postpartum period, her brother's falling out of bed while she was cradling him

While determining the sample size in the IPA, various principles were taken into consideration rather than a particular rule. The study's aim and the richness of the information obtained from the interviews about the phenomenon were the main criteria while specifying the sample size. Since IPA aims to analyze the cases in-depth, it is generally preferred to keep the sample size small (Smith & Osborn, 2003). Thus, considering the adequacy of the sample in explaining the phenomenon, the sample size of this study was suitable for an IPA study.

Measures

The Short Health Anxiety Inventory (SHAI)

The Turkish version of SHAI (Aydemir et al., 2013), initially developed by Salkovskis et al. (2002), was administered to the participants for determining their health anxiety levels. This inventory consisted of 18 items related to worry about health, awareness of bodily sensations or changes, and feared consequences of having an illness.

The 4-point Likert-type scale ranging between 0= No symptoms and 3= Very severe symptoms was used for scoring. The cut-off point for this study was determined as 37.9, which was found by Salkovskis et al. (2002) as the typical mean scores for high health anxiety. Moreover, this score was suggested to capture hypochondriac patients (Sulkowski et al., 2011). Since there was no cut-off point indicated by the Turkish adaptation study, that value was used. The Cronbach's alpha coefficient for the Turkish version was .91, indicating good reliability. Moreover, this inventory showed moderate to high correlation with other related scales such as the Hamilton Depression Scale item evaluating hypochondriasis, illustrating its validity (Aydemir et al., 2013).

The Interviews

The data were obtained through face-to-face semi-structured interviews. Some of the questions were as follows: "*When did your complaints first appear?, What does being sick mean to you?, How do you seek help if you have a complaint about your health?".* While keeping in mind the pre-prepared interview questions, the researcher tried to be open to new issues that emerged during the interviews and provide an environment where the participants could speak freely.

The Demographic Information Form

It included questions about age, marital status, education level, working status, place of residence, perceived income, physical and psychological health status, and if any, the type of treatment being received.

Procedure

Ethical approval was obtained from the Human Subjects Ethics Committee of Middle East Technical University on 6 September 2017, protocol number 2017-SOS-0146. The researchers applied for a clinic affiliated with a psychology department and several hospitals' psychiatric services to find the potential participants. Moreover, first-year psychology students were asked if they knew suitable individuals, and finally, the study was announced on a popular Facebook group. In total, 44 potential participants filled out the questionnaire forms. An informed consent form was given to each potential participant to inform them about the study and ensure confidentiality. These forms were sent to most of the potential participants via e-mail. Questionnaires were given to three participants in hard copies because of practical reasons. After the data were collected from those individuals, the eligible participants for the interview were identified. Each

participant was interviewed only once. The interviews lasted between 50 minutes and 2 hours, and they were recorded with a tape recorder. The participants were given numbers instead of their real names to protect privacy. At the end of the interviews, participants who did not receive any professional support were asked if they would like to be referred to a specialist; those who asked for a referral were informed about the options.

Data Analysis

By emphasizing how participants give meaning, perceive, and experience social phenomena, qualitative research aims to develop concepts that clarify these phenomena (Pope & Mays, 1995). Clinicians and physicians working with individuals having hypochondriacal symptoms have been advised to evaluate the history and course of the symptoms carefully and to pay attention to how those individuals interact with other people, how they use language while describing their symptoms, and how they relate to their body (Lipsitt, 2015). To contribute to practical applications, conducting research that covers these fields seems necessary, and the qualitative method is suitable for this purpose. The interpretative phenomenological analysis (IPA), which was developed by Smith (Smith et al., 1995), was chosen since it focuses on how an individual gives meaning to his or her own experiences (Willig, 2001). Based on Heidegger's hermeneutic phenomenology, in IPA, engagement with those experiences and an interpretation of them by the researcher are necessary processes to access them (Biggerstaff & Thompson, 2008; Smith, 2011; Smith & Osborn, 2003). In other words, there is no reality that is not shaped by the subject's experience and perception and by the interaction between the subject and the researcher. Also, the interpretative part of this methodology is that the researcher explains the subject's personal experiences based on her/his conceptions expressed verbally (Smith & Eatough, 2007). Since IPA focuses on how an individual gives meaning to her/his experiences (Willig, 2001), it provides a systematic approach to study subjective experiences through a very detailed examination of the case (Smith et al.,1995). For the topics related to health, IPA is a frequently used method (Cronin & Lowes, 2016) since it allows healthcare professionals to see illness (a psychological condition having a physiological dimension in this study) from the eyes of the patient (Biggerstaff & Thompson, 2008).

The analyses were performed according to the principles of the IPA (Smith & Osborn, 2003). IPA's philosophy is based on phenomenology and idiography (Smith et al., 2009); therefore, each case should be analyzed and examined in detail before reaching

more general categories. Initially, the audio record of the first interview was transcribed. This transcript was read several times to capture a holistic idea about the participant. While doing this, some notes, including the researcher's comments and thoughts, were taken on the transcripts' left margin. Then, the initial notes were transformed into emergent themes, and these themes were written on the right margin. The themes' connections were examined as a next step, and the related ones were clustered to attain subordinate and superordinate themes. After constituting subordinate and superordinate themes for the first case, the same procedure was repeated for each participant.

The Trustworthiness of the Study and Reflexivity

Bracketing is an essential part of qualitative research, suggesting that the researcher put aside his/her existing beliefs, values, knowledge, and experiences to increase credibility. However, in the IPA approach, it was accepted that the researcher had a preliminary understanding of the examined phenomenon by emphasizing the researcher's evaluation of the participant's interpretation. Thus, the researcher's perspective could not be totally bracketed (Koch, 1995). Nonetheless, with this acceptance, the researcher must recognize and be aware of his/her beliefs, values, knowledge, and experiences to increase the study's credibility because these could affect the whole research process.

This study is a part of the first author's dissertation. Thus, all of the codings were done by the first author. The first author has been working on Lacanian psychoanalysis for four years. Therefore, her perspective on psychological concepts and psychopathology was influenced by this approach. Since she perceives hypochondria as a symptom rather than a diagnosis, the diagnosis was not the primary concern. Participants were asked what kind of psychological disorders they had. Their answers were reported on the demographic information form. However, those comorbid psychiatric conditions were not used as exclusion criteria. That was also because the study's primary focus was not taking individual symptoms one by one but evaluating the person as a whole with all their symptoms. Therefore, participants' other symptoms than health anxiety were not ignored; on the contrary, they were considered as parts of what the individuals told about themselves. Besides, individuals with health concerns were an important part of the researcher's personal life. Health anxiety and anxiety, in general, were common among her family members. For this reason, sometimes, she felt that she was interviewing her family members. From time to time, she noticed that she put herself in the shoes of the children or other family members of the interviewees. Due to the possible

reflection of her feelings into the research process, such as sadness and anger, being familiar with the research subject might be disadvantageous. However, having a personal interest, taking notes about her feelings and their reflection on the research, and considering those notes both in conducting interviews and their analyses could have the advantage of being an insider. During the interviews, she also noticed that she experienced more health problems than usual. For example, she had to postpone the appointment with a participant to the following week due to temporary hoarseness. Also, in another interview, she had to take a short break due to a coughing fit. She thought that while interacting with someone who has health-related complaints, she might be similarly developing somatic complaints to cope with the feelings that awakened in her.

The second author, the major advisor of the first author, supervised the whole process, including coding. The second author, who got her master's degree in clinical psychology with cognitive-behavioral orientation and her doctoral degree in health psychology with behavioral orientation, is thought to influence the themes' naming process and interpretation of the associations among the themes.

In addition to being aware of the possible effects of the researchers' perspective, collecting data through semi-structured face-to-face interviews was another proposed strategy to increase trustworthiness (Chan et al., 2013). That allows the researcher to listen to the participants in a focused manner and talk about the participants' topics without being limited to the questions prepared in advance. Also, during the theme constituting process, the initial evaluations made on the participants' transcripts were discussed with the major advisor of the researcher. The emergent themes with direct quotations were then discussed with a research team to make the research process transparent. Hence, discussions with the advisor and the research team members were considered during the data collection and analysis processes.

Results

As a result of the cross-case comparisons and the interpretative phenomenological analysis of 14 cases, four superordinate themes emerged: '*Causal attributions of health anxiety: Loss at the core as unfinished business*,*' 'Being drawn into a vortex of symptoms*,*' 'Endless calls to experts for naming own experiences and eliminating uncertainty*,*'* and *'Every cloud has a silver lining: Benefits of being/feeling ill'*.

Table 2.

Superordinate and Subordinate Themes Emerged as a Result of Interpretative Phenomenological Analysis

1. Causal attributions of health anxiety: Loss at the core as unfinished business
1.1. Loss related anxiety "running in the family"
1.2. Being already anxious about the loss
1.3. Experiencing/observing/anticipation of a loss
2. Being drawn into a vortex of symptoms
2.1. Health-related career choice
2.2. Preoccupation with precautionary behaviours
2.3. A priori thinking
3. Endless calls to experts for naming own experiences and eliminating uncertainty
4. Every cloud has a silver lining: Benefits of being/feeling ill
4.1. Receiving attention and care
4.2. Health anxiety itself as a coping mechanism with other life difficulties
4.3. Rearrangement of priorities and relief from responsibilities: My health above all else

Causal Attributions of Health Anxiety: Loss at the Core as Unfinished Business

Loss Related Anxiety "Running in the Family"

All participants were asked when and how their health concerns began and under which conditions their complaints increased to understand which factors contributed to the onset of the health anxiety. Having an anxious parental figure was stated by participants as one of the contributing factors. Their parents, and sometimes their grandparents, were described as anxious in general or specifically anxious about health issues. The transmission of anxiety from one generation to another was mainly related to loss, and it seemed to be unresolved. Participant 12 mentioned her parents' anxiety and said that her sister also had a similar pattern. As seen in her statements below, her father and mother's anxiety began after they lost their own mothers. Thus, she attributed the beginning of her parents' health anxieties to their experiences of loss:

> *I lost both my grandmothers to cancer, and recently my aunt's husband also died of cancer. I never met my grandmothers, but I think there's a familial transfer because my father suffers from panic attacks, and my mother is likewise anxious about illnesses. ... both of their mothers died around the same time. ... My father's panic attacks began when he lost his mother, and my mother's panic attacks began when she lost hers. My sister has some small problems like theirs, too. (Participant 12)*

"Loss" refers not only to death but also to separation processes. Participant 2, for instance, pointed out the similarity between her mother and herself in terms of fear of

illness, saying: "My mother is also a bit like me, she's also afraid of sickness and stuff." More importantly, she explained this similarity between herself and her mother in terms of fear of separation:

> *Yes [laughing], my mother, my mother, she's a little like me. She also cries instantly; for example, whenever we talk, she instantly cries. I mean, she's also emotional. She also fears separation. She lost her father at a young age… (Participant 2)*

Being already Anxious about the Loss

Concerning the emergence of health anxiety, some participants indicated their predisposition to anxiety about loss even if not specific to health anxiety. Participant 8 had obsessions when she was in primary school. The extracts below showed that her obsessions were once again centered around death. She was afraid of losing someone close to her:

> *I remember having [these thoughts] even in middle school. When someone would come and just touch my desk, I would yell at them, saying, "What are you doing, move your hand!" And I would wipe the whole desk with a wet wipe, wiping the spot they touched last, and afterwards, I wouldn't use the wet wipe anywhere else, as if it could transfer the germs from their hands. The spreading of germs was an issue, [but]* ***I was directly afraid of death*** *rather than illness, and similarly of losing the people closest to me. (Participant 8)*

Experiencing/Observing/Anticipation of a Loss

The participants also associated the emergence of their health anxiety with experiencing, observing, or expecting a loss and the related difficulties that they had faced. Some of the participants had experienced illness themselves, and they related their health anxiety to that illness or illness-related procedures. Participant 12 said that she was already an anxious person, but her anxiety increased more after her friend received a diagnosis of cancer and she herself was misdiagnosed with lymphoma by a doctor.

> *About 3 months ago, my lymph nodes were swollen and I was worried about cancer. Cancer is my greatest fear. I had learned that a close friend of mine was diagnosed with cancer. When I went to the doctor after that swelling, the doctor immediately diagnosed me with lymphoma without doing any blood tests or anything particular.* ***I was already an anxious person.*** *After that, my anxiety went through the roof. (Participant 12)*

Participant 1 established the association between illness and anxiety, not only considering the possibility of losing his life but also losing his independence, power, and dignity. He stated that his anxiety had begun with gastric bleeding, which he suffered from when he was 27 years old. While he was in the hospital's emergency service waiting to receive treatment, two individuals in the service died, and that triggered his fear of death. He also said that he was afraid of experiencing similar health problems and medical procedures again:

> *Now I'm sending my children to a private school, for example, and I don't have a second source of income. My wife doesn't work, I have no one. I mean, I'm doing these things with a single salary and people around me are watching me, speculating, like what if I get sick again and fall? [I think] constant illness is like being bedridden all the time. (Participant 1)*

Participant 5 said that her psychological condition worsened due to the problems in her nuclear family. Her father did not contribute to the family financially and her mother struggled to run the household. Her father also had alcohol problems and would come home drunk. When the father came home late, he fought with the mother. Their home being small, Participant 5 witnessed all the quarrels between her parents. She said that she worried at night that her mother might harm herself; in fact, had attempted suicide twice after her father became unbearable. The following dialogue revealed that Participant 5's anxiety was connected to her fear of losing her mother:

> *My father doesn't come, and the anxiety hits me. Then, he comes again at around midnight, and the fighting starts again. Of course, whenever the fighting begins, I start following my mother around because I think she'll hurt herself. Because my mother will leave us... She can't stand him anymore; she doesn't want to deal with him, can't deal with him. ... I worry that my mother will hurt herself. One day I followed her as she's leaving home...*
>
> *Researcher: So, where was she going?*
>
> *F: To throw herself into the river. (Participant 5)*

Overall, the factors contributing to the onset of health anxiety were described by the participants as loss-related anxiety "running in the family," already being anxious about loss, and experiencing, observing, and/or anticipating loss. Thus, "loss" hereby refers to the loss of health, life, and/or loved ones due to illness, death, or separation.

Being Drawn into a Vortex of Symptoms

Health-Related Career Choice

During the interviews, participants' expressions revealed how they could not stop themselves from being drawn into the things that they complained about or were afraid of. The pursuit of or desire for a health-related career was verbalized by some participants (See Table 1). For example, Participant 14 was a medical student. She explained that her mother had became pregnant with her brother at an older age, and her mother also had liver problems. At that time, she worried that her mother would die while giving birth. After experiencing her mother's health problems, Participant 14 decided to become a doctor since she did not want to be forced to rely on *second-hand* medical information; she wanted to be able to access correct information herself. She thought that her anxiety would decrease in this process, but it did not:

> *In fact, I've chosen the wrong area of expertise. … My parents didn't want me to study medicine because they said I'd be more afraid as I learned more. I said I wouldn't be afraid and that I'd learn the truth about things because all I had then was hearsay. It didn't turn out like that, though. While my mother was sick, we were staring at the doctor expectantly, waiting for something good to be said so that we could relax. It was in that period that I decided. Otherwise, I actually really wanted to study architecture. (Participant 14)*

Preoccupation with Precautionary Behaviours

The second salient theme was the preoccupation with precautionary behaviors, including examination of the body for even small changes, searching the internet for information about symptoms and how to control them, frequently going to doctors to monitor their health conditions, and paying exaggerated attention to lifestyle habits such as nutrition. However, these behaviors occasionally had counterproductive results: anxiety levels increased rather than decreased.

Participant 6's health anxiety began after she was diagnosed with genital herpes. She stated that following her recovery, she began to fear a recurrence. She clearly explained how she took care of her health even more after facing that illness; however, her efforts sometimes led to unwelcome outcomes:

> *This time I made the limits that I set for myself a real necessity and I started to avoid some things… For example, I used to love dried nuts, which turned into "I shouldn't*

eat them." ... when I ate this stuff, my anxiety started increasing so much because my brain was telling me, "You ate this sweet, you consumed sugar, and this will be very bad for you. (Participant 6)

Participant 9 stated that she could not stop searching on the internet even though she knew that all symptoms carry a possibility of cancer according to information online:

It's always as if I'm going to have cancer, as if I have its symptoms. Whenever I have a problem, I research it first on the internet. They say not to look online, but I still can't resist, and searching there always leads to some kind of cancer. (Participant 9)

Participant 13, on the other hand, used the internet not only to find out the reasons for her physical symptoms but also to learn about other people's experiences with cancer. She described the coexistence of fear and enjoyment in this behavior. She felt the need to observe cancer patients' death processes, and wondered how those patients would describe their pain:

The thing I enjoy doing most during the day is reading many different cancer blogs. I read the blogs of terminal patients who are about to die. And every night before I sleep, I definitely make sure I read these blogs, and I'm not reading them with any anxiety. I'm just continuously imagining and following their process of suffering, how they die, what they experience. (Participant 13)

A Priori Thinking

Finally, some participants said that they were overthinking negative things, such as illness or death, that might happen in the future. Participant 2 described excessively *dreaming* about the things that would happen after her death:

*I think I **dream** too much. I think imagining too much about something, I mean, [it's unnecessary], like I won't know what happens in life after I die, so of course, there's no need to feel upset. But that's still what I dream about, I dramatize the situation, saying, "I wonder how it's going to be," and that has a bad effect on me. (Participant 2)*

The participants' choices, behaviors, and thoughts seemed to be contradictory. When they were asked questions to understand how they interpreted these situations, they sometimes answered that they did not understand why they acted as they did. However,

according to their statements, the underlying reason was a desire to better grasp the things they felt anxious about by immersing themselves in those things more deeply.

Endless Calls to Experts for Naming Experiences and Eliminating Uncertainty

One purpose of this study was to understand how individuals with health anxiety interact with health care professionals and what they expect from them, since they frequently, and sometimes obsessively, visit them. Accordingly, participants were asked questions about their relationships with and expectations of health care professionals. As seen in their responses, the participants needed physicians to name their experiences to be able to make sense of them and eliminate doubts about their health conditions. However, this need for information and clarity was not independent of the care and attention desired from the physicians.

Participant 11 explained that a physician should be sympathetic and empathetic so that he or she could understand patients. She said she did not want a patient-doctor relationship that would force her to explain her illness in great detail.

> *I don't like those morose doctors. For example, when I go for ultrasound checkups, I don't like those doctors who just make that "hmm, hmm" face because I'm worried that they see something. These people should be sympathetic, empathetic [laughing]. They should understand; those are the doctors I like. (Participant 11)*

Participant 1's following statement supports the finding that the information was not the only thing participants expected from physicians; they also expected care and attention:

> *The doctor sitting in front of you should give you confidence. You know, like saying "we'll beat this together," "you'll use this medicine or follow these instructions," or "you can always call me". When you call, you need to* ***be able to talk like friends****. This is what people with hypochondria are seeking…Your name is P., right? Doctor P. [should say] "****We'll beat this illness together.",*** *or she should say "that's normal" when I call her. With this disorder, the moment [a doctor says] "normal," the headache goes away. (Participant 1)*

Hence, for these participants, being knowledgeable was not sufficient for being "a good physician." They also expected care and attention from their physicians. However, their expectations were either not met or were met only temporarily because of their

ambiguous expectations or the uncertain nature of illness and mortality. Therefore, most of the participants complained that they were not understood or sufficiently cared for by physicians. For example, Participant 13 explained how she could not feel fully relaxed despite being taken to a physician whom she had wanted to see since she first thought that the health system had failed to detect her problem:

> *Do I have cancer? I went to the doctor a few times, I mean, to different doctors, and I was always thinking* ***they've missed something****. I have cancer but they can't find it. Then I would whine and cry, telling my family to take me to a better doctor; telling them they aren't taking me to the doctor I wanted. But even when I saw the doctor I wanted, I didn't relax much. (Participant 13)*

During the interviews, the styles of expression used by the participants in reflecting on their worries and health problems revealed another critical point. Some participants used expressions such as "rest assured that," "don't think I am exaggerating," "really," and "well, I mean, you know." or "believe me." Battologizing or repeating specific words was another communication style that seemed to accompany those expressions. Participant 10 repeated the word "increased" six times in a row while explaining how negatively she was affected by a traffic accident and her subsequent health problems:

> *How should I say this? I mean, the stress I suffered over four years gradually* ***increased, increased, increased, increased, increased, increased****. And while that [stress] increased, I started having some blood pressure problems. (Participant 10)*

Every Cloud Has a Silver Lining: Benefits of Being/Feeling Ill

Receiving Attention and Care

Almost all participants talked about the benefits of being or feeling ill despite the accompanying costs. While some gains were explicitly emphasized by the participants, others were deduced from their accounts. The first observed benefit was receiving attention or care from children, parents, partners, or physicians. Although Participant 3 did not clearly state any positive side of being ill and even emphasized how her husband ignored her, she noted that her children cared for her when she felt unwell:

> *For example, I feel sick, I have some kind of problem, so I go inside and lie down. [My husband] doesn't even come near me, do you see? He doesn't even come near me. My son is compassionate like me, so he comes ten times and he paces around asking,*

> *"Mommy, what do you need? Should I bring you this or that?" My daughter comes, "Should I do this or that?" (Participant 3)*

For Participant 8, the source of attention and care was her parents. When she was born, her father did not want her at home for a reason unknown to her. Therefore, she went to live with her grandparents. After a cyst occurred in her ovaries, she returned to the home where her parents and sister were living. In other words, a health problem contributed to her return to her nuclear family when she was 17 years old.

Health Anxiety itself as a Coping Mechanism with Other Life Difficulties

During the interviews, some participants stated that their health anxiety appeared whenever they had problems with their relationships or jobs. Interestingly, their health improved right after those problems disappeared. For example, when Participant 4 was about 17 years old, he went to a doctor due to his sleep problems; he slept too much and had trouble waking up. The blood test results revealed a significant abnormality indicating a problem with his immune system. The physicians initially suspected several different health problems, including AIDS, leukemia, lymphoma, and myelodysplastic syndrome, but after many examinations, those possibilities were excluded. They could not find a reason for the abnormalities, and they decided that Participant 4 should return for a check-up every six months. According to him, his blood values were affected by his emotional state:

> *It's very much related to my emotional state. For example, my girlfriend and I broke up a long time ago, and when we got back together three months ago, my blood values came out normal for the first time in two and a half years. (Participant 4)*

Statements such as these made the researcher think about the reasons for and functions of such an increase in health anxiety. In this regard, the following statement from Participant 7 highlights the fact that health anxiety could also be a mechanism for coping with other difficulties in life.

> *Whenever I'm upset or have a problem, this [health anxiety] shows up. I interpret it like this: I create another problem to survive the initial problem [laughing], to forget about the other problem. (Participant 7)*

Rearrangement of Priorities and Relief from Responsibilities: My Health above all else

Another benefit of being or feeling ill that emerged was the rearrangement of duties and priorities and the decision to put health above everything else. Consequently, participants experienced increases in self-care, self-acceptance, and self-worth and decreases in feelings of guilt. Participant 13 noted that she turned into a careless person whenever she felt terrible and she evaluated such moments as "bad holidays." She explained that she did not feel obliged to do the things that she would normally have to do before her increased health concerns:

> *I realize it when I'm excessively doing things I don't want to do, or, in fact, it looks like I want to do them, but when I do too many things, they seem like a vacation to me. But a horrible vacation, not a nice one; I just really don't care about anything. I mean, they don't feel like my responsibilities… I may not go to class, not attend meetings, I might hurt someone's feelings, might not answer phone calls... I really become a very indifferent person. (Participant 13)*

Similarly, Participant 7 stated that she feels free from any guilt for not fulfilling her responsibilities because her diagnosis legitimizes her lack of effort:

> *I would say that I could have been more successful. I mean, I could have worked harder and studied in a better department. But later I said, "Okay, I'm dyslexic and I couldn't have done that even if I wanted to." I was relieved when I got the diagnosis. I escaped my feelings of guilt when I got diagnosed with dyslexia. (Participant 7)*

In summary, in the context of this theme, participants stated that receiving attention and care, using health anxiety as a defense mechanism to cope with other problems, gaining the right to be exempt from responsibilities, and deciding to put health above all else were positive sides of being ill or feeling ill despite the negative aspects.

Discussion

In this study, almost all participants stated that they had at least one anxious parental figure at home. This information fits the attachment theory perspective, which suggests children form a set of representations of relationships based upon their experiences with parents (Bowlby, 1969). From a different perspective, identification with parents who spoke too much about physical complaints and illnesses, as Wahl (1963) explained, could be another explanation behind this pattern.

Moreover, participants addressed unresolved loss issues at the center of their health concerns. Losing life was one of the aspects of the loss. A positive association between death anxiety and hypochondriasis was stated in the literature (Stegge et al., 2018). Fear of death was argued as an underlying fear under the development, course, and continuity of the hypochondria by several approaches such as the terror management perspective (Arndt et al., 2005; Strachan et al., 2007) or cognitive-behavioral approach (Furer & Walker, 2008). Some participants' health concerns were focused on the reproductive areas such as the breast, ovary, or genital area. Considering that people are also afraid of dying, their concentration on these body parts can be explained by the concept of "symbolic immortality". It is described by Lifton (1979 as cited in Florian & Mikulincer, 1998) as people having difficulty accepting the fact of death at the level of consciousness tend to suppress it. The knowledge that life is finite creates a need to develop a sense of continuity, a need for a sense of symbolic immortality. One way of achieving it is the biological mode. This mode describes the situation in which a person copes with his/her mortality by ensuring the continuity of his/her generation through reproduction (Lifton, 1979 as cited in Florian & Mikulincer, 1998). Therefore, the focus of participants' anxiety on the breast or genital areas may be related to the difficulty in coping with the idea of death, and at the same time, the idea that the biological mode providing symbolic immortality will be damaged.

The mentioned loss contains not only the loss of life and loss of health but also separation issues. Participants associated losing health with losing power, reputation, independence, life, and loved ones. Fears of illness, death, and separation seem to be intertwined. Studies in the literature showed that illness anxiety feeds death anxiety, and death anxiety increases illness anxiety ((i.e. James & Wells, 2002; Noyes, et al., 2002). Thus, their causality is not clear (Stegge et al., 2018). The participants' statements about fear of losing one's life, health, or the relationship might reflect not knowing how to manage loss, including death, illness, or separation. In other words, hypochondria and the accompanying fear of separation and death reflect the inability to handle the idea of loss. According to Freud, the fear of death stems from the feeling of failure to cope with the danger and the lack of any protective force; therefore, the bodily ego's integrity is under threat (Freud, 1957-1958 as cited in Wilton, 2003).

The participants' health-related career choice and their thoughts and behaviors shaped around their health anxiety indicate the central position of the health anxiety in their lives. Many approaches have emphasized that such preoccupation is a crucial feature of

hypochondria, so this feature has come to the forefront when describing it (e.g., Noyes et al., 2003; Starcevic, 1989; van den Heuvel et al., 2014; Warwick, 1989). The participants' statements showed that the most important reason for getting within the symptom more was an effort to gain control over it. Being knowledgeable about symptoms and treatment of illnesses, taking care of health to prevent illnesses, thinking about bad things that might happen in the future, and getting prepared for them in advance by doing so, and being close to hospitals were important parts of the control. Nevertheless, the participants stated that having more information about their symptoms and controlling their health status had a two-way effect: Anxiety-reducing and anxiety-enhancing. The anxiety-enhancing nature of searching symptoms on the internet was supported by many studies (Baumgartner & Hartmann, 2011; Doherty-Torstrick et al., 2016), but there were also studies showing that this search provides a sense of control in addition to the anxiety-enhancing feature (i.e., Singh et al., 2016) supporting the findings of the current study. One of the reasons people get even more into their symptoms might be their enjoyment from these anxiety symptoms. As clearly stated by Participant 13, it seems that there is a point where the person enjoys the health-related work or health-related routine, whether consciously being aware of it or not.

Wahl (1963) mentioned that individuals with health anxiety give the impression that they are getting pleasure from being sick because they are mostly reactive to medications. Psychological and physiological explanations intensify their anxiety. In the interviews conducted in the current study, participants emphasized their relationship with physicians while explaining how they react to the doctor's explanations and how they adhere to their treatments. If the treatment is given by a doctor whose knowledge was not trusted, they either said that the given treatments had no effect or even had side effects or did not comply with the treatment at all and looked for another doctor. However, if the diagnosis and treatment came from a trusted doctor, they feel relief for a while, but then somatic complaints seem to persist in other ways.

Although the duration of anxiety or relaxation varies, each participant of the current study spoke of a cycle. These participants seek information that will help them make sense of their bodies' experiences, mainly a diagnosis. At that point, it is possible to think of the diagnosis as "object a", which is a notion used by Lacan (1965-66)[1]. Even

1 This information is taken from the source indicated as "Gallager, C. (Ed.). (2002). The object of psychoanalysis: The seminar of Jacques Lacan: Book XIII. London: Karnac Books." in the bibliography.

though a person believes that when s/he reaches "object a", s/he will find what s/he is looking for and feel complete, by nature, it is something that continually escapes them (Lacan, 1963-64[2]; Burgess, 2017). That is, individuals with hypochondriac symptoms look as if they are in search of an answer for their health problem, but when they receive a diagnosis, they do not feel relieved contrary to expectations; diagnosis is just like an "object a" which loses its meaning as soon as it is reached and leads the person to new searches. Therefore, therapists working with health anxious individuals are advised to help them understand the continuity of their *desire* to know "What is wrong with them?" after establishing a therapeutic alliance.

Experiencing enjoyment as a pain indicated the paradoxical situation wherein the subject gets unconscious satisfaction from his symptoms, which was explained as a primary gain by Freud (1959/1896). Anxiety increasing efforts that seem first to reduce anxiety may be related to people's unconscious pleasure from their symptoms. First of all, the source of pleasure was not to be sick itself, but the things it relates to. However, participants said they associate illnesses with being dependent on others' care and not becoming self-sufficient while expressing their concerns. On the other hand, they also explained how they receive care and support from the people around them due to their somatic complaints and anxiety. Hence, they may not be able to get back from complaining, and at the same time, maintaining the symptoms involuntarily, since their symptoms simultaneously contain both the fear and the wish to be dependent, or at least protection from loneliness as an unconscious motive. Participants were more concerned about chronic illnesses such as cancer, which will require acute care, and at the same time, they were constantly 'imagining' that they have such illnesses. That can be regarded as a sign that such illnesses are both feared and unwittingly desired. These illnesses can be a source of support and attention and a way of escaping from responsibilities. Moreover, most of the participants talked about having someone who takes them to the doctor. Because one of their biggest fears was to be dependent on someone for reasons such as losing functionality and being unable to work, it can be said that having a fear of being dependent and making themselves connected to others through anxiety or somatic symptoms co-occur.

2 This information is taken from the source indicated as "Feldstein, B. Fink and M. Jaanus, (Eds.) (1995), Reading seminar XI: Lacan's four fundamental concepts of psychoanalysis: The Paris seminars in English. New York: SUNY Press."in the bibliography.

Expressions of the participants such as 'rest assured that', 'do not suppose that I am exaggerating', 'really' emerged as important points in the interaction with the researcher. Those expressions were considered an effort to call the other person (in that case, the researcher) to their difficulties. The participants' communication style can be evaluated as a call to physical or mental health care professionals to get them involved.

Stuart and Noyes (1999) explained that since anxiously attached individuals did not get enough attention when they were sick as children, they may be trying to get attention by using somatization in adulthood. However, most participants explained how much their anxious parents fell on them when they became ill. Also, this finding differs from the findings of a qualitative research on hypochondria. Papis (2015) reported that participants of that study said their emotional needs were unmet by their parents, unlike most of the participants in the current study. For this reason, it is possible to think that one of the critical factors for the emergence and continuity of somatization is that somatic complaints bring attention and care. Moreover, although the finding obtained from the present study seems to differ from the literature, the possibility that these people cannot attract attention without health problems and can only attract attention when they are sick remains valid.

As stated in the article of Kirmayer and Young (1998), although some characteristics and prevalence vary from culture to culture, somatization is not unique to a single culture; on the contrary, it is the most common way of expressing emotional distress worldwide. Participants who stated that somatic symptoms increase when they are not feeling well psychologically confirm this information. According to Turkey's Mental Health Profile Report (Munir et al., 2006), psychogenic pain, defined as a physical pain associated with mental, emotional, and behavioral factors, was the most frequent psychiatric diagnosis. This finding showed that the expression of distress through the body is common in Turkey as well, which was consistent with the results of this study.

As a consequence of experiencing health problems, participants' statements also showed how their priorities changed, and health has surpassed everything. That is consistent with what Segall (1976) explained. According to him, once people thought they were ill and adopted the sick role, they had the right to be exempt from ordinary activities. Enhancement of self-care, self-acceptance, and self-worth were the consequences of putting health above everything. This is also consistent with the idea that self-centeredness is a shared feature by individuals with hypochondriac symptoms (Fenichel,

2005). According to the literature, attributing distress to somatic reasons instead of emotional difficulties protects the individual from feeling a loss of control and the adverse effects of psychiatric diagnoses on self-esteem (Kirmayer & Young, 1998). That might explain the decrease in guilt feelings found in the present study. Thus, giving efforts for the individuals to understand that the source of their problems is psychological should consider the benefit-loss balance.

The study's findings would be important not only for mental health workers but also for every professional working with health-anxious individuals, such as physicians and surgeons, since they frequently encounter people with hypochondriac complaints. It would not be right to think that medical doctors are only related to those people's physical symptoms. The physical-psychological distinction made by the experts does not correspond with the reality of people with hypochondriac complaints. Even if there is no physiological basis for the illness, they thought they had, these individuals experienced it as if it had that basis. Therefore, it would not help these patients to tell them that they do not have a physiological problem or are physiologically well. Moreover, in the interviews, participants referred to the importance of the doctor's knowledge when explaining what they expect from physicians. However, participants emphasized not only the physicians' knowledge but also how much they understood, whether they were empathetic or put them off. Rather than the information itself, the relationship between the physician and the patient becomes more critical, showing the importance of transference. Many studies in the literature have demonstrated the importance of the alliance between patients and professionals (e.g., Weck et al., 2015; Xiong et al., 2007).

For qualitative studies, particularly those using interpretative phenomenological analysis, establishing rapport is essential (Pietkiewicz & Smith, 2014). For that purpose, in the beginning, the researcher introduced herself and explained the interview's aim explicitly, although the participants had brief information about these before coming to the interviews. Moreover, the researcher used strategies such as genuine listening, adopting an open and attentive body posture, and using open-ended questions to help participants elaborate their stories. As an indicator of established rapport, participants had no difficulty talking about their illnesses or their anxiety about becoming ill. Even when they were asked to introduce themselves, they often started to talk about those issues directly. This situation has been evaluated as people with health anxiety establish a relationship with others by talking about their illnesses, and their transfers develop rapidly in that sense. That supports the idea that imagined, feared, or exaggerated illnesses

could provide a set of signifiers around which the individual is organized and can contact others (Butler-Rees, 2011). The participants were comfortable talking about the research topic, which partially eliminated the disadvantages of interviewing with them only once. Nevertheless, at least a second interview could be conducted to see the impact of the first interview on the participants, elaborate on some issues, if necessary, and observe what participants would like to talk about more after the first interview, mainly focused on illnesses.

Another limitation of the study could be the limited number of male participants compared to female participants. Nevertheless, the ratio represented the prevalence rates in the community. According to Turkey's Mental Health Profile Report, the rate of patients diagnosed with hypochondriasis was 0.8% for women and 0.3% for men (Erol et al., 1998).

As a result, therapists working with patients with hypochondria should help the patient understand the continuity of their desire to know if something is in themselves and what it is after establishing a therapeutic alliance with the patient. In fact, for both groups, hypochondria has been a subject that has been ignored for a while. The reason may be the disappointment experienced by the professionals due to the fact that the information they provide to the patients does not satisfy them.

Ethics Committee Approval: Ethical approval was obtained from the Human Subjects Ethics Committee of Middle East Technical University on 6 September 2017, protocol number 2017-SOS-0146.
Peer-review: Externally peer-reviewed.
Author Contributions: Conception/Design of Study- B.P.B., Ö.B.; Data Acquisition- B.P.B.; Data Analysis/Interpretation- B.P.B., Ö.B.; Drafting Manuscript- B.P.B., Ö.B.; Critical Revision of Manuscript- B.P.B., Ö.B.; Final Approval and Accountability- B.P.B., Ö.B.
Conflict of Interest: The authors have no conflict of interest to declare.
Grant Support: The authors declared that this study has received no financial support.

Etik Komite Onayı: Orta Doğu Teknik Üniversitesi İnsan Denekleri Etik Kurulundan 6 Eylül 2017 tarihinde protokol numarası 2017-SOS-0146 olan etik onay alınmıştır.
Hakem Değerlendirmesi: Dış bağımsız.
Yazar Katkıları: Çalışma Konsepti/Tasarım- B.P.B., Ö.B.; Veri Toplama- B.P.B.; Veri Analizi/Yorumlama- B.P.B., Ö.B.; Yazı Taslağı- B.P.B., Ö.B.; İçeriğin Eleştirel İncelemesi- B.P.B., Ö.B.; Son Onay ve Sorumluluk- B.P.B., Ö.B.
Çıkar Çatışması: Yazarlar çıkar çatışması bildirmemiştir.
Finansal Destek: Yazarlar bu çalışma için finansal destek almadığını beyan etmiştir.

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