

CHAPTER 3

A COGNITIVE-BEHAVIORAL PERSPECTIVE

Individuals who worry excessively about their health are often given very little information about health anxiety. Physicians or family members may become frustrated by the repeated attempts to gain reassurance about health issues and may see the person as a *complainer*. People who are struggling with health anxiety often feel quite alienated in the health care system. They may feel that their concerns are not taken seriously and may have seen many health care professionals over the years and never received suggestions about how to cope with their symptoms and anxiety. It is important to help clients understand how their health anxiety may have developed and how it is maintained. Models for hypochondriasis and for somatization are relevant in understanding health anxiety.

HYPOCHONDRIASIS

Barsky (2001b), Barsky and Wyshak (1990), and Kellner (1986, 1987) have published pioneering work outlining models of hypochondriasis. Cognitive-behavioral models of hypochondriasis propose that this disorder involves the tendency to misinterpret bodily symptoms. These models generally emphasize the role of perceptual and cognitive abnormalities with the illness behaviors being viewed as secondary consequences of

these abnormalities. Barsky's somatosensory amplification model of hypochondriasis (Barsky, 2001b; Barsky & Wyshak, 1990) is summarized as follows:

... personally threatening life events prompt predisposed individuals to suspect that they have become ill. This suspicion leads them to selectively attend to benign bodily sensations and health information that confirm their suspicions and to ignore disconfirmatory evidence. Benign bodily sensations are thereby amplified and misattributed to the putative disease, which further substantiates their disease convictions (Barsky & Ahern, 2004, pp. 1464–1465).

Kellner (1986, 1987) stresses the importance of childhood experiences, such as disease in the family, which may sensitize the individual to focus on somatic symptoms. He suggests that full-blown hypochondriasis develops following some kind of stressor that causes anxiety or depression with associated somatic symptoms. The somatic symptoms may also be produced by such mechanisms as overactivity of the autonomic nervous system, increased muscular tension, endocrine activity, and biochemical changes caused by hyperventilation. The change in somatic activity is misinterpreted as an indication of a disease process. Typically, this idea of being seriously ill abates as a result of a physician's reassurance or the disappearance of the symptoms. Kellner and other cognitive theorists argue that if the catastrophizing persists then the person will become more anxious. As anxiety increases so does the person's tendency to focus on somatic symptoms, thus strengthening the fear of disease. In this way, the vicious cycle of hypochondriasis develops.

Perhaps the most frequently cited cognitive model of hypochondriasis is the one proposed by Paul Salkovskis and his colleagues at Oxford University (Salkovskis & Warwick, 1986, 2001; Warwick & Salkovskis, 1990, 2001). Like Kellner, these researchers emphasize the importance of the person's learning history in the development of maladaptive beliefs relating to illness, somatic symptoms, and health-related behaviors. Salkovskis suggests that previous experiences with illness and general negative assumptions about health may predispose an individual to develop health anxiety when combined with a critical, precipitating health event and negative interpretations of this event. He emphasizes that misinterpretations of bodily symptoms or health information can lead to increased physiological arousal and, hence, result in increased physical symptoms. Factors maintaining health anxiety include the tendency for people to selectively focus on information confirming their health fears, the increasing ability of clients to detect small changes in normal physiological processes, and safety-seeking behaviors, including

checking of bodily symptoms, reassurance seeking, and avoidance of feared situations. Although there are clearly behavioral components in this model, including the impact of avoidance and other safety behaviors on anxiety levels, the Oxford group emphasizes the cognitive components, both in descriptions of their model and in treatment applications.

The cognitive-behavioral model for health anxiety overlaps with the cognitive model of panic disorder developed by the Oxford group. These researchers argue that the principal differences between the two disorders are that the feared consequence in panic disorder is immediate (having a panic attack or dying on the spot from a heart attack), whereas the feared consequence in hypochondriasis is delayed (e.g., gradual death from cancer); and that the feared symptoms in panic disorder are symptoms related to physiological arousal (e.g., increased heart rate, shortness of breath, sweating) whereas those feared in hypochondriasis (e.g., lumps, rash, pain) are not typically arousal-related (see Salkovskis & Clark, 1993; Salkovskis & Warwick, 2001). This is not an absolute distinction, however, because concern about acute symptoms and dying suddenly (e.g., from a heart attack or stroke) are also common in individuals with hypochondriasis and there is a high level of comorbidity between panic disorder and hypochondriasis (Furer et al., 1997).

SOMATIZATION

The primary models proposed to account for the development and maintenance of somatization emphasize learned social behavior, psychophysiological abnormalities, or a combination of these factors. Bertagnolli, Harris, and Arean (1994), for example, suggest that individuals with somatization disorder have difficulty differentiating between physical and emotional arousal. They believe that all their somatic symptoms have a physical basis and, therefore, they tend to seek out frequent medical attention. A vicious cycle develops as the medical consultations lead to increased focus on the bodily symptoms, which results in increased pain and other somatic complaints.

Rief, Hiller, and Margraf (1998) recommend a model of somatization "that integrates cognitive, affective, behavioral, and physiological aspects" (p. 594). These authors propose that cognitive components of the model include misinterpretation of bodily symptoms, the belief that good health is characterized by the absence of somatic symptoms, and a view of the self as weak and unable to tolerate stress. Selective attention to bodily symptoms contributes to these misinterpretations. Beliefs about being weak and ill may lead to avoidance of physical activity. This, in turn, leads

to reduced physical fitness, lack of stamina associated with inactivity, and increased probability that the individual will develop physical problems.

Nezu, Nezu, and Lombardo (2001) outline a similar cognitive-behavioral model for medically unexplained symptoms, emphasizing the role of the physical symptoms, cognitions that exacerbate the physical symptoms, general negative affect, hypervigilance, reassurance-seeking, and reduced activity level. These authors discuss the ways in which various learning mechanisms (including social learning, and operant and respondent conditioning) initiate and maintain the somatization tendencies.

EVIDENCE IN SUPPORT OF COGNITIVE-BEHAVIORAL FORMULATIONS

PERCEPTUAL BIASES

Much of the research examining cognitive-behavioral models of health anxiety has focussed on the perceptual component of the model. It is hypothesized, for example, that people with hypochondriasis tend to experience normal bodily sensations as being more aversive and more intense than others (Barsky, 1979; Barsky & Klerman, 1983; Mayou, 1976). They may have increased awareness of bodily sensations and a lower pain threshold. Psychiatric outpatients with hypochondriasis and general anxiety have been shown to be more accurate in their assessment of heart rate changes than patients with agoraphobia and social anxiety (Tyrer, Lee, & Alexander, 1980). Individuals with hypochondriasis also report awareness of significantly more bodily symptoms than do healthy controls (Haenen, Schmidt, Kroeze, & van den Hout, 1996). Participants with disease phobia appear to have lower tolerance for the experimentally induced pain of electrical shock and lower thresholds for detecting sensation than psychiatric inpatients (Bianchi, 1971). Similarly, individuals with hypochondriasis demonstrated lower tolerance for cold than healthy controls (Gramling, Clawson, & McDonald, 1996). Hanback and Revelle (1978) reported that the visual and auditory sensitivities of participants with hypochondriacal tendencies were generally higher than for those with low scores on a hypochondriasis scale. Similarly, there is some evidence supporting the notion of perceptual biases in individuals with somatization disorder (James, Gordon, Kraiuhin, Howson, & Meares, 1990). These researchers compared 10 individuals who met DSM-III-R criteria for somatization disorder and 10 normal controls with respect to their responsiveness to auditory stimuli of various intensities. The sample

with somatization disorder displayed enhanced central nervous system response to sensory input. Elevated basal levels of physiological arousal and heightened perceptual sensitivity would increase awareness of minor changes in bodily functions and symptomatology.

ATTENTIONAL BIASES

There is also evidence that focussed attention increases the perception of bodily sensations. Haenen et al. (1996), for example, found that individuals with hypochondriasis reported significantly more bodily symptoms when instructed to concentrate on internal sensations as compared to baseline and to a period of focus on a distracting task. A series of studies with individuals with specific phobia of spiders supports the hypothesis that attention to pain increases the experience of pain, while distraction decreases it (Arntz & De Jong, 1993; Arntz, Dreessen, & De Jong, 1994; Arntz, Dreessen, & Merckelbach, 1991). Similar effects of distraction on pain have been reported for individuals with high and low scores on a measure of hypochondriacal concerns (Lautenbacher, Pauli, Zaudig, & Birbaumer, 1998).

The evidence for perceptual and attentional biases in individuals with health anxiety is not completely consistent, however. Barsky, Brener, Coeytaux, and Cleary (1995), for example, found that medical outpatients with hypochondriasis were not more accurately aware of normal cardiac activity than were their nonhypochondriacal subjects. Lecci and Cohen (2002) argue that the inconsistency in the findings on perceptual abnormalities is related to differences in how hypochondriasis is assessed, as well as to the circumstances in which the assessment of perceptual differences is conducted. Their study suggested that individuals with hypochondriacal tendencies display perceptual biases only when illness concern is activated. Lecci and Cohen manipulated illness concern by giving participants a fake medical exam and telling them that their blood pressure was dangerously high. Under these conditions, individuals with high scores on a measure of somatosensory amplification showed an increased focus on task-irrelevant, illness-related stimuli during the perceptual assessment. Thus, perceptual bias and increased attention to health information may occur only when an individual is in a state of increased health anxiety.

COGNITIVE FACTORS

Interpretation of bodily sensations as indicative of serious disease, a central component of the cognitive-behavioral model, appears to be important in explaining some of the findings regarding perceptual and attentional

biases. Kellner, Abbott, Winslow, and Pathak (1987) reported that patients with hypochondriasis differed from anxious and depressed psychiatric patients in their health-related cognitions. They endorsed greater worries about disease, concern about pain, death anxiety, awareness of bodily sensations related to hearing or reading about a disease, and difficulty distracting themselves when they experience bodily symptoms. Patients with hypochondriasis also reported less confidence in their physician's diagnoses and quickly developed illness worries again after reassurance. Health services utilization was higher for those adults with hypochondriasis.

Several studies have examined the interplay between hypochondriasis and interpretation of bodily symptoms. Hitchcock and Mathews (1992) and Marcus (1999) demonstrated that, in nonclinical samples, individuals with higher levels of hypochondriacal concerns were more likely to interpret bodily symptoms as indicative of disease than were individuals with low levels of hypochondriasis. This pattern has also been reported with general medical practice patients (MacLeod, Haynes, & Sensky, 1998). Barsky, Coeytaux, Sarnie, and Cleary (1993) described similar findings with patients with a clinical diagnosis of hypochondriasis. They also found that hypochondriacal patients were more likely to consider common and ambiguous bodily symptoms to be pathological and indicative of sickness, as compared to a sample of nonhypochondriacal individuals. Thus, individuals with hypochondriasis believe that they have to be symptom-free to be healthy. Marcus and Church (2003) found that the tendency to overestimate the likelihood of disease could not be attributed to high levels of depression or general anxiety, but was predicted only by the level of hypochondriasis. Barsky, Ahern, et al. (2001) note that individuals with hypochondriasis do not see themselves as generally at high risk for injury or disaster. When compared to nonhypochondriacal individuals, they reported no greater estimate of risk for being in an accident or being the victim of a crime. Their overestimation of risk was limited to the likelihood of developing a serious disease.

We are aware of only one study that examines similarities and differences in cognitions among individuals with somatization problems and those with hypochondriasis (Rief et al., 1998). These authors found that both groups engage in catastrophic misinterpretation of bodily symptoms, believe that one must be symptom-free to be in good health, and report increased awareness of mild autonomic bodily sensations. Individuals with somatization problems without hypochondriasis describe beliefs about being weak and unable to tolerate physical effort. Intolerance of bodily complaints, meaning that the individual is quick to take medication or seek medical attention for a symptom, is more characteristic of individuals with hypochondriasis.

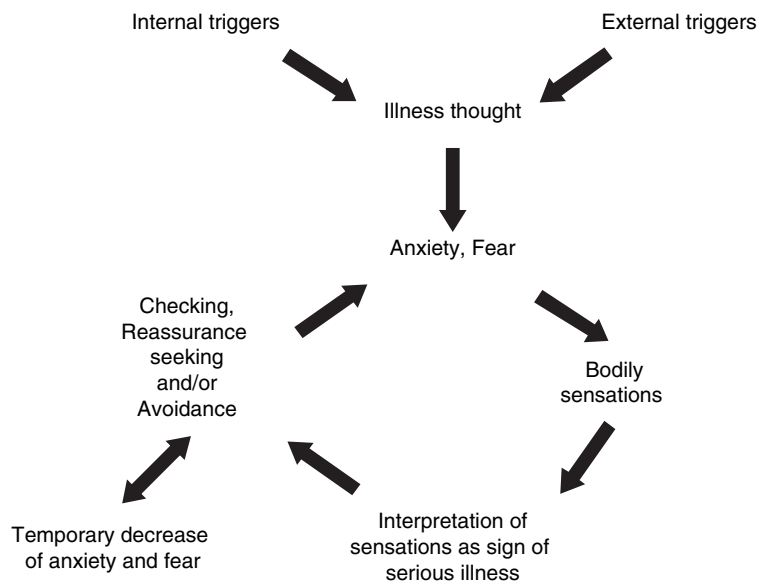
SAFETY BEHAVIORS

The cognitive-behavioral model suggests that safety behaviors such as reassurance seeking, bodily checking, reliance on safety signals, and avoidance behaviors are significant in maintaining health anxiety. There is limited research, however, investigating the effects of these behaviors in this population. An early study by Salkovskis and Warwick (1986) found that reassurance from medical professionals produced an immediate but temporary decrease in anxiety, followed by increased anxiety and reassurance-seeking behaviors. The high rate of health service utilization among individuals with health anxiety also supports the view that reassurance seeking is a central feature of this problem (see Chapter 1).

As with other conditions where anxiety is prominent, a common feature of hypochondriasis is the avoidance of situations and thoughts related to illness and death. Many individuals find themselves avoiding activities such as visiting friends who are ill, reading stories or watching movies about illness or death, reading the obituaries in the newspaper, and attending funerals (Warwick & Marks, 1988). While the typical presentation of hypochondriasis involves excessive use of the health care system, some individuals with health anxiety may avoid the use of appropriate health care services because of anxiety (Noyes et al., 2000). Much more research is needed to evaluate the impact of checking the body for symptoms, obtaining reassurance about health, and avoidance behaviors in the development and maintenance of health anxiety.

COMPONENTS OF THE COGNITIVE-BEHAVIORAL MODEL FOR HEALTH ANXIETY

We use a model of health anxiety similar to that described by the Oxford group, albeit with greater emphasis on the behavioral factors. Health anxiety typically develops in the context of a biological predisposition to anxiety, illness or death-related experiences, and/or stressful life events. This model illustrates the factors involved in episodes of health anxiety (see Handout 3.1). Clients are generally receptive to a formulation of health anxiety that suggests that there are common triggers for worries about health. These triggers may include internal sensations such as bodily symptoms or changes in physiological function that are interpreted as signs of serious disease. External triggers, such as reading or hearing about illness, may also provoke episodes of anxiety. Hypervigilance results in an increased awareness of bodily symptoms.

Handout 3.1. Health anxiety: Cognitive-behavioral model.

The individual may employ a variety of safety behaviors in an effort to reduce anxiety: checking the body for signs and symptoms of illness, seeking reassurance about health issues, and reliance on safety signals (e.g., carrying anxiolytic medication, staying near a hospital). Avoidance of illness and death-related situations may develop in an attempt to cope with anxiety. Over time, these strategies increase health anxiety. Each of these components of health anxiety is described in more detail below.

Jim: What if I have a brain tumor?

Jim has been having painful headaches for the past few days. Every time the headache starts (it starts right behind the eyes) he worries about what is causing this pain. The first thought that comes to his mind is that it must be from a brain tumor, or perhaps from an aneurysm. He tries to tell himself that the headache is just from stress but this doesn't help much. Jim finds himself rubbing his temples and forehead to see if he feels any lumps. When he notices that there might be a bit of swelling around his right temple, his anxiety becomes very intense. He asks his wife about this and she tells him he is just fine. Jim wonders whether he should go to his doctor to check this out.

Jennifer: Do I have MS?

Jennifer was reading an article about the signs and symptoms of multiple sclerosis in a magazine last week. Yesterday she started noticing some sensations in her hands, which she described as tingling and shooting sensations that ran through her fingers and up her arms. Jennifer is certain that this is exactly like one of the MS symptoms described in the article. She worries about this and wonders if she has other symptoms of MS as well. Later that day, she notices some dark spots in her vision when she moves her eyes and she thinks maybe her vision is a bit blurred as well. She is certain that these symptoms are all part of early MS and this makes her feel very anxious and panicky. She decides to search the Internet for more information on MS.

INTERNAL TRIGGERS

For many individuals, health worries fluctuate over time. This may occur because the triggers for health anxiety are present only intermittently. Possibly the most common triggers for episodes of health anxiety are internal ones. Many individuals report that physical symptoms are critical in setting off a period of increased disease fear or disease conviction. New symptoms, such as a rash or pain, or chronic symptoms such as headaches, may trigger fears of serious disease. Some individuals find that any new symptom can cause health anxiety. This anxiety is alleviated

only when the symptom disappears or is adequately explained. Others report that only certain types of symptoms cause worry for them, such as those related to the abdominal area (perhaps because they have a family history of bowel cancer). Chronic symptoms, such as headaches or other pain problems, may be particularly challenging if people are not satisfied with the medical explanation they have received.

Health anxiety may also increase when a person has an illness. The physical symptoms accompanying a milder problem such as a flu or a muscle injury may trigger increased worrying. Individuals may question the diagnosis or worry that a more serious disease process is the true reason for their symptoms rather than the more benign diagnosis they have received. Women going through a pregnancy may find that the many unfamiliar physical symptoms can trigger worries about both the baby's and the mother's health. (See Chapter 13 for more discussion about pregnancy.)

EXTERNAL TRIGGERS

External triggers may include media stories about illness, being diagnosed with an illness, having a friend or relative diagnosed with a serious illness, and experiences with death. Any of these external triggers may set off a chain of worry, checking, avoidance, and disease conviction. This episode may last for weeks, days, or months. Triggers for health anxiety may be highly individualized and a trigger for one person may have no impact at all on the health anxiety of someone else.

Certain external triggers appear to cause difficulty for many individuals with health anxiety. For example, extensive media coverage of a disease outbreak can set off substantial health anxiety in a community. Reports describing serious diseases that present with common physical symptoms (e.g., fatigue, flu-like symptoms) that can affect anyone (not just vulnerable populations) and do not have straightforward cures tend to be particularly anxiety-evoking. We found, for example, that there was a surge in concern about flesh-eating disease, sudden acute respiratory syndrome (SARS), and West-Nile virus among our clients after news coverage of these diseases. Many individuals, even those who do not typically have difficulty with health anxiety, may have some increased anxiety during a disease outbreak or when a "new" disease or virus is identified. For most people, this increased anxiety is temporary and generally does not disrupt daily living. For some individuals, however, the increased anxiety may be more significant.

Media coverage of commonly misdiagnosed diseases may also trigger health anxiety. For example, stories about under-diagnosis of heart disease in women and how some symptoms related to heart disease may be incorrectly attributed to other, less serious, causes can

cause substantial distress for some women. Similarly, hearing a story from a friend about a misdiagnosis that resulted in dire consequences may produce heightened desire for reassurance from health care professionals.

Health anxiety often increases when the individual is faced with a medical procedure or when a loved one is dealing with a medical crisis. When people have a mild illness, such as a flu, they may worry about being susceptible to more serious diseases or they may find that their increased physical symptoms (e.g., muscle aches, nausea, fatigue) trigger increased fears. Having to undergo a medical procedure or test can cause worries about what will be discovered. Uncertainty about what bodily symptoms are to be expected after a procedure may also trigger increased fears. This issue is addressed in Chapter 15. When a loved one is diagnosed with a serious illness, it is common for family members to consider their own vulnerability to that same disease.

For Jennifer, reading the article about MS is a clear trigger for her worries about this disease. Jim's fears do not seem related to external triggers. Internal triggers are prominent in both case examples.

ILLNESS-RELATED THOUGHTS

The internal and external triggers described above may result in health-related thoughts or images. For example, a person experiencing painful headaches (like our friend Jim) might say to himself, "I have really been working too hard this week. I need to get some rest and I think I should cut back on my coffee so that I will feel better." Alternatively, the headaches might give rise to thoughts such as "I have heard that people with brain tumors usually start off with headaches that they dismiss as nothing serious. Then they end up dying terrible deaths! I should go to the doctor right away." Needless to say, Jim would feel much more relaxed and would cope more effectively with his headaches if he were able to take the former approach. Unfortunately, his thoughts veer off in the direction of brain cancer and a painful death. These frightening thoughts contribute to the anxiety cycle.

For some individuals, the thoughts may be very specific and relate to fears or conviction about a certain disease, such as: "I must have stomach cancer" or "I am sure that this pain means I have a tumor." For others, the thoughts may reflect a more general fear that they are seriously ill or that they will become ill in the future. Examples of such thoughts include: "My sister's breast cancer means that I will die from breast cancer for sure." "The doctor must have missed something: this redness on my arm can't be just eczema," and "The doctor is sending me for an MRI so there must

be something seriously wrong.” Many health-related thoughts are based on misinterpretations of bodily symptoms, but it is important to note that some, such as the thought about breast cancer, do not involve the direct experience of bodily symptoms.

For many individuals with health anxiety, intolerance of uncertainty appears to be a central concern. Intolerance of uncertainty has been defined as “an excessive tendency to find uncertain situations stressful and upsetting, to believe that unexpected events are negative and should be avoided, and to think that being uncertain about the future is unfair” (Dugas et al. 2005, p. 58). This cognitive style has been investigated primarily in individuals with generalized anxiety disorder (Ladouceur et al., 1999), but it is likely also relevant for individuals with health anxiety. Worries for individuals with health anxiety and somatic focus often center on doubts about the future (e.g., whether their symptoms worsen) and great discomfort with not knowing with certainty the outcome of potential choices (e.g., seeing another doctor or having further medical investigations) and future events (e.g., whether they will develop cancer).

HYPERVIGILANCE

When a person feels threatened (by illness or death in this case), the body reacts accordingly with physiological changes, including increased heart rate, accelerated breathing, sweating, and muscle tension. These changes would help prepare the body to cope with actual physical danger. Since there is no actual danger in this situation, the physiological reactions have a different effect. The increased arousal may result in increased vigilance. Vigilance has survival value: if an individual is very alert and is carefully scanning the environment, he or she is likely to detect a threat earlier and to take protective action. People with health anxiety may turn this increased vigilance inwards and become ever more aware of bodily symptoms. This increased focus in turn leads to increased health-related thoughts and images and higher levels of anxiety.

SAFETY BEHAVIORS

Checking and Reassurance-Seeking

Hypervigilance may easily lead to repeated checking of aspects of health functioning. In an attempt to cope with the threats they perceive, many people with health anxiety check their bodies regularly to assess their physical health and seek reassurance from others about the state of their health.

Typical examples of checking behaviors include probing the body for lumps, monitoring moles, monitoring pulse rate or blood pressure, checking for weight loss, monitoring pain levels or unusual bodily sensations, and frequent breast self-examinations. Reassurance-seeking strategies may include asking a family member, friend, or health care provider about symptoms, and researching symptoms or diseases in medical textbooks or on the Internet. Some clients report immediate anxiety reduction as a result of checking or reassurance seeking. They may feel a brief reprieve when they find no evidence of disease (e.g., do not find a lump during breast self-examination). Generally, this anxiety reduction is short-lived. People worry that they did not check thoroughly enough and therefore missed something important, or they may worry that something new has developed since they last checked a particular symptom. The anxiety then rebounds and the person may be tempted to check again or obtain further reassurance, perhaps from a different source.

Interestingly, many clients describe no anxiety reduction or even an increase in anxiety related to checking and reassurance seeking. However, they may believe that checking serves as a preventative strategy: "If I don't check my moles today, then I will be even more worried about them tomorrow."

Attempts to obtain reassurance from health care professionals may also be problematic. At times, the physician will send the client for extensive (and excessive) medical testing in an effort to allay the client's fears. This can have iatrogenic effects: the client may find that being sent for further investigations sets off new worries: "If the doctor is sending me for a CT scan, then I must have a serious disease that is hard to detect. My doctor obviously thinks there is something to be concerned about."

Another problem with checking and reassurance-seeking behaviors is that clients may find something that confirms their fears. For example, if a woman engages in daily breast self-examinations, she is likely at some point to find a breast lump. This discovery will have two effects: it will produce much anxiety about having breast cancer, and it will reinforce the belief that repeated checking is essential in detecting signs of disease. Checking and reassurance-seeking behaviors thus likely play a role in increasing or at least maintaining health anxiety.

Jim's checking behaviors include rubbing his forehead and his temples to see if he can detect any lumps. His body checking results in an initial decrease in his anxiety but he then experiences panicky feelings when he finds swelling around his temple. Jim seeks reassurance from his wife and considers going to the doctor to get further reassurance about his symptoms. Jim does not find his wife's calm words very helpful. He fears that she no longer takes his concerns seriously and that she automatically dismisses any health fears he shares with her.

Jennifer relies on the Internet and medical articles for information and reassurance about her MS fears. She finds this to be quite a frightening strategy because every article she reads about MS seems to include descriptions of at least one symptom she has experienced. She is also frustrated because some of the articles and Web sites have conflicting information, so she is no longer sure what information to trust.

Safety Signals

People with health anxiety may develop reliance on safety signals such as always staying within a certain distance of a hospital or physician's office, carrying a cell phone in case of medical emergency, having food or juice in a purse or bag in case of episodes of dizziness, and always carrying certain medications even though they are rarely used. Having these safety signals nearby may result in temporary reduction in anxiety for some individuals. However, reliance on these safety signals may result in decreased confidence in ability to cope with challenging situations. Clients may become very anxious if they realize that they have forgotten their cell phone or water bottle and may feel that they are putting their health at risk if they get too far away from a hospital.

Avoidance of Death and Illness-Related Situations

A common aspect of health anxiety is the avoidance of situations related to illness and death. Many individuals avoid activities like visiting friends who are ill, reading stories or watching movies about illness or death, reading the obituaries in the newspaper, and attending funerals. They may avoid thoughts about death, not have a will, and not inform family members about their funeral wishes. While individuals with health anxiety typically make excessive use of the health care system and engage in substantial checking of the body, some may avoid routine physician visits and recommended assessments. The reduction in anxiety maintains the avoidance behavior but creates several problems. Continual avoidance of illness and death-related situations erodes self-confidence and diminishes ability to cope with such situations. Many individuals find that avoidance spreads, with more and more situations causing discomfort and resulting in avoidance behaviors. Another difficulty with using avoidance as a coping strategy is that it is impossible to completely avoid reminders of illness and death. We all experience illnesses, both personal illnesses and illness in loved ones. Individuals may find that even mild conditions such as a cold or flu trigger high levels of anxiety. Experiences with death are also unavoidable. We will all lose friends and family members to death many times over the course of our own lives and we will ultimately

die ourselves. It is, impossible to read the newspaper or watch television without seeing some stories related to health or death. Similarly, it is very difficult to spend time with others without hearing anecdotes related to illness and death.

Jim began finding it very difficult to read books or watch TV shows where a character had brain cancer. As time went on, he found it more and more difficult to hear stories related to all types of tumors and cancers. He would ask his wife to turn off the TV whenever health-related news stories came on or if cancer storylines unexpectedly arose on other programs. His wife was initially understanding but began to find it annoying when Jim's anxiety meant that she had to hide in the basement to watch her favorite show after a main character was diagnosed with breast cancer.

IMPLICATIONS FOR TREATMENT

An important feature of the cognitive-behavioral model of health anxiety is that it provides clear direction for treatment. Helping clients understand how their health anxiety may have developed and how it is maintained provides an excellent basis for discussion of how the individual can intervene to disrupt the health anxiety cycle. The model thus leads smoothly to the development of a cognitive-behavioral intervention to address the individual's specific concerns. Chapters 4 and 6 of this volume outline various cognitive-behavioral approaches for health anxiety and more detailed descriptions of the principal treatment components are provided in Chapters 7–11.