Managing Health Anxiety

THE TALKING THERAPIES UK SELF-HELP SERIES



Managing Health Anxiety

An eight-module CBT programme for mild-to-moderate health anxiety, working with the cognitive patterns that maintain it while preserving appropriate engagement with genuine medical care

A self-help workbook · 8 modules · about 8 weeks

TALKING THERAPIES UK

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First edition, 2026.

This workbook accompanies the Managing Health Anxiety programme on the Talking Therapies UK self-help platform. Its text is drawn from the programme and is kept current with it: whenever the programme changes, the workbook is set again.

Revision 12. This printing was set on 15 November 2026 from the programme as it stood that day.

A note on using this workbook. It offers self-help based on established psychological approaches for difficulties of mild to moderate severity. It is not a substitute for assessment or treatment by a qualified professional and is not designed for use in a crisis. The examples in it are fictional; no real person appears in them. If you are worried about your safety, or your difficulties are getting worse, the page headed “When self-help is not enough” says where to turn.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

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How to use this workbook

Health anxiety is the experience of recurrent, excessive worry about having or developing a serious illness, when the level of concern is out of proportion to the actual medical evidence. The picture is recognisable: hours spent searching symptoms online, repeated GP appointments that produce reassurance that does not last, persistent body checking, the sense that every twinge or sensation might be the first sign of something serious, and the awareness that the worry is consuming a disproportionate amount of mental and emotional bandwidth. This eight-module programme uses the cognitive model of health anxiety developed by Paul Salkovskis at the Institute of Psychiatry in London, which is the standard CBT approach to health anxiety in clinical practice, the framework used in NHS Talking Therapies, and the basis of the most rigorously evaluated treatment protocols for health anxiety internationally. The model and the methods are well-tested; the format is self-directed rather than therapist-led. A non-negotiable framing first. The programme is explicitly for mild-to-moderate health anxiety, and explicitly not a substitute for medical evaluation of new or persisting physical symptoms. Throughout the programme, the message is consistent: when in doubt about a symptom, see your GP. The work the programme does is on the cognitive patterns that produce excessive worry about health when symptoms have already been medically assessed and do not warrant the level of concern, and on the maintenance behaviours that have been keeping the anxiety going. The Salkovskis cognitive model. The model proposes that health anxiety is maintained by the interaction of three things: catastrophic interpretation of bodily sensations (reading ordinary signals from the body as indications of serious illness), perceived inability to influence the feared outcome (the sense that nothing you can do will reduce the risk), and the maintenance behaviours that have grown up around the worry. The therapeutic work targets all three components: the cognitive interpretation, the perceived helplessness, and the behaviours. Catastrophic interpretation of body sensations. The body produces a constant stream of sensations, most of which never reach awareness. In health anxiety, attention is sharply tuned to bodily signal, and ordinary sensations are read as potentially serious: a tension headache becomes a possible brain tumour, a benign skin mark becomes a possible cancer, a normal heart rhythm variation becomes a possible cardiac event. The cognitive work identifies these catastrophic interpretations as they happen, examines whether they hold up against the actual evidence, including the medical evidence that has already been gathered, and develops more accurate alternatives. The reassurance-seeking trap. One of the most distinctive features of health anxiety is the seeking of reassurance, from doctors, from family, from internet sources, and the discovery that the reassurance produces only brief relief before the worry returns, often stronger than before. This is not a moral failing; it is a predictable feature of the way the anxiety system processes safety information. The behavioural modules work explicitly with the reassurance pattern, helping you reduce the seeking gradually while building tolerance of the underlying uncertainty. Body checking and internet searching. Two specific maintenance behaviours get dedicated attention: the repeated examination of the body (palpating, comparing, monitoring) and the searching of symptoms online. Both feel protective, both produce a brief reduction in anxiety, and both reliably increase the underlying anxiety over the longer term by sensitising attention to bodily signal and by feeding the cognitive system with worst-case material. Behavioural experiments. The behavioural work centres on structured experiments in which the predictions of

the health anxiety system are tested against actual experience: predictions about what will happen if you stop checking for a defined period, predictions about how long anxiety will last if you do not seek reassurance, predictions about the consequences of allowing uncertainty to remain rather than resolving it. The accumulation of disconfirming evidence is what shifts the underlying pattern over time. The maintenance plan. The final module is a personalised maintenance plan: the early warning signs that health anxiety patterns are reasserting themselves, the specific strategies that work for you at each level of intensity, the conditions under which further medical evaluation is the right move, and the conditions under which stepping up to therapist-led care or to a specialist health anxiety service is appropriate. Who this is for and what it is not. The programme is suitable for adults whose health anxiety has reached the point of interfering with daily life, who have had at least some medical evaluation of the specific symptoms they worry about, and who are willing to engage with the structured exposure and response-prevention work that the cognitive-behavioural approach requires. It is not appropriate for someone whose physical symptoms have not been medically assessed; the priority in that situation is medical evaluation rather than self-help work. It is not a substitute for individual therapy where health anxiety sits alongside severe depression, complex trauma, obsessive-compulsive disorder requiring its own treatment, or active suicidal ideation; the final module covers when stepping up is the right move. If you are in crisis, please contact Samaritans on 116 123, text SHOUT to 85258, or NHS 111 option 2.

This workbook is the written form of the Managing Health Anxiety programme on the Talking Therapies UK self-help platform. It follows the programme module by module: each part of the book is one module, and each chapter is one piece of the module's teaching, set in the order the programme presents it.

Read the chapters of a part in order, then turn to the worksheets that follow them. The worksheets are the part of the work that changes things, so give them the time they ask for and come back to them as the weeks go on. You may copy or print the worksheets for your own use, as often as you need.

Most people work through one module a week, which takes the whole programme about 8 weeks. Go at the pace that suits you: a module done properly is worth more than two done quickly.

The check-in questionnaires let you see how things are changing. Complete each one when you reach it, note the date and your total, and compare it with the last.

When self-help is not enough

- If you are in danger now, or have seriously harmed yourself, call 999 or go to your nearest accident and emergency department.
- If you need help urgently but it is not an emergency, call NHS 111 or contact your GP surgery.
- Samaritans are there day and night, every day of the year: call 116 123 free from any phone.
- If you would rather not talk, text SHOUT to 85258 for free, confidential support at any hour.
- If your difficulties are getting worse as you work through this book, or you find yourself thinking about ending your life, stop and speak to your GP or a mental health professional. A workbook can be a good start, and some difficulties need more help than a book can give.

What this workbook will help you to do

- By the end of this module you will:
- Understand health anxiety as a specific cognitive-behavioural picture rather than as personal weakness
- Know the difference between sensible health vigilance and clinically significant health anxiety
- Recognise the cost of unaddressed health anxiety and the case for treatment
- Have set three goals for what this programme should change
- Understand the Salkovskis cognitive model of health anxiety in working detail
- Recognise the role of misinterpretation in producing health anxiety from ordinary bodily sensations
- Know how the model identifies the points where the rest of the programme will intervene
- Have begun mapping your own version of the model from a recent health-anxiety episode
- Understand the four main maintenance cycles in health anxiety

PART 1

Understanding Health Anxiety

What health anxiety is, how it differs from sensible health concern, and the framework this programme will use

CHAPTER 1

Welcome to the programme

This is an eight-module programme for people whose lives are being shaped by health anxiety. The condition is more common than is often recognised; around 5% of adults meet the criteria for clinically significant health anxiety at some point in their lives, and many more carry health-anxiety patterns that fall short of formal diagnosis but still substantially affect how they live. The picture is recognisable: hours spent searching symptoms on the internet, repeated GP appointments that produce reassurance that does not last, persistent body checking, the sense that every twinge or sensation might be the first sign of something serious, the difficulty in fully enjoying activities because part of attention is always on monitoring the body.

The framework in this programme is the Salkovskis cognitive model of health anxiety, developed by Paul Salkovskis in the 1980s and 1990s and refined since. The model is the standard CBT approach to health anxiety and is the basis of the protocols used in NHS Talking Therapies. The evidence base is solid; randomised controlled trials consistently show substantial reductions in health anxiety and in associated GP visits and investigations, with gains that hold over the long term.

A note that needs to be made at the outset and that will recur throughout the programme. This programme is for excessive worry about health when symptoms have been medically assessed and do not warrant the level of concern, or when there are no specific symptoms but the worry is ongoing. It is not a substitute for medical evaluation of new or persisting physical symptoms. If you have a symptom that has not been medically assessed, the right action is to see your GP, not to use the techniques in this programme to manage the worry. The programme works on the cognitive patterns that produce excessive worry about health where the medical picture is clear; it does not replace medical care.

This is a fundamental boundary of the programme. CBT for health anxiety is sometimes misunderstood as instructing people to ignore symptoms or to stop seeing doctors. It is not that, and the programme will be clear about this throughout. The aim is to change the relationship with health worry where the worry has become excessive, not to reduce appropriate medical engagement. Many people with chronic health anxiety actually have less good medical care than

they should, because their relationship with healthcare is so distorted that they cannot use it effectively; learning to use medical care appropriately is part of what the programme is doing.

This first module sets out what health anxiety is, where it sits on the spectrum from sensible vigilance to clinical condition, what it costs, and what the programme will be doing across the eight weeks.

CHAPTER 2

What health anxiety is

Health anxiety is recurrent, excessive worry about having or developing a serious illness, where the level of concern is out of proportion to the actual medical evidence. The condition has been called hypochondriasis in older literature; the contemporary term health anxiety is preferred because it is less stigmatising and more accurately describes what the person is experiencing.

The spectrum

Health anxiety, like most mental-health conditions, exists on a spectrum.

Sensible health vigilance. Everyone notices changes in their body and forms judgements about whether they warrant attention. The new mole worth showing the GP. The persistent cough that needs investigation. The change in bowel habit that should be reviewed. This is normal, healthy, and important; it is not what the programme is about. Reducing this kind of vigilance would be harmful.

Health-conscious living. Some people pay more attention to their health than the average. They notice changes more carefully, attend appointments more readily, ask more questions of healthcare professionals, do more research on conditions they have or might have. This is also normal, particularly in people who have had previous serious health issues, who have family histories of significant conditions, or who simply have temperaments that engage actively with health information. It is not health anxiety.

Mild health anxiety. Some worry about health beyond what the actual evidence warrants, but not enough to substantially constrain life. The person notices ambiguous bodily sensations and worries about them more than the situation calls for, sometimes searches the internet about symptoms, occasionally seeks reassurance from doctors or family members. The worry resolves with reassurance, at least for a while. The cost is some loss of peace of mind and some time spent on health-related thinking that could be elsewhere.

Moderate health anxiety. The worry constrains life more substantially. Internet searches happen most days. GP visits are more frequent than the medical picture warrants. Reassurance from doctors works briefly but does not last. Body checking is regular. The person spends substantial mental and emotional energy on health concerns. Activities are sometimes avoided because of health worry. Quality of life is affected.

Severe health anxiety (clinical). The condition has reached the level of significant impairment. Daily life is dominated by health concerns. Multiple doctors are seen. Multiple investigations are demanded. Reassurance produces only brief relief before the worry returns, often about a different symptom or condition. The person may have what is sometimes called the doctor-shopping pattern, going from GP to specialist to second opinion without finding the reassurance that lasts. Substantial quality of life is lost. The programme is part of the picture for this level but typically needs to be combined with individual therapy.

Severe health anxiety with avoidance. A different presentation. Some people with severe health

anxiety actually avoid medical care, because the possibility of being told something serious is too frightening. They do not see GPs, do not follow up on symptoms, do not engage with healthcare. This presentation is in some ways more dangerous than the doctor-shopping version because real medical issues can go unaddressed. Self-help alone is unlikely to be sufficient.

The programme is calibrated for mild-to-moderate health anxiety

The interventions in this programme are well-suited to the mild and moderate range. People at this level can do the cognitive and behavioural work without the level of clinical support that more severe presentations need. People with severe health anxiety benefit from the framework but typically need clinician-led care alongside; the final module covers the step-up criteria.

A useful self-assessment: in a typical week, how many hours go into health-related worry, body checking, internet searching, or seeking reassurance? How much does health worry interfere with activities you would otherwise enjoy? How long do reassurance from doctors or negative test results provide actual relief? Does the worry move from one health concern to another over time? The honest answers locate you on the spectrum.

CHAPTER 3

What health anxiety costs and what the programme will do

Unaddressed health anxiety has substantial costs, and the costs are part of why treatment is worth pursuing. Naming the costs honestly helps motivate the work the rest of the programme will require.

The costs

Time. Hours per week spent on health-related thinking, searching, checking, and seeking reassurance. The hours add up over years to enormous totals; people with chronic health anxiety often calculate that they have spent the equivalent of months of their lives on the worry.

Quality of life. Activities that should be enjoyable are contaminated by health worry. The hike where you cannot enjoy the view because you are monitoring your heart. The film you cannot follow because you are worrying about the headache. The conversation you cannot be present in because you are scanning your body. The cumulative effect across years is a substantially reduced quality of life.

Relationships. Health anxiety affects relationships in several ways. Partners and family members become exhausted by the repeated reassurance seeking. Friends find the worry difficult to engage with. The person becomes self-absorbed in a way that makes intimacy harder. Some relationships end over time because of the cumulative strain.

Financial cost. Repeated medical appointments, sometimes private ones to expedite reassurance. Tests and investigations. Time off work. Travel costs. Health insurance premiums. The financial cost of severe health anxiety is substantial.

Paradoxical effect on actual health. People with chronic health anxiety often have, paradoxically, worse actual health than they would otherwise have. The chronic stress of the worry has measurable effects on cardiovascular health, immune function, sleep, and gastrointestinal symptoms. The very thing the worry was trying to prevent (poor health) is partly produced by the worry itself.

Reduced ability to use medical care effectively. Most importantly for the medical picture: people with severe health anxiety often have a distorted relationship with healthcare that makes them less able to use it effectively. The person who shows up for the same symptom every fortnight, despite repeated reassurance, is not getting good medical care; they are getting compromised care because the relationship has broken down. The doctor stops investigating thoroughly because they have done the investigations many times. The person stops trusting the reassurance because it does not last. The system becomes dysfunctional. Restoring a working relationship with medical care is one of the things the programme aims to do.

What the programme will do

The eight modules cover the ground that an evidence-based CBT-for-health-anxiety treatment covers.

Module 2 introduces the Salkovskis cognitive model in detail: how health anxiety develops and how it maintains itself once it starts. Module 3 covers the maintenance cycles in practical terms: body checking, reassurance seeking, internet searching, avoidance, and how each maintains the anxiety. Module 4 works on identifying the specific catastrophic interpretations of bodily sensations that drive the cycle. Module 5 introduces behavioural experiments, including the structured reduction of safety behaviours. Module 6 addresses body-focused attention, the way that excessive monitoring produces and amplifies the very sensations that get interpreted as evidence of illness. Module 7 covers the external sources of worry and reassurance: the internet, doctors, family members, and how to manage these in ways that support rather than undermine the work. Module 8 closes with a maintenance plan and clear step-up criteria.

The programme is the self-directed version of what an individual CBT-for-health-anxiety course would cover. It is more demanding than generic worry advice but considerably more effective for this specific picture, and the techniques are the same ones used in successful clinical treatment.

A NOTE

This message will be repeated throughout the programme because it is important. This programme is for excessive worry about health when symptoms do not warrant the level of concern, or when symptoms have already been medically assessed and the assessment has been adequate. It is NOT a substitute for medical evaluation of new or persisting physical symptoms. If you develop a new symptom, or if a symptom changes character, or if a symptom persists for more than a couple of weeks without explanation, see your GP. The work the programme does on health worry assumes that the medical picture has been or is being appropriately addressed. The programme does not aim to make you stop seeing doctors when you should; it aims to help you see doctors appropriately rather than excessively.

Emma, thirty-eight, project manager. Her father died of a heart attack at fifty-two when Emma was twenty-three. Since then she has been cardiac-vigilant; in the last two years the vigilance has crossed into health anxiety. Her cardiac investigations across the past eighteen months are all reassuring: ECGs normal, echocardiogram normal, cholesterol normal, blood pressure on the high-normal side but not concerning. Her GP has told her, kindly, that he does not need to see her again about her heart unless something changes.

Monday morning, 7.10am. Emma wakes and immediately notices her heart. The first conscious act of her day is to check her pulse at her wrist. The pulse is 72 beats per minute, which is normal. She notices that her pulse felt slightly irregular on the third beat. She checks again. The next minute it is steady. She gets out of bed and gets ready for work.

Monday, 9.40am. In her morning meeting, Emma becomes aware that her heart is beating slightly faster than usual. She estimates it at maybe 90 to 95. She knows this is within normal range during conversation. The catastrophic thought arrives anyway: what if this is a different rhythm, what if the GP missed something, what if this is the start of something. She tries to ignore it. The

meeting continues.

Monday, 11am. Between meetings, Emma opens a private browser window and searches fast heart rate during meetings woman 38. She reads three forum posts and one NHS page. The forum posts include a man whose fast heart rate turned out to be atrial fibrillation; the NHS page is reassuring but Emma reads it twice. By 11.30 she has spent twenty minutes online. She closes the browser feeling worse than when she opened it.

Monday evening, 9pm. Emma checks her pulse three more times during the evening. Each check is brief; each one confirms a normal rate. After each check she feels relief for about ten minutes, then the urge to check returns. She goes to bed and lies awake for thirty minutes listening to her heart in the silence.

Tuesday morning, 7am. Emma wakes feeling tired. She does not immediately check her pulse this morning, because she has half-promised herself yesterday that she would try to break the pattern. Within ten minutes the not-checking has become anxious enough that she checks. Normal. The pattern from Monday repeats.

Wednesday lunchtime. Emma considers booking another GP appointment. She has been telling herself for two weeks that she will not, because the GP has already told her she does not need to come back. She decides to wait one more day before booking.

Thursday afternoon. Emma's partner notices her checking her pulse during dinner. He says, kindly but with a note of strain, please can you stop doing that. Emma feels embarrassed and snaps slightly at him. They eat the rest of the meal in tense silence.

Friday morning. Emma books a private cardiology consultation for £180. She has had three private consultations in the past year. She knows, intellectually, that they have all been reassuring and that the reassurance has not lasted. The booking gives her a slight relief that she will be seen.

Across the week. Emma estimates, when she audits, that she has spent perhaps four hours on health-related thinking, checking, searching, and worrying. The actual cardiac picture has not changed in two years and is reassuring. The worry has remained essentially constant across that period despite the consistent reassurance. The pattern is what the programme works on. Module 2 begins to explain why the reassurance has not lasted, and the rest of the programme is the structured work to change the pattern.

WORKSHEET

Sort each statement along the health-anxiety spectrum

Before setting your personal goals for the programme, sort twelve statements by which of three positions along the spectrum each one represents. The distinction between appropriate health vigilance (which is normal, healthy, and should not be reduced), the mild-to-moderate health anxiety pattern (which the programme is calibrated for), and severe clinical health anxiety (which usually needs clinician-led care alongside) is the foundation for the rest of the programme; recognising which is which in other people's examples builds the recognition skill you will need when looking at your own pattern.

Sensible health vigilance is appropriate, healthy, and important: noticing changes worth investigating, attending screening appointments, asking GPs about new or persistent symptoms in

proportion to the actual medical picture. Mild-to-moderate health anxiety pattern is excessive worry beyond what the evidence warrants, with internet searching, repeated reassurance seeking, body checking, and some constraint on quality of life. Severe health anxiety (clinical) is the level of significant impairment, either with doctor-shopping (multiple GPs, demanded investigations, repeated specialist visits) or with the dangerous avoidance variant (avoiding medical care entirely because possible findings are too frightening). The programme is calibrated for the middle category; the severe category usually needs clinician-led care alongside.

The groups: A Sensible health vigilance B Mild-to-moderate health anxiety pattern C Severe health anxiety (clinical)

Write the letter of the group each item belongs to in its box.

☐ 1. Booking a GP appointment to show a new mole on my shoulder that has changed shape and colour across the past three months

☐ 2. Searching the internet about a particular bodily sensation on most days, with sessions of forty minutes or more becoming common across the past year

☐ 3. Seeing four different GPs and two private specialists in the past three months about the same symptom, demanding investigations that have already been completed, with each reassurance lasting only a day or two before the worry returns about something else

☐ 4. Attending the routine cervical screening appointment when the invitation arrives, on the same schedule as the rest of my age group

☐ 5. Avoiding the GP entirely for the past two years despite having had a symptom I should have shown them, because the possibility of being told something serious feels too frightening to face

☐ 6. Checking my pulse three or four times across a typical day, and asking my partner more than once a week whether they think my health concern of the moment is serious

☐ 7. Daily life genuinely dominated by health concerns; multiple hours per day on body checking, internet searching, or seeking reassurance, with substantial quality of life lost and most activities affected

☐ 8. Following up on the persistent cough I have had for four weeks that has not resolved on its own, by booking an appointment with my GP this week

☐ 9. A pattern of doctor-shopping across the past two years, going from GP to specialist to second opinion without ever finding the reassurance that lasts, even when investigations have been thorough and the findings clear

☐ 10. Engaging with the bowel-cancer screening kit when it arrives in the post on my fiftieth birthday, completing it and returning it within the recommended window

☐ 11. Worry about health that constrains some activities (an occasional event skipped, an occasional internet search session) but does not substantially dominate daily life; reassurance from doctors works for a while before the worry returns

☐ 12. Having dismissed the persistent change in bowel habit for the past eight months, postponing the GP appointment repeatedly, despite knowing intellectually that the change warrants investigation

The answers are at the back of the book.

WORKSHEET

Set three goals for the programme

Take fifteen minutes to set three concrete goals. Specific, observable goals work better than abstract ones; worry less about my health is too vague, go a full day without searching symptoms online is workable.

Set three goals. Specific, observable, and modest. Goals about reducing specific health-anxiety behaviours work well; goals about feeling differently are harder to measure.

Goal 1

How I will know I am making progress on Goal 1

Goal 2

How I will know I am making progress on Goal 2

Goal 3

How I will know I am making progress on Goal 3

CHAPTER 4

Closing Module 1

You have a working understanding of what health anxiety is, where it sits on the spectrum, what it costs, and the kind of work the programme will do. You have three concrete goals.

Looking ahead

Module 2 introduces the Salkovskis cognitive model in detail. The model identifies the specific mechanism by which ordinary bodily sensations get misinterpreted as signs of serious illness, the role of attention and behaviour in maintaining the misinterpretation, and the points where the rest of the programme will intervene. The model is the framework for everything that follows.

Practice for the week ahead

Notice across the week the moments where health worry activates. Note what triggered it (a sensation, a piece of news, a thought, a conversation), what the worry contained, what you did in response, how long it lasted. The point is observation; the interventions begin in module three. As before: if a new symptom or a change in symptom prompts the noticing, see your GP, do not use the noticing as a reason to delay medical care.

CHECK-IN

Mood check-in (PHQ-9)

Before you begin, take a few minutes to complete this short questionnaire. It is the same one used in NHS Talking Therapies and gives us a baseline against which to measure your progress over the programme.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3

8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Total: _____ Date: _____

Add up the numbers you have circled. A total of 0 to 4 suggests minimal symptoms of depression, 5 to 9 mild, 10 to 14 moderate, 15 to 19 moderately severe and 20 to 27 severe. Note your total and the date, so you can compare the next check-in with this one.

If you circled anything other than 0 for the last question, please talk to your GP or call NHS 111 today. If you are in danger now, call 999.

The PHQ-9 and GAD-7 were developed by Drs Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission is required to reproduce, translate, display or distribute them.

CHECK-IN

Everyday life check-in (WSAS)

And one more short questionnaire about how things are affecting everyday life: work, home, social life, relationships and leisure. Functioning often recovers on a different timetable to symptoms, and it matters just as much.

This check-in uses the WSAS (Work and Social Adjustment Scale). If you are using the online programme, complete it there, where your scores are kept and compared for you. If you are working from this book alone, your GP or therapist can give you a copy.

WORKSHEET

Taking this forward

Before you move on, take two minutes to make this module harder to lose. Skills fade fastest in exactly the moments they are needed most, so the work here is to decide now, while things are steady, what you will reach for when they are not.

If things ever feel much worse rather than better, that is a signal to reach out rather than push on alone: use the messaging button to contact the practice, speak to your GP, or if you feel unsafe right now contact 999 or the Samaritans on 116 123.

Three short answers, in your own words. First: what single idea or skill from this module do you most want to keep? Second: when, realistically, will it be hardest to use, name the actual situation. Third: what exactly will you do in that moment? Write it as a sentence you could follow when stressed.

PART 2

The Cognitive Model of Health Anxiety

How ordinary bodily sensations get misinterpreted, and how the misinterpretation maintains itself

CHAPTER 5

Why ordinary bodies produce so many sensations

A useful starting point for understanding health anxiety is the recognition that ordinary healthy bodies produce many sensations every day. The heart beats, sometimes faster, sometimes slower, sometimes with the slight irregularity that is normal in healthy hearts. The gut digests, with its various rumblings, mild crampings, occasional discomforts. The skin produces sensations of warmth, coolness, itching, the brief tingles that are part of normal nerve function. The muscles ache from the day's activity. The head sometimes hurts. The joints sometimes feel stiff. The breath is sometimes deeper, sometimes shallower. The energy waxes and wanes across the day.

Most of these sensations pass without registering. The non-anxious person experiences hundreds of bodily sensations per day and notices a tiny fraction of them; the rest occur below the threshold of attention. The body is doing its work, and the conscious mind is engaged with other things.

In health anxiety, this filtering breaks down. The sensations that would have passed unnoticed register, get attended to, get interpreted, and get connected to the possibility of serious illness. The same body is producing the same sensations as anyone else's; the difference is in how the sensations are processed.

The Salkovskis cognitive model maps the processing in detail and identifies the specific points where the processing goes from ordinary noticing to clinical health anxiety. Understanding the model is what makes the rest of the programme effective; until you can see the specific mechanism by which sensations become anxiety, the interventions look like generic worry advice rather than the targeted disruption of specific maintaining factors that they actually are.

This module covers the model, the role of early experiences in setting up vulnerability to health anxiety, and the maintenance cycles that keep the picture going day to day. The exercise asks you to map your own version of the model.

CHAPTER 6

The Salkovskis model in detail

The Salkovskis model of health anxiety identifies a specific sequence by which ordinary bodily sensations become clinical health anxiety. The sequence has several stages, each of which is a target for intervention.

Stage 1: The trigger

A trigger initiates the sequence. The trigger is usually one of three kinds.

A bodily sensation. Something the person notices in their body: a headache, a chest twinge, a lump, an unusual sensation, a change in some bodily function. The sensation can be entirely ordinary (the kinds of sensations everyone has many times per day) or can be more unusual; what matters for the model is that the person has noticed it.

External information about illness. A piece of news about a celebrity's diagnosis. A friend's relative's death. A health awareness campaign. A documentary. A conversation about someone's illness. The information triggers the sequence even when there is no specific symptom.

A memory or association. Something reminds the person of an illness or of a previous health worry. The anniversary of a relative's diagnosis. A return to a place associated with previous illness. A medical appointment for an unrelated reason that activates the broader health-related anxiety.

The trigger is something the person notices, and it may be internal or external. The noticing is selective; the same sensation that produced no response yesterday produces the full sequence today, because something about today made the sensation register.

Stage 2: Misinterpretation

Once the trigger is registered, it is interpreted. In the non-anxious person, the interpretation is typically benign: that is an ordinary sensation, that news was about someone else, that is not relevant to me. The interpretation is rapid, automatic, and resolves the situation.

In health anxiety, the interpretation is catastrophic: this sensation could be serious, this is the first sign of cancer, this might be the start of something terrible. The interpretation does not require evidence; it operates on possibility. The sensation could be the first sign; the person could be developing a serious condition; the news could be relevant. The catastrophic interpretation is the central cognitive event in the model, and it is the target for direct intervention.

The interpretation is usually held with high confidence in the moment, even when later examination reveals it to be unreasonable. The mind treats the catastrophic possibility as if it were a likely outcome rather than as one possibility among many less serious ones.

Stage 3: Anxiety and physical activation

The catastrophic interpretation triggers the body's stress response. Heart rate increases. Muscle tension rises. The sympathetic nervous system activates. The activation produces additional bodily sensations (a faster heart, sweating, gastrointestinal disturbance, headache) that are then themselves interpreted as further evidence of illness.

This is one of the central self-sustaining features of health anxiety: the very anxiety produced by the catastrophic interpretation produces additional bodily sensations, which are then interpreted catastrophically, which produces more anxiety, which produces more sensations. The cycle compounds within minutes and produces a felt experience of escalating illness that is being driven by the anxiety itself.

Stage 4: Behaviours

The catastrophic interpretation produces behaviours intended to manage the threat. Module 3 covers these in detail; the basic categories are checking (examining the body for evidence), reassurance seeking (asking doctors, family members, the internet), avoidance (not engaging with health information, not going to medical appointments), and over-investigation (demanding tests, repeated GP visits).

Each of these behaviours feels protective. Each, paradoxically, maintains the cycle. The checking produces additional bodily awareness that generates more sensations to interpret. The reassurance produces brief relief that does not last and trains the mind to require external reassurance to manage health worry. The avoidance prevents the natural processing that would otherwise reduce the anxiety over time. The over-investigation reinforces the framing of every sensation as a potential serious illness.

Stage 5: Maintenance and consolidation

The behaviours, plus the temporary relief that some of them produce, plus the cumulative effect on attention and interpretation, consolidate the cycle. Each iteration makes the next iteration more likely; the threshold for the catastrophic interpretation drops; the sensations that would have passed unnoticed before become triggers; the behavioural repertoire expands. Without intervention, the picture gradually worsens over months and years.

A NOTE

The same bodily sensations can produce different experiences depending on the interpretation. This is the central insight of the cognitive model. The chest twinge that another person experiences as a momentary muscle tension, the person with health anxiety experiences as a possible heart attack. The sensation is the same; the meaning attached to it is different; the consequences are different. The work of the programme is on the meaning, not on the sensations themselves, which are part of having a body and which cannot be eliminated.

David, forty-five, IT consultant. A close friend was diagnosed with multiple sclerosis eighteen months ago. David's health anxiety since then has been neurologically themed: any tingling, numbness, weakness, or unsteadiness gets read as a possible MS sign. He has had a neurological

assessment that found nothing. He has been told, clearly, that his symptoms are not consistent with MS. The reassurance held for about two weeks. The pattern below is a Tuesday morning two months later.

The triggering sensation. David is sitting at his desk. He has been working for about three hours. He notices a slight tingling in the fingers of his left hand. The sensation is mild; in someone without health anxiety it would barely register, or would be attributed correctly to having held the mouse in the same position for too long.

Catastrophic misinterpretation. Within five seconds, the interpretation arrives: that is the kind of tingling people describe in early MS, that is exactly what my friend described, this is what they were calling paraesthesia, my neurologist said it was unlikely but did not say it was impossible. The interpretation arrives with high credibility despite the prior medical reassurance.

Anxiety and physical activation. Adrenaline begins to release. David's heart rate rises by perhaps ten beats per minute. His breathing quickens slightly. He becomes warmer. The skin of his face flushes. These sensations themselves register. The flush is read as possibly evidence of an autonomic problem, the breathing change as possibly evidence of respiratory involvement, the elevated heart rate as possibly evidence of the systemic spread of the imagined neurological condition. The activation has produced new sensations that now also need interpreting.

Attentional shift. David's attention is now substantially on his body. He notices the position of his left hand. He moves it. The tingling diminishes for a second (because the nerve had been compressed) and then resumes when he holds the new position. The brief change is read as confirming that the tingling is dynamic, possibly intermittent in a worrying way. He becomes aware of his right hand, which feels slightly different from his left (one of the perennial features of ordinary body awareness is that the two sides feel slightly different). The difference is registered as further possible evidence.

Behaviours. David opens a private browser tab. He types early MS symptoms tingling left hand. He scrolls through five results, including the NHS page, one medical journal abstract, and three forum posts. One of the forum posts describes a woman whose MS diagnosis began with tingling in one hand. David reads the post twice. He spends fifteen minutes on the searches. He then phones his GP surgery to ask for an appointment; the receptionist offers one in nine days, which feels too far away; he asks for a phone call back today instead. He puts the phone down and notices that his anxiety has gone down slightly, because he has done something. The relief is the immediate effect of the behaviour.

Maintenance and consolidation. Across the next few hours David checks his left hand sensation perhaps twenty times. Each check, by directing attention to the hand, reproduces the sensation, which is then registered as ongoing evidence. The GP phones back at 4pm and is again reassuring; the reassurance holds for the rest of the afternoon. By 9pm David is checking again. By the next morning he has booked another private neurologist appointment.

What has happened in cognitive-model terms. A genuinely benign sensation (mild paraesthesia from sustained mouse use) was interpreted catastrophically (early MS sign). The catastrophic interpretation produced anxiety, which produced additional sensations. Attention narrowed to the body, which amplified those sensations and produced new ones. Behaviours (searching, GP contact, future appointments) produced brief relief and consolidated the framing. The next

iteration is now more likely than the last, because the threshold for the catastrophic interpretation has been lowered slightly by this episode's repetition.

The model makes the cycle visible. Once visible, each stage becomes a candidate for intervention. The rest of the programme works on the stages systematically.

WORKSHEET

Sort each fragment into the Salkovskis stage it represents

Before reading about the vulnerability factors that increase risk, sort twelve fragments by which stage of the Salkovskis model each one represents. In a real episode the stages do not arrive labelled and the cycle compounds within minutes; learning to recognise the stages in isolation is what makes the model visible when you look at your own recent episodes in the exercise that follows.

Trigger is the initiating event: a bodily sensation, external information about illness, a memory or association that has just registered. Catastrophic misinterpretation is the central cognitive event: the bodily sensation or piece of information is treated as evidence of the worst possible cause. Anxiety and physical activation is the body's stress response and the additional sensations it produces (faster heart, sweating, gut disturbance) that are then themselves interpreted as further evidence of illness. Behaviours are the responses intended to manage the threat: checking, reassurance seeking, internet searching, avoidance, demanding investigations.

The groups: A Trigger B Catastrophic misinterpretation C Anxiety and physical activation D Behaviours

Write the letter of the group each item belongs to in its box.

- [ ] 1. A small twinge in the chest, noticed while reading the newspaper at the kitchen table on Tuesday morning, the kind of sensation the body produces many times a day
- [ ] 2. This twinge could be the first sign of a heart attack starting, this is exactly the kind of thing my uncle described before his event last year, this could be the beginning of something serious
- [ ] 3. Heart rate climbing in the minutes after the catastrophic thought arrives, breath becoming shallow, a hot sensation building in the chest that is itself being noticed and folded back into the worry
- [ ] 4. Phoning the GP surgery to book an appointment for this afternoon, opening the symptom-checker website on my phone, asking my partner whether my colour looks right
- [ ] 5. Reading the news headline about the celebrity who has just been diagnosed with pancreatic cancer in her early forties
- [ ] 6. This could be relevant to me, my age is similar, my background is similar, the same condition could be developing in me right now without my knowing
- [ ] 7. The autonomic arousal that builds in the next twenty minutes after the news: tight chest, gut churning, hands cold, a sense of dread in the body that was not there fifteen minutes ago
- [ ] 8. Searching the symptoms of pancreatic cancer on three different websites in the next hour, comparing my own situation to each of the symptom lists, looking for the elements that match
- [ ] 9. A faint headache, the kind that arrives in mid-afternoon and that most adults have several times a week, registered today because something earlier had primed the worry

- [ ] 10. This headache could be the first sign of a brain tumour, what if it is one of the slow-growing ones, what if the headache has been more frequent recently and I just have not been tracking it
- [ ] 11. Heart racing, jaw tense, palms damp, the headache now feeling more pronounced because the anxiety has produced muscle tension around the temples that is being misread as the original headache worsening
- [ ] 12. Pressing my fingers along my scalp checking for tender areas, examining my pupils in the bathroom mirror to see whether they look equal, asking my partner whether I seem different today

The answers are at the back of the book.

The end of the sample

This is a free sample of “Managing Health Anxiety”, and it ends here.

Everything you have read here is from the opening of the book, set exactly as it is printed in it. The rest follows in the same way, chapter by chapter, with its worksheets, its examples and its reference list.

The full book is on sale in the Talking Therapies UK shop. A copy is yours to keep, as a PDF and an ebook, licensed to you by name: a short line saying so is printed at the foot of each page of the PDF and on the title page of the ebook.