‘One can feel well but one can never know one is well’ wrote the philosopher Kant, acknowledging his own inclination towards hypochondria. Told that he does not have an ulcer, one of Woody Allen’s neurotically anxious film counterparts simply retorts ‘they haven’t found one yet’. The hypochondriac may be in good health but remains tormented by supposed symptoms and the certainty of the illnesses to which they point. In Mark Haddon’s novel *A Spot of Bother* (2006), the central character finds a small lesion on his hip and plunges into hypochondriac panic; though diagnosed as no more than discoid eczema, he knows the spot is a fatal cancer. That tests indicate nothing wrong brings no relief to the hypochondriac; indeed, so-called health is a very doubtful state of affairs, which was Kant’s point. None of which makes hypochondriacs altogether welcome at their medical centre, arousing as they can impatience and professional unease with their unshakeable conviction that something is amiss. M, the title character of Graham Swift’s story ‘The Hypochondriac’ (1985), turns up repeatedly at his local surgery always to be reassured that all is well, until ordered never to return. Subsequently informed that M is seriously ill, his doctor delays a home visit, finally arriving to find that M has died in hospital—but of what? Autopsy reports ‘could reach no certain conclusions about the causes of M’s death’, which is a tribute to his hypochondriac identity: his hypochondria was justified and medical science failed him.

The medical term today is ‘hypochondriasis’, leaving ‘hypochondria’ as the lay term for more or less excessive health anxiety. The current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) includes hypochondriasis among the somatoform disorders, defining it as preoccupation with fears of having, or the idea that one has, a serious disease based on misinterpretation of one or more bodily symptoms. Hypochondriacal concerns may be transient, prompted by specific circumstances (bereavement, for example); equally they may appear in the course of another mental condition (depression, for example). Where the concerns are primary and continue for over 6 months, the diagnosis of the specific mental disorder can be made. The iconic figure of the hypochondriac is the imaginary invalid fearfully obsessed with his health and his doctors depicted in Molière’s comedy *Le Malade imaginaire* (1673), or in Daumier’s 1841 lithograph of a haggard-faced sufferer anxiously taking his pulse (Fig. 1). Naturally enough, hypochondria has been linked to undue fear of death; hypochondriacs, as Darwin’s grandfather Erasmus put it, are ‘attended by so much fear, or expectation, of dying as to induce them to think of nothing but their own health’.

The hypochondriac seeks reassurance, yet reassurance is felt as rejection. Doctors have accredited knowledge, but hypochondriacs know better, and come armed with information gathered from available medical or pseudo-medical sources. One of Webster’s New World Dictionary’s 2008 ‘words of the year’ was ‘cyberchondria’, meaning anxieties about common symptomatology based on internet searches. A Microsoft study of the same year found that searches for such things as headache were as likely to lead to

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**BOOK REVIEW**

**Hypochondria: medical condition, creative malady**

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**TORMENTED HOPE: NINE HYPOCHONDRIAC LIVES**

By Brian Dillon 2009.
Dublin: Penguin Ireland
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ISBN: 978-1844881345

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2010
Dublin: Penguin Ireland
Price: £8.99
ISBN: 9780141044057
pages describing serious conditions as benign ones, with a consequent escalation of unfounded medical concerns. That commercial internet services now offer individuals genome sequencing and identification of disease-causing mutations can only bring new hypochondriac possibilities. Typically, the hypochondriac multiplies consultations, doctor-shopping for the ideal physician who will take his or her condition seriously, rather than dismissing it as ‘nothing wrong’, and thereby demonstrating obvious medical incompetence. The physician must face the hypochondriac’s fears and take responsibility for deciding there is no cause for concern, with the worry that nevertheless there might be. Moreover, the risk exists of iatrogenic illness: diagnostic investigations—‘just to be sure’—may lead to induction of a disorder, reinforcing the patient’s hypochondriac convictions.

Brian Dillon’s *Tormented Hope* opens with the lived experience of the hypochondriac, written from personal knowledge. His first book, *In the Dark Room* (2005), told of an unhappy childhood, the death of both parents while in his teens and his mother’s years of pain from scleroderma. Becoming obsessed with his own health, he developed ‘a prodigious medical imagination’ and took his supposed illnesses round numerous surgeries and hospitals. In *Tormented Hope*, he turns to ‘nine hypochondriac lives’, with chapters on each to exemplify aspects of ‘the hypochondriac character’. Neither a history of hypochondria, nor an investigation into ‘what makes a hypochondriac’, the book is intended for the general reader, telling the hypochondriacal stories of James Boswell, Charlotte Brontë, Charles Darwin, Florence Nightingale, Alice James (sister of novelist Henry and psychologist-philosopher William), Daniel Paul Schreber (famously studied by Freud), Marcel Proust, Glenn Gould and Andy Warhol. Disarmingly, Dillon admits that the lives were chosen according to no exact criteria, save that their stories seemed compelling. All nine ‘wrote’ of their health, many indeed keeping meticulous records and Dillon draws on published diaries, letters, memoirs, novels, films even, as well as on existing biographies. The chapter-per-life format forbids substantial treatment, yet Dillon captures nicely the feel of these lives, mixing reflections on hypochondria with novelistish story-telling and scene-setting—recounting the precautions surrounding Proust’s breakfast croissant, or imagining the sun streaming into James’s bedroom and the fussings of her nurse when a renowned physician calls.

Hypochondria has been known as an illness for over two thousand years. First an anatomical term, the word referred (and still does) to the right and left regions of the upper lateral portion of the abdomen and the viscera situated therein (‘hypochondria’ being the plural term, ‘hypochondrium’ the singular, used for the whole area). The Greeks linked a pathology of these regions to the physiological theory of the humours and to a form of melancholia, a morbid entity with digestive symptoms caused by an abundance of ‘black bile’, the atrabile that was one of the cardinal humours of the humoral doctrine underlying ancient and medieval physiology. The Oxford English Dictionary’s first recorded anatomical use of ‘hypochondria’ in English comes from a mid-16th century physician writing of a medicine that ‘healeth flatulentnes of Hypochondria’; while the word’s use for a morbid state of mind, characterized by general depression and lowness of spirits, appears in the following century. Broadly speaking, the history of hypochondria is the movement from a physical or physiological condition to a mental or psychological one, though different kinds of explanation often overlap.

For Robert Burton in *The Anatomy of Melancholy* (1621; Fig. 2), the ‘hypocondries’ were one of the seats of melancholy. A frontispiece added to the third edition (1628) depicts the several types of the melancholic, among them Hypocondriacus shown in conventional melancholic pose, potions from his apothecary scattered around him: ‘Hypocondriacus leans on his arme/Winde in his side doth him much harme/And troubles him full sore’, as a poetic ‘Argument’ explained in subsequent editions. As expected, the ‘Causes of Hypochondriacall or Windie Melancholy’ lie in the abdominal viscera, with symptoms that include ‘sharp belchings, fulsome crudities, heat in the bowels, comely fits, turbulent dreams’ and many more. Burton’s account is from within the theory of the humours; there may be psychological effects—fear and sadness—but they stem from excess of black bile and disorder of the hypochondria. Some few decades later, Thomas Willis replaced humoral physiology with an anatomical consideration of the brain and nerves, seeing ‘hypochondriacal affects’ as being largely ‘convulsions and contractions of the nervous parts’. Physical and mental symptoms—‘distractions of the spirit’—go together. Thomas Sydenham, Willis’s contemporary, made hypochondria a matter of the ‘animal spirits’, those conducting agents between mind and body whose action could be affected by either: lack of ‘firmness’ of the spirits brings ‘disturbance and inconsistency of both mind and body’.
The 18th century saw a growth in works devoted to hypochondria and related disorders, with differing accounts of the interactions between the mental and the physical. In Bernard de Mandeville’s *Treatise of the Hypochondriack and Hysterick Passions* (1711), a long-afflicted ‘hypochondriaticus confirmatus’ with gastro-intestinal symptoms is assured that ‘disorders of the Nerves and Lownesses of the Spirits, are mechanically accounted for’ (1729), as the title suggests, regards psychological processes as the expression of events in the nerves and fibres making up the brain, this providing the basis for a ‘mechanical’ explanation of hypochondria. While Robinson is a determined somatist, the trend is towards ideas of nervous organization that suggest the influence of mind on body. For Robert Whytt in his *Observations on the Nature, Causes, and Cure of those Disorders which have been commonly called Nervous, Hypochondriac, or Hysteric, to which are prefixed Some Remarks on the Sympathy of the Nerves* (1765), nervous disorders follow from either ‘a too great delicacy and sensibility of the whole nervous system’ or ‘an uncommon weakness, or a depraved or unnatural feeling, in some of the organs of the body’. The delicate balance of fibres between the nerves and the brain forms connections and correspondences that make organs or body parts sympathetic with each other. Such ‘sympathy of the nerves’ explains how changes in the body can be produced by ‘the several passions in the mind’, hypochondria resulting from the interaction of the two, a matter, so to speak, of pathological sympathy.

Burton mentions the case of a student who believed himself made of glass and lived in fear of being shattered, a case given major literary expression in Cervantes’ novella *El Licenciado Vidriera* (1613). For Burton and others, it exemplified hypochondria as madness; as it still did two centuries later when Samuel Taylor Coleridge cited the ‘glass graduate’ in his classification of hypochondriasis as a ‘division of madness’, that of ‘being out of one’s senses’ (distinct from ‘derangement of the understanding’ ‘being out of one’s wits’). The 18th century had largely separated hypochondria from insanity; it might affect the intellectual faculties but seldom resulted in lunacy. If Samuel Johnson could talk of his hypochondria as madness, Boswell insisted it was not—‘the mind itself was ever entire’. Coleridge’s out-of-one’s-senses hypochondriasis continues, however, in the 19th-century conception of ‘delusional hypochondriasis’ linked to a disturbance of brain function. For the psychiatrist Sir George Savage (1892), hypochondria covered a disorder ‘varying from slight over-sensitiveness to insanity with marked delusions and actively suicidal tendencies’. Today DSM-IV-TR keeps hypochondriasis distinct from delusional disorders: it lacks ‘delusional intensity’, though there is ‘often a thin line between preoccupation and fear which is a conviction and that which is a delusion’.

If hypochondria is associated with a particular nervous sensibility, special qualities can be attributed to the hypochondriac. Sir Richard Blackmore, author of A *Treatise of the Spleen and Vapours: or, Hypochondriacal and Hysterical Affections* (1725), describes hypochondriacs as having ‘quick Apprehension and Vivacity of Fancy and Imagination’, as well as possessing superior intelligence (the philosopher Hume called hypochondria ‘the Disease of the Learned’). So much so that moderate forms of the condition are ‘rather desirable than hurtful’ and best not treated. Johnson thought this a foolish notion; Boswell, his biographer, agreed, while nevertheless consoling himself and his fellows with the thought that their ‘sufferings mark our superiority’. The idea was found too in the most celebrated 18th-century work, George Cheyne’s *The English Malady: or, A Treatise of Nervous Diseases of all Kinds, as Spleen, Vapours, Lowness of Spirits, Hypochondriacal, and Hysterical Distempers, &c* (1733). Intended for ‘common intelligent readers’, especially sufferers like Cheyne himself, it was something of a bestseller. Health is again a matter of ‘strong Spirits and firm Fibres’; ill health one of ‘Weakness of Nerves’, with mental disorders stemming from a somatic disorder of the nerves. Cheyne thus always focused on the hypochondria, sure to find that ‘the Stomach, Guts, Liver, Spleen, Mesentery or some of the great and necessary Organs, or Glands of the lower Belly were obstructed, knotted, schirrous, or spoil’d’. The English were notably prone to hypochondria and other such ‘distempers’ as a result of such factors as damp air and unhealthy towns, but crucially too of the wealth and abundance of the contemporary society. Everything, from rich food to the growth of ‘Contemplative and Sedentary Professions’, made for
the prevalence of nervous disorders amongst ‘People of Condition’—these disorders testifying indeed to their distinction; to their class.

Gender terms could also make a difference. Today hypochondriasis is common in both males and females. The recognition of hypochondria as a condition affecting females appeared early on, at the same time that hypochondria and hysteria were also gender differentiated, the latter continuing to be seen as particular to females. Johnson’s Dictionary (1755) conventionally defines hysteria as linked to disorders of the womb, hence female; though already a century earlier Willis had drawn the two together as disorders of the brain, while Sydenham had described them as alike ‘as one egg is to another’. In Johnson’s own century, Blackmore and Whytt considered them ‘the same malady’, though they also maintained hysteria’s relation to females, whose nervous system was ‘generally more moveable than in men’. Hypochondria was associated with males, but female hypochondriacs were recognized. Of the three hypochondriac young adults of Jane Austen’s Sanditon (1817), for example, two are female.

Treatments were various. Burton ended the ‘Anatomy’ with the precept ‘Be not solitary, be not idle’. Johnson thought the antidote was employment, though Boswell also favoured ‘the reading of lives’ and the pleasures of the metropolis. The Methodist John Wesley recommended quicksilver in the morning and elixir of vitellae and the pleasures of the metropolis. The Methodist John Wesley recommended quicksilver in the morning and elixir of vitellae as linked to disorders of the womb, hence female; though already a century earlier Willis had drawn the two together as disorders of the brain, while Sydenham had described them as alike ‘as one egg is to another’. In Johnson’s own century, Blackmore and Whytt considered them ‘the same malady’, though they also maintained hysteria’s relation to females, whose nervous system was ‘generally more moveable than in men’. Hypochondria was associated with males, but female hypochondriacs were recognized. Of the three hypochondriac young adults of Jane Austen’s Sanditon (1817), for example, two are female.

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Dillon’s lives run from the 18th to the 20th centuries. His case is that hypochondria for these individuals was ‘a kind of calling, almost a vocation’, structuring their lives in a way that allowed them time and space: ‘At once crippled and cosseted by fear, the hypochondriac suffered in order to work, to write or to discover in solitude.’ This idea of ‘creative malady’ stems originally from the book of that title by the physician Sir George Pickering, who examined the positive role of psychoneurotic illness in six talented lives (Dillon’s Darwin, Nightingale and Proust among them). Dillon narrows the focus to hypochondria, proposing the ‘ambitious, if perilous, conjecture’ of an intimate link between the health anxieties of his subjects and their creative or intellectual labours. The lives share much as regards invalidism and suffering, though the meaning, reality and evidence of hypochondria as a diagnosis shifts in each case—‘what exactly was the matter with…?’ is a recurrent—and undecided—question from life to life.

Dillon introduces his creative hypochondria thesis with the textbook example of self-diagnosed hypochondriac James Boswell. Born with ‘a melancholy temperament’, Boswell was early seized by ‘a terrible hypochondria’ with which he struggled thereafter; that he should write the life of Johnson was fitting given the latter’s own ‘vile melancholy’ and ‘horrible hypochondria’. Boswell’s melancholy came with the classic digestive symptoms, his hypochondria both a physical condition and a state of ‘disordered imagination’ to be resisted. To which end he developed what Dillon characterizes as a ‘fraught, compulsive, hypochondriac relation to time’, forever making lists and timetables, filling his days with writing commitments, including monthly essays for the London Magazine written indeed in the persona of ‘The Hypochondriack’. The obsession with time served to control his hypochondria, shaking him from lethargy; but the hypochondria itself produced the obsession, generated his literary activity.

The other lives follow apace. The young Charlotte Brontë found life ‘a continual waking Night-mare’, with no repose for her ‘morbid nerves’ (‘sensation for them is all suffering’). Hypochondria, her word, continued over the years: intense depression, headaches, dyspepsia, troubled eyesight. Her novels reflect this: the autobiographical Villette (1853), for example, has a ‘low-spirited’ heroine who is similarly diagnosed, only too familiar with ‘that strangest spectre, Hypochondria’. Dillon reads Brontë’s hypochondria as her means of removing herself from family and social duties: ‘by falling ill… she can find for herself the right kind of solitude, in which to invent her future self’. Darwin, back in England after the years on the Beagle, developed a range of symptoms, primarily gastro-intestinal, and embarked on an invalid existence. In 1849, he spent time at Dr James Gully’s fashionable Water Cure Establishment in Malvern, where his condition was diagnosed as ‘nervous dyspepsia’ consequent on excessive mental exertion and attendant bad circulation. The cold water treatment to improve circulation and relieve the inflamed nerves of the stomach was effective enough for Darwin to endure it at home, submitting to daily drenchings in his garden, despite which his ill health continued; whether or not this was psychosomatic remains a matter of debate. Darwin himself, drafting The Origin of Species and dreading public controversy, declared his work to be the cause, ‘of the main part of the ills to which my flesh is heir’, though physical conditions—notably Chagas and Crohn’s diseases—have been proposed to explain his symptoms. The point, however, is not so much physical or mental as both together: somatic conditions and psychoneurotic disorder; or strategy, since the outcome was the isolation he needed. Illness was, in Pickering’s phrase, ‘a social weapon’, shielding him from public life.

The same goes for Florence Nightingale, described by Lytton Strachey as employing the ‘machinery of illness’ against the world; by Pickering as ‘a beautiful case of a psychoneurosis with a purpose’. A young female given to depression and low self-opinion, she found her saving mission in the Crimea. Home again, she collapsed with severe cardiac symptoms, recovered, but remained depressed, afflicted by nausea, insomnia, laryngitis and palpitations. She too began years of reclusive invalidism, conducting her vigorous campaigns for hospital improvements from her bed, cut off from time-wasting social demands. If this was a strategy, she was nevertheless genuinely ill, probably suffering from chronic brucellosis, the myriad symptoms of which were easily attributable to ‘neurasthenia’. Dillon judges her ‘the most ambitious of high Victorian hypochondriacs’; saintly perhaps, but also ‘a monster of self-belief, self-delusion and expertly deployed
enfeeblement’. After which it comes as something of a surprise to find Alice James celebrated as ‘a curiously fearless kind of hypochondriac’, worried less about what might be found wrong with her than about the ministrations of her physicians, who she was pleased to record nevertheless acknowledged her ‘abnormally sensitive nervous organization’. Given which, her position as a female, and this in a family of eminent males, took its toll. Biographers see her as turning victimization into a career, expressing anger through intractable illness, which brother Henry indeed declared ‘the only solution for her of the practical problem of life’. Treated for neurasthenia, she had what she called ‘violent attacks of hysteria’ and ‘squallid indigestions’, suffered spinal pain, and saw her life as a battle between body and will. She made illness, Dillon argues somewhat awkwardly, an intellectual and artistic work ‘comparable, in the domestic sphere, with the public labours of her brothers’; her hypochondria allowed her ‘to be just ill enough not to have to face the creative and emotional void at the heart of her short life’. When finally diagnosed with cancer, she gained an end to medical uncertainties and the relief of something concrete, to which she responded with such self-possession that Dillon declares to be itself pathological.

Proust thought of writing a book about doctors, which he could well have done given the number he consulted and his distrust of them. He suffered from asthma, was hypersensitive, and intensely hypochondriac, mostly confining himself to bed in his cork-lined room. One partial exception to his distrust was the neurologist Edouard Brissaud, whom Proust did think vastly intelligent, though a poor doctor—‘[he] thinks . . . one should live on trional’. For Brissaud, author of a book on the subject, asthma was a neurosis; Proust agreed, not doubting that his asthma and other ailments were linked to his nervous disposition. Dillon concludes that through invalidism he responded to his illnesses by living them as justification for the isolation needed to write A la recherche du temps perdu, the novel whose language and matter are grounded in his hypochondriac sensitivity.

Glenn Gould and Andy Warhol shared acute hypochondria. Gould kept a diary of his imagined symptoms, noting blood pressure, digestion, flatulence, spots on the tongue, whatever his anxiety suggested. Public recitals were abandoned for the safety of his home recording studio where he could create the best environment for his work, while avoiding the health hazards of the outside world; hypochondria thus became a condition of his artistic fulfillment. Warhol, who claimed three nervous breakdowns as a child, was obsessed with his health and appearance, longing for a ‘good body’, but tormented by his ‘bad’ one, a body open to illness, infection, ageing, in which he could never feel at home. Dillon sees in his films particularly a kind of diagnosis of his ‘style of hypochondria’. In Sleep (1963), for example, Warhol’s camera-eye contemplates for over five hours a sleeping naked man, a projection on screen of the longed-for, at-one-with-itself body, the positive to the negative in the hypochondriac two-bodies split that structures Warhol’s life and art, determining their chronic concern with beauty and death.

Written testimonies aside, what these eight lives have in common are combinations of symptoms, physical illnesses and nervous conditions with psychosomatic effects, illustrating versions of ‘the hypochondriacal character’, from the hypochondria of melancholy and depression to that of acute health anxiety. But what of the ninth? Pickering had Freud as one of his lives; Dillon takes the German jurist Daniel Paul Schreber, on whose Memoirs of My Nervous Illness (1903) Freud based an analysis of him as ‘a case of paranoia’. Schreber returns us to delusional insanity, to ‘glass graduate’ hypochondria, and Freud, indeed, came to understand hypochondria not in terms of neurosis but rather in those of paranoid psychosis. Paranoiacs ‘almost invariably’ become convinced that one or more bodily organs have been assaulted or removed; a conviction Freud described as the production of an ‘organ speech’ in which organs take on the representation of the underlying unconscious material. Amongst other things, Schreber believed that his stomach had been stolen, that his spinal cord was being pumped out, and that he was being turned into a woman by God (his rigidly controlling and demanding father, object of unconscious conflicts and desires). Not that Schreber regarded his mind as anything other than perfectly healthy, save for ‘some unimportant hypochondriacal ideas’; another delusion, and one that unwittingly falls in with Freud’s insistence on hypochondria as a matter of more than a few neurotic health anxieties (DSM-IV-TR, it can be noted, recognizes a ‘monosymptomatic hypochondriacal psychosis’ among its delusional disorders). Schreber is thus different from Dillon’s other lives: his condition did not free him, it confined him in asylums. That the Memoirs are an extraordinary record of his delusional paranoia, praised for their qualities as imaginative literature—for Schreber they were quite simply the truth—does not make him another hypochondriacal character like Brontë or Gould, another instance of creative malady. The Memoirs were themselves part of the delusional condition and that condition was not strategically negotiated in the interests of some separate purposeful pursuit, was quite apart from the hypochondria that Dillon explores in his other lives.

Hypochondria has now become the lifestyle of a world in which we are forever enjoined to look good, live healthy, be happy; a world, in other words, in which we are to be permanently anxious. Dillon hails Warhol as ‘our hypochondriacal precursor’: his living in one body while longing for another gives apt enough expression of our situation in an age of media-fuelled health preoccupations and body-image vigilance. The French surgeon René Leriche famously defined health as ‘life in the silence of the organs’. Hypochondria in its historical understandings has always been an emphatic loss of such silence. What we have today is a range and diversity of hypochondriac manifestations; as clinical condition, yes, but then much more too as culturally extensive anxiety and preoccupation; to which Dillon’s book itself bears witness even while helping us through the presentation of its chosen lives better to understand hypochondria on its past and present terms.

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