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WHEN HEALTH IS AN ATTITUDINAL MATTER: A QUALITATIVE STUDY

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Running Head: **Health as an Attitudinal Matter**

When Health is an Attitudinal Matter: A Qualitative Research

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Bios

Sabrina Cipolletta, PhD, is an assistant professor in the Department of General Psychology at the University of Padova in Padova, Italy. She is the director of PsyMed, a psychology laboratory, where clinical and research activities are conducted. Her research interests focus mainly on health psychology in a constructivist perspective.

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Abstract

Health and illness are complex constructs for which a biomedical approach alone is insufficient. The purpose of the present study was to explore how personal attitudes towards health and illness affect health experience. By adopting a constructivist perspective, we carried out individual semi-structured interviews with 15 persons enrolled in a yoga class in northern Italy. We analyzed the interview data using interpretative phenomenological analysis and found that participants' attitudes toward health and wellness were linked to their experiences and perceptions of health and illness, their somatic awareness, and their constructions of themselves and of their relations. The findings point toward the importance of people taking responsibility for their health. In addition, they suggest that health care should be personalized: approaching people as a complex unity and health and illness as inextricable parts of their lives.

Key Words

constructivism; health attitude; illness experience; qualitative analysis

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Nowadays it is widely recognized that illness is closely related to social, psychological, and behavioral aspects of people's ways of life. Approximately the 50% of all morbidity and mortality causes in the United States is connected to life style, behavior and social factors (Institute of Medicine, 1982; McGinnis & Foege, 1993). For this reason understanding illness experience not only in medical terms has become a primary aim.

A constructivist perspective may be useful to this aim because it overcomes the distinction between physical or psychological illness, considering them as two different ways of reading the same unitary expression, i.e. the interacting person (Cipolletta, 2013; Varela, Thompson, & Rosch, 1991). In this article we adopt a constructivist perspective in order to understand personal attitudes towards health and illness. We start by reviewing the literature on the relationship between personal attitudes and health and later introduce the concept of somatic awareness. Personal attitudes and somatic awareness are explored in the following study within a constructivist perspective.

The effects of personal attitudes on illness experience

Several studies highlighted how persons' perceptions, attitudes, beliefs and behaviors play an important role in disease progression, recovery and even survival. Studies on immune system functioning have heightened the interrelation between psychological factors and physical aspects of illness (Dobbin, Harts, McCain, Martin, & Cousin, 1991; Esterling, Kiecolt-Glaser, Bodnar, & Glaser, 1994; Fawzy et al., 1990). Petersen, Heesacker and Schwartz (2001) have proposed that illness and recovery are affected by biological processes, but not defined by them. In fact the biological interpretation of illness is not sufficient to explain the differences among people suffering from any particular disease.

These inputs suggest how illness has not a universal meaning, but assumes different meanings according to the person who experiences it and the moment he or she is living in his

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or her life (Idler & Kasl, 1992; Justice, 1998; Kaplan, 1995; Patrick & Erikson, 1993). Many veterans diagnosed with posttraumatic stress disorder do not seek mental health care because they do not perceive themselves as having a mental problem requiring a treatment (Fikretoglu, Guay, Pedlar, & Brunet, 2008; Hoge, Auchterlonie, & Milliken, 2006), the management of psoriasis is linked to patients' own perception of disability and quality of life (Wahl & Gjengedal, 2002), and some people report good self-perceived health in the face of knowing they have a disease or disability (Justice, 1999). Attitude toward illness plays an important role in moderating the impact of illness-related stress on adjustment (LeBovidge, Lavigne, & Miller, 2005).

Furthermore, the prognosis may change according to its meaning. For example, survival from breast cancer has been predicted more by psychological adjustment than by medical criteria (S. Kreitler, H. Kreitler, Chaitchik, Shaked & Shaked, 1997). The individual's health perception better predicts the mortality than the presence of disease and it is also an indicator of the use of general health services (Idler & Kasl, 1991; Wilson & Cleary, 1995). Feeling healthy is a psychological construct influenced by both personal and cultural beliefs regarding the causes and nature of illness (Borrayo & Jenkins, 2001).

Considering the phenomenon of "disease mongering", the essential role of personal beliefs emerges once again as an influence on the disease process: over-diagnosis, obtained through screening, entails an increase of the disease incidence (Davies & Welch, 2006; Welch & Black, 2010; Welch, Schwartz, & Woloshin, 2006). For example, screening for osteoporosis and assessment of fracture risk biomedicalizes ageing and bone health, creating a new patient population (Salter, Howe, McDaid, Blacklock, & Lenaghan, 2011). The osteoporosis prevention in relatively healthy older women has been described as an approach to treating a population "at risk of being at risk" (Godlee, 2008). Consequently a risk factor becomes a disease, thereby increasing demand for tests and drugs (Alonso-Coello, Garcia-

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Franco, Guyatt, & Moynihan, 2008). Patients' perceptions of being at risk of fracture is strongly linked to whether or not they actually had been diagnosed with osteoporosis (Giangregorio et al. 2009), becoming a sort of self-fulfilling prophecy.

Somatic awareness

At a deeper level of analysis, we note that some people frequently focus on internal bodily cues and are sensitive to physiological fluctuations while others are relatively unaware of internal sensations and seem to easily neglect pain and distress (Hansell, Sherman, & Mechanic, 1991). These qualitative differences among people may be understood in terms of somatic awareness, defined as the extent of sensitivity and attentiveness to internal cues and sensations (Shields, Mallory, & Simon, 1989). Several studies have described the benefits and adaptive qualities of somatic awareness. It helps in the management of chronic disease (Mehling et al., 2009), it is connected with lower levels of somatization, eating disorders, self-objectification, depression (Bogaerts et al., 2008; Gustafsson, Edlund, Kjellin, & Norring, 2010), and with higher level of body satisfaction and responsiveness (Daubenmier, 2005; Dittman & Freedman, 2009). It is negatively associated with alexithymia (B. M. Herbert, C. Herbert, & Pollatos, 2011), and a low level of alexithymia implies a decrease of hospital convalescence days (Donati, Solano, Pecci, Persichetti, & Colaci, 2001).

Somatic awareness may produce its health benefits through the mediation of control and responsibility. A sense of responsibility can put us in a preventive position with regard to our health. For example, acquisition of knowledge about illness can reduce anxiety and allow the person to take the control of the situation and its consequences (Jerret & Costello, 1996; Pinder, 1990). In a treatment program for chronic pain, awareness and knowledge of how habits, attitudes and bodily practices are developed and established allowed changes in these modalities and also brought about pain reduction (Steihaug & Malterud, 2008). Even giving a

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name to one's illness can result in some alleviation of it because it can give the disease a place in one's own life (Van Manen, 1998).

Somatic awareness is also described as a cognitive attitude characterized by exaggerated attention to body cues, rumination, and negative beliefs about the effects of body signals (Cioffi, 1991). Heightened awareness of somatic signals can be distressing and maladaptive, as shown by several studies that indicate a link between somatic awareness and medicalization (Hansell et al. 1991), high level of anxiety (Schmidt & Telch, 1997), hypertension and cardiovascular activity (Koroboki et al., 2010; Pollatos, Traut-Mattausch, Scroeder, & Schandry, 2007; Stewart, Buffett-Jerrott, & Kokaram, 2001), intense reaction to some stimuli associated with a major neuronal activation (Herbert, Pollatos, & Schandry, 2007; Pollatos, Gramann, & Schandry, 2007), and somatosensory amplification (Bekker , Croon, & Vermaas, 2002; Spoor, Bekker, Van Heck, & Croon, 2005).

All these studies bring us to the conclusion that somatic awareness is not positive or negative in itself, as has been noted by some authors (Ginzburg, Barak, Tsur, & Defrin, 2011; Harrington & Loffredo 2007). Harrington and Loffredo (2007) observed that the private self-consciousness factors of self-reflectiveness (a person's tendency to think about oneself a lot and to constantly think of one's motivations for actions) and internal state awareness (the awareness of one's inner feelings and knowledge of how one's mind works) are linked in opposite ways with psychological well-being. Ginzburg et al. (2011) also distinguished between what they called attentiveness and sensitiveness and found out that the first was associated with hypochondriasis and anxiety, whereas the second was related to low anxiety and high self-reported health. Higher pain thresholds and lower pain catastrophizing were found among research participants with low attentiveness and high sensitiveness.

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A constructivist perspective on health and illness

This brief review of the literature has surveyed some studies on people's attitudes toward illness mostly from a cognitive theoretical point of view. In a cognitive approach somatic information and cognitive interpretation are both seen as distinct and important pieces of information and separate phenomena in their own right. They are abstracted and exist independently of their context. In contrast, in a constructivist perspective, somatic information (or any event) is not that an important and distinct phenomenon in its own right. It acquires and is given its full importance, significance, and existence to the person only when it is given some interpretation by the persons based on the context in which they are living at that moment. Likewise, illness is also a personal elaboration of the individual in comparison to a series of events whose meaning is not given, but which depends on the construction that the person makes of it. From this perspective, the search for the cause of illness takes a person-centered view that considers illness as an intentional act and a personal construction (Cipolletta & Pruneddu, 2009).

In a previous study one of us proposed that the different ways in which people experience illness depend on their ways of being and their tendency to confide in themselves or in others for help (Cipolletta, Beccarello, & Galan, 2012). The basic assumption of that study was that illness is linked to social and personal processes that govern the maintenance of our identity. These are contextualized primeval, non-verbal, and embodied processes which a person develops in relation with others. In personal construct psychology, this interdependence is named a dependency construct (Kelly, 1979a; Walker, 2005) and is involved in the personal ways we live and cope with illness (Talbot, Cooper, & Ellis, 1991) and give and receive care (Cipolletta, Shams, Tonello, & Pruneddu, 2013).

Expanding on the work of previous research, in our study we examined how personal attitude towards health and illness is related to somatic awareness and, more generally, to our

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ways of staying in relation with others. Looking for understanding rather than offering explanations, embracing rather than judging, remaining close to lived experience rather than analyzing, we choose to adopt a qualitative approach to our research (Hurwitz Greenhalgh, & Skultans, 2004; Malterud, 2001).

Method

Participants

We recruited the participants among people that, at the moment of the contact, were attending a yoga class at a yoga centre in Verona (Italy). The yoga class participation and the willingness to share one's own experience were the only two selection criteria adopted. These participants were invited to take part in the study because we thought they could offer some meaningful insight into the topic. Being in a yoga class, the participants would be more primed or cued to reflect on their body and illness experiences.

The final number of participants was not predetermined. The data collection was based on both principles of saturation, the point where variation ceases (Morse, 1993), usually when the number of interviews reaches around 15 (+/-10) (Kvale, 1996), and with regard to the maximum number of people that Interpretative Phenomenological Analysis recommends, i.e. no more than 15 (Reid, Flowers, & Larkin, 2005). In the end, the total number of participants was 15 (14 women and one man) aged between 36 and 63 (average age = 46.8).

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Data collection

The study was approved by a university ethics committee and participants signed an informed consent. All interviews were tape recorded, subsequently transcribed verbatim. To ensure confidentiality, all identifying information was removed from the transcripts prior to analysis and fictitious names were assigned.

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The aims and method of the research were first presented to potential participants. Those who accepted to participate were given an appointment with the interviewer (a researcher trained in performing clinical interviews) and freely selected the location for the interview. Twelve of the fifteen interviews were carried out in the participant's home and the rest took place in the interviewer's home.

In order to understand the world from the subjects' point of view we used semi-structured interviews (Kvale, 1996). Moving from a neutral, objective, positivist perspective to an embodied inter-subjectivity approach that dwells within researcher-participants encounters (Finlay 2005), we adopted a curious and facilitative, rather than challenging and interrogative, stance. Although conversational and flexible, the interviews followed a scheme of questions covering the themes we wanted to explore. Interviews lasted between 40 and 55 minutes, and were focused on the presence/absence of some diseases and the way the persons perceived and lived their health and illness. We also explored the persons' relations with their bodies and with other persons and their ways of coping with illness and other everyday situations. Accordingly, we explored how the persons described and construed themselves and their relationships. The interview ended with a short summary of what the interviewer understood of the participant's experience to verify the meaning of the dialogue. Just after the encounter the interviewer noted her immediate impressions about the participants' experiences. In this process the interviewer followed Burns' (2003) idea that one's embodiment does not express the truth, but expresses conditions of possibility among multiple possibilities.

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Data analysis

Interview transcripts were analyzed using interpretative phenomenological analysis (IPA). The aim of this approach is to understand how participants make sense of their experiences by

identifying recurrent themes in their narratives. IPA allows for the exploration of participants' individual perspectives and for the interpretation of the meanings that their experience holds for them, offering an insider's perspective of the phenomena (Brocki & Wearden 2006). Following the guidelines identified by Smith and Osborn (2003), two of us proceeded individually to the analysis of the transcripts through a series of steps. The first step involved a repeated reading of the transcripts to become familiar with the participants' narratives and to annotate what was significant. In the second step, recurrent themes were identified and linked to quotes that expressed the essence of their contents. Next, themes were clustered together into super-ordinate themes. Finally, we re-read all interviews to verify whether the identified themes were recognizable in the transcripts and to ensure that all salient themes had been found. Disagreements between our individual interpretations were resolved by discussion. The third author supervised all the steps of the process and revised the final themes.

At the end of this process we indentified three thematic areas:

1. Health/illness experience: How illness and health are experienced and what kind of meaning they have.
2. Body awareness: How persons live their body sensations.
3. Self-construction: How persons describe themselves and their relationships.

We grouped participants with similar experiences on each thematic area in order to identify different health attitudes.

Results

Health and illness status were referred to in many different ways in the transcripts. Somebody expressed a "perfect health status", never broken by any kind of illness. Somebody else claimed to be affected by various pathologies. People also differed from each other in the

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ways they perceived illness. A common back pain represented for someone a puzzling problem, and for someone else a manageable condition, while others did not pay attention to it at all. Again different meanings were given to illness experience: an unhappy and external event or an occasion to re-construct their whole identity, a starting point or an arrival point, or an unseen point.

With regard to the body, participants reported a general attention toward their diet, physical activities, and body signals. This attention sometimes resulted in exasperation, other times it was superficial, and sometimes resulted in their awareness of their bodily state. Thus, the construct of body awareness, when it was present, emerged in a variety of ways from a quiet sensitivity to internal sensations, to an obsession characterized by a constant monitoring of one's body in order to detect body cues. Related to the personal differences about attitudes toward body, health and illness, the motivation for starting yoga, and the way it was experienced, assumes importance and allows us to clarify the preceding thematic areas. Thus, for some participants yoga represented a personal space, for others a spiritual, or, on the contrary, a physical activity, such as aerobics. For others again it served to cure physical disease or to increase somatic awareness giving quiet to the mind.

Finally, the thematic area of self-construction was connected with the tendency to rely on one's own self or to confide in others in managing everyday events. For some participants it was difficult to admit and, consequently, express the need for help, whereas others could not step forward in their life without support. These different approaches had implications for the way to live and perceive illness, health, and for somatic awareness.

Given all these differences emerged in each thematic area, we chose to group participants on the basis of common themes or the similarities of their experiences found in the three thematic areas. In this way we identified four main attitudes toward health and illness: opportunity, denial, preoccupation and ambivalence.

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Opportunity

Five women, about forty years old, had in common similar ways to live their health, to perceive it as an opportunity, to place themselves in an active position, and to assume responsibility for what happened. Furthermore, illness did not represent a stopping point, but a starting point to become more aware and change, as one woman's words well express:

> Illness experience severely tests you. It's a terrible experience but at the same time gives you the opportunity to understand a lot of things. I have always been a closed person, I couldn't say what I really thought, I kept the things inside of me, but not because I was not honest, I feared to hurt others with my words. I was a constricted person. It is not by chance that I had a tumor just on the throat …. Now I feel better. During the illness period I have gone to a psychotherapist who helped me a lot … Illness obliged me to think, to understand, to link, to became an authentic person. "Thanks to it" I have changed the way I see my life.

This group of women considered mind and body as a unity and subsequently attributed a psychological meaning to body signals. One of them "thanks to yoga and a psychotherapy", which she defined as "an investment" in herself, became more aware of her body and "got sick less". An American woman who had been living in Italy for a long time connected her lack of familiar roots, an "American thing" that represented an "open wound" for her to actively address:.

> I don't have strong roots. Ever since I was young I changed my home many times, I spent part of my life roaming. Now that I practice Yoga, I understand that my feet and ankle problems can be connected with my life instability. For the same reason, I think, I have some difficulties with equilibrium asana. I am not planted. I physically work on this lack, because for me there is a connection between body and mind: the more you have a flexible body, the more you are a flexible person.

As regards their approach to others, the attempt to reconstruct their identities, being aware of their limits and possibilities and tackling vicious circles also by accepting change,

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was traceable in these women's stories. They could select their relationships or liked to stay in others' company, but needed time for themselves. One of them had lived a "masochistic love-story" for a long time and remained attached to her parents, mostly her father, not succeeding to break her "umbilical cord", but built a new "healthy" relationship in the last few years, and was looking for autonomy from her parents.

Denial

"I live in a normal way, I am a strong and normal person with good health", said a woman, and when she was asked if she suffered or had suffered in the past from any illness, even a little one, she surely and quickly answered: "No, I have and I had perfect health. I have never been sick." Her words well synthesize the general life attitude of four women, aged from 40 to 60, who tended to ignore their health problems, avoiding paying attention to them, or belittling body signals.

One of them, for example, suffered from back pain but she considered it a light disease that did not interfere with her life, sometimes forgetting it. She defined herself as a strong and active person and a hard worker. Her words regarding her attitude toward life and illness were significant to understand why she tended to avoid all those aspects that could undermine her identity.

> I am not afraid of age, because it is not sure that I'll live to old age. I hope only not to be affected by any sort of disease that would oblige me to be controlled by someone. All along I manage and take care of myself, and I would continue in this way until the end of my life.

Similarly two other women suffered from low back pain that they had since they were young and tended to accept the chronic disease passively, as one of them said "it is not possible to cure at all this kind of disease". She preferred to avoid attributing importance to this situation;

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she had learned "to live with it". The other woman solved the problem by minimizing and ignoring it. "I suffer from a low back pain that, after some research, I have found that involves an hernia … It is not an invalidating problem for me, when I feel pain I do not care!"

All these women used to pay attention to diet or physical activity, but did not seem to express a deeper somatic awareness. They also described themselves as hard workers, expressing satisfaction and pride at being able to work hard. They did not pay attention to their own needs and neglected their body and health. According to them, health deals with a "strong and functioning body".

> My body is strong, it is able to do many things. I am not a person who gets tired easily. I work hard, I do many different physical activities. For me it is important to have a strong and functioning body because I have many things to do.

These stories were characterized by loneliness and a difficulty with staying in a relationship or by a loss of role when a meaningful relationship ended. This is the case of a woman who lost her role of wife due to divorce and of another who edified her identity by her role of wife and mother defined as "a sort of tower of strength". One woman indicated how in her private life she tended to rely on herself, in spite of the fact that she had a few relationships, once again with her relatives: "I have some important people near me, mostly my sister, but at the end there's only you, and only you can solve your problems. My relationships are important, but I prefer to maintain a sort of distance."

Preoccupation

Two women, apparently very different from each other, shared a common health attitude. The first woman looked strong and sometimes aggressive. Her life was marked by many tragedies and serious diseases that she enumerated one after the other a few minutes after the start of the interview. She had three malignant tumors, a serious car incident, a tricky pregnancy

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following a problematic labor, and lymphatic disease during her adolescence. She recounted these experiences with a sort of aggressive impassivity against her difficult life. The second woman instead claimed to have good health, but was preoccupied with physical symptoms. She noticed every little change in her body with apprehension and anxiety, because every sign could be a possible indication of some serious disease.

> I often have a sore throat. Sometimes it happens that I dream that I lose my voice. I would like to know why I'm worried about this. I notice my body sensations and I would like to give every symptom a clear explanation.

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Anxiety emerged as her personal method for coping with life events; in the past she had a difficult period of life when she had suffered from panic attacks. She remembered them as devastating events that arrived "when you least expected," so she could not keep control.

Both women paid scrupulous attention to internal signals. They ate healthy meals, they did physical exercise, they used alternative medicine, and they made use of preventive treatments to ensure that they were healthy.

The first was a lonely woman who lived alone after her marriage ended, and she had two sons with whom she did not have a good relationship. She gave the impression that to protect herself she projected blame on others and convinced herself that it was better to "stay alone than to be in bad company". She looked at the world in terms of black and white, claiming good qualities for herself and attributing to others what she did not accept in herself. On the contrary, the second woman had a large and apparently good family and had a terrible fear of staying alone.

Ambivalence

Three women and a man, aged from 40 to 63, regarded and lived their health status in an ambivalent, and consequently problematic way. They knew their symptoms in a rational way;

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they were able to connect them to some attitudes and particular moments in their life; at the same time they could not find different ways to be and to live, they could not move toward different solutions. Using the man's words, they seemed to "make a breakthrough and then take one step back". They remained "stopped person," who lived in a sort of limbo paying attention to body signals but maintaining a defensive attitude, not going off "the beaten track". Their lives are a constellation of injuries derived from ignoring their body signals.

> For a long time I didn't care about my body. I didn't accept my limits. So my body was often broken: bones, knees, hip, I underwent three surgeries. At that time I played basketball and went on in spite of my broken articulations.

> If I think when I was twenty I had literally flagellated my body. My legs were destroyed, mostly the knees, but I continued to play volleyball until I was forced to have an operation on my legs. Now my body attitude is a little bit different. I can say that I am less of a masochist, I have learned to listen to myself.

From their narrations emerged recurrent self-descriptions as "active", "responsible" and "independent" and a common role of caring: they construed themselves as people able to satisfy the expectations of the others. However, they felt like a failure and rejected if they did not succeed in doing it because by failing to do so they provoked them pain. One man and one woman worked as critical care nurses, an occupation that defined them as "strong", that they had freely chosen to feel more satisfied because, as one of them said, "only if I work hard, I feel happy about myself". The other two women worked respectively as a physiotherapist and as massage therapist.

Discussion

Our aim was to understand the relations among the participants' attitudes toward health and illness, their somatic awareness, and the way they constructed themselves and their personal relationships. More particularly, we tried to understand the different ways of experiencing

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health and illness making use of a constructivist perspective. We proceeded with a phenomenological analysis of the interviews that was coherent with the constructivist framework because both derive their approaches from the re-construing of personal experiences. Moreover, personal construct psychology (PCP) allowed us to enlarge the results obtained through IPA because PCP offers additional diagnostic dimensions useful to understand these results.

We found that health attitudes changed according to the different ways people construed themselves, their interpersonal relationships, and social support. We also found that somatic awareness was not always positive, but that once again, it depended on how it was lived. Sometimes it implied anxiety or somatization, for others it simply meant to be conscious of one's own health status, e.g. the capacity to sense the body signs without it becoming an obsession or a worry. This observation is consistent with previous results (Harrington & Loffredo, 2007; Ginzburg et al., 2011) that highlighted how an excessive tendency to think about oneself may lead to rumination whereas the ability to sense and identify body input constitutes body awareness and favors well-being. We tried to insert these different modalities within a more comprehensive understanding of the person in order to discern why somebody chooses one modality and somebody else another. The identification of the different trajectories summarized below may be useful also to this aim.

The four trajectories of experiences and their implications for clinical and social work

In the first path of experience, illness represented an opportunity to change, to do something new through seeing new possibilities, that allowed understanding the meaning of what has happened in the participant's life and to re-construe roles. A breaking point occurred in the participant's life: cancer or psychotherapy in some cases, the end of a love affair in other cases. In that moment, rather than continuing in the usual way, the participants elaborated

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more functional alternatives. They sometimes referred to them as learning to live again, that led them to a sense of a "new me". This experience may be read in terms of aggressiveness, defined by Kelly (1955) as the active elaboration of one's own perceptual field. These women seemed to have found an equilibrium between mind and body; they had an healthy somatic awareness that allowed them to be responsible for their own well-being. Applying Ginzburg's (2011) categories we can say that they were sensitive, but not obsessively attentive, to internal signals and sensations. Finally, the relationships of these women, based on the possibility to confide in themselves and others for help, fostered self-management and personal change. As Delmar et al. (2006) highlighted, the ability to ask for help can be decisive for achieving and remaining in harmony with oneself.

This way of coping with health and illness offers health professionals the possibility to enter in a collaborative relationship that is based on the active role of both the participants in the interaction. These clients of health services actively search for a solution and trust health professionals, and thereby they may be helped by reinforcing the solution they have already found, i.e. by supporting their attempt to give meaning to their health and illness experience and to maintain an explorative attitude toward their health status.

In the second kind of experience the person ignored or minimized their health problems. Some of them described their bodies as healthy and strong and themselves as hardworking; some others, in face of an illness, did not question "more than one's due" or expressed a "don't care" about it attitude. They expressed satisfaction, happiness and pride at being able to work hard and were used to deny their needs. These women's lives were governed by constriction, defined by Kelly (1955) as the narrowing of one's own perceptual field in order to minimize apparent incompatibilities. Constriction allowed them to avoid seeing, or giving importance, to possible illness in order to maintain their core roles. The threat of becoming dependent on the assistance of others, and consequently, being an

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inconvenience to them, derives from a view of the human beings living in a liberal, individual-oriented society (Delmar et al. 2006). This was especially true for these women who would have felt ill or frail, and, consequently in need of help if they had recognized the existence of a problem. This was unbearable for them because they had based and maintained their identity as independent persons.

These women took care of their bodies with a correct diet and healthy physical activity because being healthy involves a sense of control. Thus there was an attentiveness to the external aspects of the body, the one that characterizes proprioception, i.e. "the perception of joint angles and muscles tensions, of movement, posture and balance" (Mehling et al. 2009: 2), but there was a lack of sensitiveness, which would allow them to perceive the internal sensations of the body, in accord with Mehling's idea of the interoception, e.g. the processing of sensory input from inside the body (Mehling et al. 2009). This path is similar to Ginzburg et al.'s (2011) category of disconnection, i.e. the tendency to have both low attentiveness and low sensitiveness. This is a precarious position because it may prevent people from recognizing and caring about some illness (see Cipolletta, Beccarello, & Galan 2012).

We can hypothesize a link between this path of experience and alexithymia, i.e. between externally oriented thinking and the difficulty to identify and to describe one's emotions (Herbert et al. 2011). This perceptual orientation appears to be related to the possibility of disease insurgence: the tendency to constrict appears to be a common attitude in persons with cancer (Cipolletta & Pruneddu, 2009) and in women who had a stroke and who, for the first time after the illness, experienced their bodies as dependent on health care professionals and relatives (Kvigne & Kirkevold, 2003).

People who experience health and illness in this way tend to avoid resorting to health services and usually arrive there when illness is already in an advanced stage. Sometimes they avoid caring for themselves, thus posing problems in terms of compliance. With people who

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have similar experiences, it is preferable to avoid contradicting or doubting their conviction to be strong and healthy by trying to convince them that they are not so healthy or conveying to them the message that they are lying or omitting something. It is more useful to help these people to adopt an exploratory attitude that allows them to recognize the signs of a worsening condition.

Giving to the present or the possible illness an exaggerated role in edifying one's own identity and taking advantage from the secondary gains of the illness characterized the third path. Illness allowed these participants to receive the attention and love that they expressly asked for or on the contrary they denied because their relationships were fundamentally based on dependency constructs. With regard to somatic awareness, these women tended to place both high attentiveness and sensitiveness to body signals causing rumination (Ginzburg et al 2011; Harrington & Loffredo 2007). We could define their somatic awareness as worry, but we decline to rely on the use of an imaginary or exaggerated illness as an explanation, because our attempt is to understand others' experiences without judgment. Thus we would consider the choice to be focused on their health status as a solution, the best solution that these persons found to maintain their identity.

This path of experience is the most difficult to approach because, in this case, the patients present problems that health professionals do not recognize. In these cases, perpetuating their ruinous search for a solution would be useless or even harmful. Confirming the gravity of the problem or supporting the person's choice by looking for a solution would reinforce these persons' choices and make them feel more worried than they already are. On the other hand, contradicting the person or minimizing the problem would probably generate conflict. If a solution is strongly required, it may be more useful to propose a placebo or some alternative therapies. It is also possible to suggest asking for psychological support to help the person shift his or her attention from the symptom to life. This proposal might be probably

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avoided because these patients accept with difficulty the possibility to consider their illness from a psychological point of view and assume that this means to be mad or "imaginary ill", as sometimes they experienced in treatment by health professionals. Often these patients passively wait for a solution, and then it may be sufficient to reassure them by expressing understanding of their experience and, in so doing, giving it meaning. If anxiety is considered to be the reaction of persons to something that they do not know, as Kelly (1955) defined it, giving meaning to the unknown may already be a cure.

In the last path, the persons lived their everyday illnesses in an ambiguous and problematic way. They enlarged their perceptive fields in order to consider body signals and illness. They were able to give them rational explanations, but they could not accept the possibility to change their roles, and remained in the same suffering position. We can find the reason for this attitude in these participants' adopted role of caring: they construed themselves as people able to satisfy the expectations of others and felt wrong and rejected if they did not succeed in doing it. So being ill and needing care would represent a direction that departs from this role and could not be allowed. In other words, to be sick would make them feel guilty because, according to Kelly's (1955) definition of guilt, they would have to leave their habitual role, which was construed on the basis of the self as a responsible person.

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This group of participants knew their body signs and signals but, at the same time, they neglected or abused their bodies. They also feared what these bodily signs might imply and this led them to somatization. This result is in line with Ginzburg et al.'s (2011) observation that a high attention but a low sensitiveness to body cues characterizes somatization, i.e. the tendency to focus attention on somatic signals as signs of illness.

These people may be helped to retrieve their old roles and continue to live satisfying lives if a medical solution can solve their problems. Otherwise, psychotherapy might help

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them to re-construe their personal roles in a way that would allow them to consider and integrate illness in their lives.

Before concluding, we would like to underline that the above described paths to health and illness cannot be considered to be diagnostic categories. They might rather be used as transitory constructs, namely a way of channeling clinical intervention. In fact, we think that it is possible to choose a more appropriate treatment on the basis of the understanding of the person's experience of health and illness. If people are considered to be the best experts on their lives, as a personal construct perspective does, even if they choose to ignore or exaggerate their healthy or ill conditions, we would concentrate our efforts and interventions based on understanding what they are trying to do through their bodies.

Limitations and challenges

The limits of the present study include the selected sample that was mainly composed of women in a specific geographic area and attending a yoga class. This prevented us from exploring the experiences of different people, e.g. of men, people from different geographic areas, and those who are not used to focusing on their bodies, as the practice of yoga may imply. Nevertheless, our observations may be considered to present a valid picture of the variety of health attitudes among persons living in similar contexts.

These findings were probably made possible by the approach used, its strength being precisely the exploration of personal experience. Enlarging the exploration of these fields of experiences to different populations and comparing the differences that would emerge from different cultures may be the challenge for future research.

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Conclusions

Health and illness assume different meanings in relation to the different and unique ways people give meaning to the world. Illness is a questioning act, behaviorally expressed, as Kelly (1979b) pointed out:

> My clients taught me that symptom was an issue one expresses through the act of being his self present, not a malignancy that fastens itself upon a man. What they experienced as symptoms were urgent questions, behaviorally expressed, which had somehow lost the threads that lead either to answers or to better questions. (p.19).

It is important to engage people in an active search for solutions that better fit their unique lives and experiences. Our findings point towards the importance of a respectful and collaborative orientation by health care providers towards the health concerns and life struggles of their clients.

We explored how individual attitudes toward health and illness were linked to somatic awareness and to personal ways of constructing and remaining in relationships with others. Remembering that communication first passes through the body (Salmon, 1985), and that our personal roles are constructed in the embodied interaction with others (Butt, 1998; Cipolletta, 2013), we looked at the life of the person as a whole, with illness as the aspect of particular interest, rather than use an approach that separates different aspects of the person. In this approach, illness emerges as a form of intentional communication with a peculiar meaning in participant's life. We consider intentionality as an intrinsic aspect of the person, as Kelly (1955) stated when he said that processes are psychologically channelized by the ways we anticipate events. In other words, even illness has a meaning and purpose in the life of the person. Thus, we could say that the participants intentionally lived different modes of health and illness. Intentionality implies that we cannot consider ourselves and others as shackled by nature or circumstance, but as persons who are responsible of our own being, health, and illness.

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In conclusion, the present study represents an attempt to consider health and illness as aspects of people's attitudes toward their lives and relationships, starting from a constructivist perspective. Within this perspective, the traditional division between body and mind is overcome. As a consequence, illness cannot be reduced to a disease to be cured and professionals must become aware that the people's needs are not exhausted after receiving medical assistance or surgical intervention. They can help to bring about reflective awareness of what and why modalities of body experience are disturbed and what may be done to promote meaningful and liveable relations between the embodied being and the world, as Van Manen (1998) suggests.

Further research might be conducted in order to explore the relationship between the attitudes toward health and illness we identified and specific illnesses. Moreover, longitudinal studies might allow us to explore health and illness trajectories associated with eventual changes in these attitudes derived from new life experiences or specific psychological interventions. Our aim was not to arrive at definite results, but to open the way to new questions and reflections, in line with Kelly's (1979b) idea that the best answer to a question is two better questions.

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