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'I had to go to the hospital and it was freaking me out': Needle phobic encounter space

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ABSTRACT

Recent research in the geography of health care moves beyond distributive concerns focusing more sensitively on the nature of health care settings. As part of this, a growing number of studies explore the importance of individuals' personal circumstances on their emplaced experiences and agency. Extending this line of inquiry, and drawing on ideas in emotional geographies, the current study illustrates how experiences and agency can be impacted profoundly by needle phobia. Interviews with 11 self-identifying sufferers explore the physical, emotional, behavioral and spatial manifestations of their condition. Specifically how their fear of, and reactions to, clinical objects and procedures (needles and their insertion by health professionals into the body) and health care settings (that possess the risk of encountering or host the encounters with, these objects and procedures), can combine as a single spatial affect.

1. Experience in geographies of health care

While a longstanding tradition in the geographical study of health care focuses on how resources are distributed and the consequences (see Joseph and Phillips, 1984; Eyles, 1990; Powell, 1995; Mohan, 1998), an emerging focus of research during the last fifteen years has been on the nature of health care settings, many studies engaging with broad medical, political, corporate and cultural movements that transform them over time (see Andrews and Evans, 2008). A fundamental issue in research has been how the physical form of health care institutions sends messages which affect how they are felt and regarded (often as austere, uncaring and frightening—see Kearns and Barnett, 1997). While acknowledging the considerable challenges involved in changing these perceptions, an argument has been that, through design and manipulation, clinical settings can be made more therapeutic in a holistic sense (Gesler, 2003; Gesler et al., 2004; Curtis et al., 2007; Evans et al., 2009). Meanwhile, beyond a concern for architecture and design there has been a sustained interest in research on what powerful interests feel health care settings should represent and become, and what they have done specifically to make their visions a reality (Andrews et al., 2011). In particular, studies have explained how consumerist ideology in health care creates 'consumption landscapes' (Gesler and Kearns, 2002), whereby either the market and private sector colonizes parts of public health care institutions or they, more thoroughly, embrace corporate branding and other strategies (see Kearns and Barnett, 1992, 1999, 2000; Moon and Brown, 1998; Kearns et al., 2003; Moon et al., 2005, 2006; Joseph et al., 2009).

An emerging strand of research, focused at the micro-scale, has recently complemented these interests and begun to explore how the particular characteristics and personal situations of people who frequent health care places affect their place experiences and agency and ultimately, through their interactions, create cultures of places (Gesler, 1999; Poland et al., 2005; Rapport et al., 2006; Andrews and Evans, 2008). One focus of attention in this more 'people-sensitive'/humanistic geography of health care has been on health care work; particularly how nurses contribute to the making of clinical environments (Andrews, 2006; Carolan et al., 2006). Moreover, reflecting changes in sites of service provision, scholars have focused increasingly on people's contributions to, and experiences of, care provided in the community (including homes, Dyck et al., 2005; Milligan, 2009). Substantial attention here, for example, has been paid to services provided for 'difficult to reach' populations – such as people who are homeless, alcoholic or mentally ill – their daily lives and the spatial strategies, attachments and identities involved (Pinfold, 2000; Conradson, 2003; Conradson and Moon, 2009; Wilton and Deverteuil, 2006; Parr, 2008; Curtis, 2010).

While recent research has involved a varied attempt to move beyond mapping services and understand health care far more intimately, two criticisms can reasonably be made of the geography of health care. First, despite much discussion about creating better environments and care for people, with the exception of some the aforementioned humanistic research, surprisingly few

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studies focus directly on people's experiences. Indeed, empirically the literature is more focused on general 'feelings about' places and how they are produced by structural forces, rather than on how places are felt and acted in the moment. This is a limited approach, studies viewing health care landscapes somewhat like 'texts' that can be abstracted, observed and decoded for their meaning (see Gesler, 1991; Duncan and Ley, 1993; Kearns and Barnett, 1997). Surprisingly this has been the case despite the sustained focus in health geography on 'therapeutic landscapes' (Gesler, 1992; Smyth, 2005) and their potential for understanding why people do or do not associate places with healing (for exceptions see Martin et al., 2005; Donovan and Williams, 2007; McLean, 2007). Second, only the aforementioned humanistic research recognizes that mental status plays an important part in how individuals perceive and act in relation to health care settings. However, beyond the focus there on conditions medically assessed to be 'serious', more common psychological conditions are not considered, despite the fact that they might be impactful (see Davidson, 2005). These include various forms of anxiety, social phobias and specific phobias, the most relevant of the latter group in terms of health care being pharmacophobia, iatrophobia, traumatophobia, hemophobia, mysophobia, thanatophobia and agliphobia (i.e. fears of drugs, doctors, injury, blood, contamination, dying and pain—see Bartolucci et al., 1989; Francis and Pennell, 2000; Kose and Mandiraciogulu, 2007).

To draw attention to the importance of inquiries into experiences, and also to these types of conditions, the current study considers Trypanophobia (called needle phobia from here on) and the processes through which feelings and agency towards health care places might develop in relation to it. Prior to describing the empirical study, needle phobia is introduced through a review of key research on the condition. Following this, insights provided by other fields of human geography are explored; specifically debates on fear, emotions and affect.

2. Needle phobia

From a medical perspective, needle phobia is an 'irrationally high' level of fear of clinical procedures involving the placing of needles into the body for either injecting medicines or for introducing and extracting blood (otherwise known as 'bloodwork') (Hamilton, 1995; Willemsen et al., 2002; Thurgate and Heppell, 2005). Whether or not one accepts the altogether problematic concept of irrationality (see Davidson, 2005), what is clear is that needle phobia is common. Studies indicate that up to one-quarter of the population suffers from needle phobia to some extent—estimates varying from 4% to 25% (Hamilton, 1995; Zambanini et al., 1999; Willemsen et al., 2002). In terms of etiology, one theory suggests that needle phobia is rooted in human evolution and past contexts of mortality. Commentators have observed that most deaths in human history have been caused by skin penetration by teeth, claws, hand held weapons and bullets (Willemsen et al., 2002). The argument follows that until recent decades, in generation over generation, those persons who avoided skin wounds tended to live longer lives than those who did not. Hence needle phobia is thought to be a residual inherited aversion in a proportion of the population to puncturing skin (Hamilton, 1995; Willemsen et al., 2002), an idea supported by evidence that needle phobia tends to run in families (Willemsen et al., 2002). Other explanations for needle phobia focus on it as learned behavior, originating in a previous personal adverse experience with needles or injections, or through witnessing another person, such as a parent, have an adverse experience. Another theory posits that needle phobia, like many other specific phobias, results from psychological transference (Willemsen et al., 2002). While a psychoanalytic explanation focuses on anxiety displaced from an internal drive to a neutral object that needs to be controlled (including needles), Object Relations Theory focuses on infant relationships with parents and the projection of any hateful feelings for parents onto objects (including needles) (Willemsen et al., 2002). Notably there is little agreement among academics on which of these explanations, or combinations of explanations, for needle phobia are most plausible.

In terms of experience, as Andrews and Shaw (2010) explain, on encountering a needle insertion possibility, sufferers can experience a range of physical and emotional responses including anxiety, fear, erratic heart rate, high blood pressure, increased sensitivity to pain, shock, vertigo, fainting, excessive sweating and nausea (Fernandes, 2003; Hanas and Ludvigsson, 2005). As a result they can respond behaviorally by tactically avoiding health care altogether (by not consulting a doctor on future occasions when otherwise they would have) or partially (by consulting a doctor but avoiding or refusing treatments involving needle insertion) (Zambanini and Feher, 1997; Lemasney et al., 1988; Willemsen et al., 2002; Tompkins et al., 2007). Both behaviors potentially lead to harmful health outcomes if underlying health problems remain undetected or untreated, or if public health interventions, such as vaccinations, are passed up (Nir et al., 2003; Andrews and Shaw, 2010).

Whether or not sufferers receive specialized treatment for their phobia seems to depend on a range of factors including the personal impact of their condition, their health seeking behavior (affected, for example, by factors such as confidence to disclose, perceived stigma, concern over 'overburdening' their doctor and personal views on whether it is possible to cure needle phobia), their access to services (including their chance encounters with proactive practitioners, and need or ability to travel) (Ost, 1989). If sufferers are treated, approaches offered by conventional medicine include behavioral therapy, graded exposure therapy, supportive education and anti-anxiety drugs (Willemsen et al., 2002; Thurgate and Heppell, 2005; Searing et al., 2006). Alternatively, approaches offered by the holistic medicine sector include relaxation, meditation, autogenic training and hypnosis (Dash, 1981; Lu and Lu, 1999; Willemsen et al., 2002). Whether conventional medicine or not, most of the aforementioned approaches involve the challenge of building and sustaining therapeutic relationships between carers and clients over time in the context of regular treatment sessions (Andrews and Shaw, 2010).

Despite these possibilities, the majority of sufferers of needle phobia are not treated, arriving at this situation through one of two routes. Either they seek but do not find appropriate treatment, or more often they do not seek it at all and simply live with their condition (Andrews and Shaw, 2010). Either way, when untreated sufferers present for health care in other (non-phobia) illness contexts and require injections or bloodwork, health professionals, even if aware of their condition, have only limited time and options with which to assist. Possibilities available to professionals include attempting quickly, through conversation, to develop a trusting and positive encounter, using alternatives to needles or smaller needles (Bareille et al., 1997; Kettwich et al., 2007) and distraction and diversion techniques (Gonzalez et al., 1993; Sparkes, 2001; Uman et al., 2006; Andrews and Shaw, 2010). As Andrews and Shaw (2010) suggest, none of these possibilities are long term 'cures' for needle phobia, but instead are instantaneous therapeutic strategies which are highly variable in terms of when and where they are practiced, and are rarely regulated by institutional guidelines and policies. In any case, they do nothing to change the fact that sufferers of needle of needle phobia still have to enter clinical environments and encounter their fears.