

A Case Study of Individually Delivered Mindfulness-Based Cognitive Behavioral Therapy for Severe Health Anxiety

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Health anxiety involves persistent worry about one's physical health, despite medical reassurance. Cognitive-behavioral therapy (CBT) is currently the most widely used, evidence-based treatment for health anxiety. Mindfulness-based cognitive therapy (MBCT) is an evidence-based cognitive-behavioral treatment approach that may be useful for health anxiety due to its focus on nonjudgmental awareness and acceptance of physical and emotional events. MBCT has largely been evaluated in a group format; however, the majority of outpatient CBT providers rely also on individual treatments. No research to date has examined the utility of MBCT delivered as an individual therapy for patients with health anxiety. The purpose of the current case study is to describe the delivery, acceptability, and effects of an individually delivered mindfulness-based cognitive-behavioral intervention on health anxiety symptoms for a young woman with severe health anxiety referred to outpatient behavioral medicine by her primary care provider. The treatment was a 16-session, patient-centered intervention largely delivered using MBCT techniques, supplemented by traditional cognitive-behavioral techniques. The patient completed a validated self-report measure of health anxiety symptoms (SHAI) at the beginning of each session. The treatment was found to be acceptable, as evidenced by high treatment attendance and patient feedback. The patient reported significant cognitive, affective, and behavioral improvements, including a 67% reduction in medical visits. Health anxiety scores on the SHAI showed a 52% decrease from the first to last session, reliable change index score of 12.11, and fell below the clinical cutoff at the final session, demonstrating clinical significance. These results suggest that it is feasible to adapt MBCT for the individual treatment of health anxiety, and that controlled trials of individual MBCT are warranted.

HEALTH anxiety¹ is a chronic psychological disorder that affects up to 10% of the general population (American Psychiatric Association [APA], 2000). Health anxiety involves persistent worry about one's physical health and a preoccupation with the fear of having or acquiring an illness, which persists despite medical evaluation (APA, 2013; Salkovskis, Rimes, Warwick, & Clark, 2002). Health anxiety symptoms result in significant distress and functional impairment, as individuals

either avoid medical visits entirely, or repeatedly visit medical professionals to alleviate their health concerns (APA, 2013). Among the latter, the provided reassurance only lasts until a new physical symptom develops, or it is not fully trusted at all (Lovas & Barsky, 2010). Health anxiety is unique from other anxiety disorders due to greater preoccupation regarding negative consequences of physical illness (Abramowitz, Olatunji, & Deacon, 2007) and is also distinct from anxiety due to medical conditions because illness beliefs are inaccurate or mistaken: individuals are either medically healthy, or experience anxiety that is disproportionate to their physical health status (Abramowitz, Deacon, & Valentiner, 2006). As a result of these high levels of health care utilization, health anxiety is associated with a significant social burden and increased health care costs, as well as high levels of occupational disability (Abramowitz, Deacon, & Valentiner, 2006; Barsky, Ettner, Horsky, & Bates, 2001; Creed & Barsky, 2004; Mykletun et al., 2009). Thus, there is an important need for evidence-based interventions that can effectively treat this disorder.

Cognitive-behavioral therapy (CBT) is currently the most widely used, evidence-based treatment for health anxiety

¹ Health anxiety was referred to as Hypochondriasis in the DSM-IV and is now referred to as Somatic Symptom Disorder and Illness Anxiety Disorder in the DSM-5. We use the term "health anxiety" throughout this paper for consistency with previous literature, and to encompass multiple related conditions that may benefit from a mindfulness-based approach, particularly given that these diagnostic changes are new and without established empirical support (e.g., Bailer, Kersner, Witthoft, Diener, Mier, & Rist, 2016).

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(Taylor & Asmundson, 2004; Thomson & Page, 2007). According to cognitive-behavioral conceptualizations, health anxiety results from maladaptive illness beliefs that lead to an attentional bias towards health-related cues (e.g., somatic sensations and changes), catastrophic misinterpretations of those cues, and avoidance-oriented safety-seeking behaviors (Abramowitz et al., 2006). These safety-seeking behaviors are negatively reinforced because they temporarily reduce anxiety symptoms; however, they ultimately serve to reinforce illness beliefs and maintain the health anxiety cycle by preventing experiential learning and disconfirmation of anxious thoughts (Abramowitz et al., 2006). Thus, CBT interventions for health anxiety focus on changing health-related thoughts (e.g., by estimating the probability of feared events, examining evidence for and against catastrophic thoughts), and reducing reassurance-seeking behaviors (e.g., through behavioral experiments and exposure exercises; Taylor & Asmundson, 2004). Extant research indicates that CBT produces significantly greater improvements in health anxiety symptoms, physical symptoms, and overall functioning as compared to active and no-treatment control groups (Sorensen, Birket-Smith, Wattar, Buemann, & Salkovskis, 2011; Salkovskis, Warwick, & Deale, 2003; Thomson & Page, 2007). However, studies of CBT for health anxiety have also shown relatively low enrollment rates and high attrition rates, suggesting that existing treatments are not always acceptable to patients (e.g., Barsky & Ahern, 2004; Greeven et al., 2007; Visser & Bouman, 2001).

One challenge of CBT for some individuals with health anxiety may involve the use of cognitive restructuring. For patients with health anxiety, targeting the way of relating and responding to catastrophic thoughts may be more useful than targeting the content of the thoughts themselves, given that (a) patients often hold rigid beliefs about health and illness, which do not permanently change after corrective information from health care professionals; (b) the content of thoughts can vary widely when new physical symptoms are observed; and (c) the feared outcomes often relate to events that could reasonably occur in the future, making them less amenable to restructuring (e.g., the possibility of developing cancer; McManus, Surawy, Muse, Vazquez-Montes & Williams, 2012). Thus, teaching patients to “decenter” from these catastrophic thoughts (i.e., notice them as transient mental events that are not necessarily accurate or need to be acted on), rather than challenge the content of individual thoughts specifically, may be an alternative strategy to cognitive restructuring in a CBT-based approach.

Mindfulness training is a cognitive-behavioral treatment approach that facilitates cognitive decentering and is an efficacious treatment for reducing anxiety and medical symptoms (e.g., Faramarzi, Yazdani, & Barat, 2015; Ferszt et al., 2015; Lengacher et al., 2014; Schoultz,

Atherton, & Watson, 2015). Mindfulness training involves the self-regulation of attention toward present-moment experiences with an attitude of openness, nonjudgment, and curiosity (Bishop et al., 2004). It is the process of noticing the internal or external events happening in the present moment, including noticing when the mind has wandered or become entangled with certain stimuli (e.g., maladaptive thoughts, physical sensations), and gently bringing the mind back to the moment. Mindfulness-based CBT interventions, such as Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2002), Mindfulness-Based Relapse Prevention (MBRP; Bowen, Chawla, & Marlatt, 2011), and Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1982), are group-based programs that integrate mindfulness training with traditional cognitive-behavioral principles; these interventions have demonstrated medium-to-large effect sizes for preventing relapse of depression and substance use (Segal et al., 2010; Witkiewitz & Bowen, 2010), as well as treating a range of anxiety disorders, mood disorders, and physical health symptoms (e.g., chronic pain; Chiesa & Serretti, 2011; Grossman, Niemann, Schmidt, & Walach, 2004; Hofmann, Sawyer, Witt, & Oh, 2010).

Research has recently focused on applying MBCT to health anxiety specifically. Surawy and colleagues (2015) recently provided a theoretical rationale for MBCT for health anxiety, suggesting that MBCT can reduce health anxiety by teaching patients how to develop a more accepting relationship with internal experiences and view their thoughts more objectively (i.e., cognitive decentering). The ability to notice and accept internal experiences may help individuals with health anxiety (a) become aware and accepting of bodily sensations; (b) respond to these sensations intentionally, rather than react to them automatically; (c) remain engaged in the present moment, rather than become carried away with future-oriented fears; and (d) identify early warning signs to prevent anxiety from escalating (Surawy et al., 2015). In line with this theory, the results of two recent pilot studies of MBCT (delivered as a group therapy) demonstrated significant improvements in health anxiety symptoms, which were correlated with improvements in mindfulness and maintained up to 1 year later (Lovas & Barsky, 2010; McManus et al., 2012).

These two recent pilot studies suggest the potential utility of using MBCT to address health anxiety. However, to date, there has been no examination of MBCT for health anxiety in an actual clinical practice setting, and no research using an individual MBCT approach to address health anxiety. Although it may be a likely assumption that the intervention would be feasible and acceptable in individual settings, supported by patients having voiced a preference for individualized MBCT protocols (Lau, Colley, Willett, & Lynd, 2012) and evidence to support

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