Mindfulness-based cognitive therapy (MBCT) for severe health anxiety

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Anxiety about health will affect most people at some point in their lives, but it becomes a clinically significant problem for up to five per cent of the population[1, 2]. Severe health anxiety is diagnosed in the *Diagnostic and Statistical Manual of Mental Disorders*[3] as 'hypochondriasis' or as 'hypochondriacal disorder' in the International Classification of Diseases[4]. There is ongoing debate about the usefulness of the diagnosis, as well as about whether hypochondriasis is better classified as a somatoform disorder or as an anxiety disorder[5]. As a label, the diagnosis of 'hypochondriasis' has negative connotations so it is less pejorative and more clinically useful to conceptualise hypochondriasis as severe and persistent health anxiety (HA), lying at the far end of a continuum that has mild health anxiety at its other end[6, 7].

People with HA fear that they have, or may develop, a serious disease and struggle to dismiss these fears even when they recognise that they are unrealistic. Typically they seek repeated reassurance that they are not ill from family members or medical staff, or by looking up symptoms on the internet. Others try to manage their fears through avoiding anything that triggers thoughts of illness or death (eg television programmes, hospitals, doctors). HA may focus on a single illness, such as multiple sclerosis or cancer but more often the worries include a number of possible conditions, or shift between different diseases over time. Often people who worry about their health have good reason to do so – they may have significant health problems or have lost someone close to them through sudden illness. However, excessive worry about health actually incurs health risks through receiving unnecessary invasive tests or medications, or avoiding the GP altogether, thus missing important screening tests. In addition to the personal distress and impairment, those with HA also place a significant burden on health services, utilising an estimated 41-78 per cent more health care than average per year[8].

> Charlie was in his early 50s when he developed HA. He enjoyed his job as a PE teacher and football coach and had been a keen sportsman who prized physical fitness. Charlie's HA was triggered by his brother's sudden death from a previously undetected heart condition. Around the same time his mother passed away from bowel cancer. Understandably, Charlie became concerned about his own health, and in particular his heart function. But even when he had been reassured that he did not share his brother's heart condition, and his bowel was healthy, he could not help worrying that his heart might give out at any point or a cancerous growth might be festering away inside. He gave up all exercise, avoided strenuous activity, and became hypervigilant to bodily sensations, scanning and checking his body for any warning signs of abnormal functioning. Visits to his GP just left him more anxious as he would question what the doctor really meant when he said that he was 'almost certain' that it wasn't cancer, or why he referred him for more tests if he really didn't think there was anything wrong.

Treating health anxiety

A recent review concluded that cognitive therapy, behaviour therapy, cognitive-behaviour therapy and behavioural stress management are all effective in reducing the symptoms of HA[9]. Drawing on cognitive-behavioural models of HA, CBT addresses the vicious cycles thought to be responsible for maintaining the disorder, such as hypervigilence to bodily sensations, avoidance, checking and reassurance seeking[10, 11]. However, as yet it has proven difficult to establish the superiority of CBT over other approaches to treating HA as has been demonstrated for other anxiety disorders (eg Greeven et al, 2007[12]). Furthermore, the long-term impact of CBT on HA is unclear, drop-out rates are high, and the possibility that improvements are due to non-specific factors has not been ruled out[9]. Lovas and Barsky[13] noted that, in spite of the existence of evidence-based treatments for HA, recovery rates are low and morbidity remains high. Thus, it remains a priority to explore innovative treatments to reduce the distress and interference caused by this prevalent condition.

In recent years a 'third wave' of development has been incorporated into CBT approaches. This movement shifts the focus of CBT away from challenging the content of thinking towards changing the individual's relationship with their thoughts.

Prominent among the 'third wave' approaches is mindfulness-based cognitive therapy (MBCT) which combines aspects of cognitive therapy with training in meditation[14]. Originally developed as a relapse prevention treatment for depression13, MBCT has since been successfully adapted to treat a number of other disorders[15, 16]. Initial evidence indicates that MBCT may also provide an acceptable and effective treatment for HA[13, 17, 18]. Hence, a randomised controlled trial (RCT) is currently being conducted at Oxford University's Department of Psychiatry to fully evaluate the effectiveness of MBCT for HA. This article provides an overview of what has been learnt in providing MBCT classes for people with HA.

Why might MBCT be useful for HA?

There are a number of reasons why MBCT may be beneficial for HA:

- Individuals with HA often respond to thoughts and feelings by dwelling on or worrying about their content, or trying to suppress or avoid them[11], thereby maintaining the preoccupation[19]. MBCT encourages participants to notice and 'let go' of these repetitive unhelpful response patterns. It encourages relating to thoughts and feelings as passing mental events that arise, become objects of awareness, and then pass away, thus providing an alternative to engaging in rumination, worry or avoidance.

- Those with HA tend to be hypervigilant for bodily changes and sensations which could be interpreted as signs of illness[1]. This attentional focus increases the intensity of the sensations, thus maintaining the disease conviction[20]. By enabling participants to directly experience the body as sensations come and go, rather than getting caught up in thinking about the body and what the sensations may mean, MBCT may break this cycle of HA and prevent the catastrophic interpretation and escalation of bodily sensations.

- One of the core elements of MBCT is an attitude of compassion, warmth and non-judgemental acceptance. MBCT encourages participants to approach difficult thoughts, images and feelings with compassion and curiosity. The practices foster an attitude of kindness towards the self rather than harsh judgements and self-criticism, particularly in the face of setbacks. By increasing compassion to the self in the face of negative thoughts and feelings, MBCT can reduce experiential avoidance, relieve distress and promote wellbeing and resilience[21].

- MBCT aims to reduce the likelihood of relapse by teaching participants to notice their unique early warning signs of anxiety and providing them with a set of skills which can be used to 'nip them in the bud' and prevent escalations of HA from being triggered. This may be especially useful in the treatment of HA as it is a chronic episodic condition[8].

The eight-week programme

The MBCT intervention being delivered to HA participants as part of the RCT is closely based on the MBCT programme for depression outlined by Segal, Williams and Teasdale[14]. The programme begins with an individual 'pre-class assessment' in which the MBCT teacher assesses suitability for the programme (those currently abusing drugs or alcohol and those who are actively suicidal are excluded), collaboratively develops an individual problem formulation, and provides information about what to expect during the course. The remaining sessions are delivered in a group format over eight weekly sessions of two hours each. Typically the groups consist of one experienced MBCT teacher and one less experienced clinician, with eight to 12 participants. This format and ratio facilitates the group being run more as a class rather than as a therapy session.

Sessions 1-3:

The first three sessions closely follow the structure outlined in the MBCT programme. The key focus is on learning how to pay purposeful attention in each moment, without judgement. This is achieved through teaching the meditation practices which underpin the MBCT programme: the body scan; mindful movement; sitting meditation practices; and the three- minute breathing space. In addition, participants are asked to practise the exercises for up to an hour a day between classes. Participants are taught to notice how often in daily life we do things automatically without awareness (eg eating or bathing) and are encouraged to notice how quickly the mind shifts from one topic to another. Having noted the wandering mind, participants practise returning gently but firmly to a present, single focus of the body and breath. The emphasis here is on learning to accept the mind's wandering nature whilst recognising the possibility of re-focusing attention.

Session 4:

The fourth session has more of a disorder-specific educational focus and thus is more of a departure from the original MBCT programme. This session uses cognitive-behavioural models of HA[10, 11] as a basis for discussion of the processes which maintain HA, such as worry, rumination, checking and reassurance-seeking. The triggers, thoughts, emotions and behaviours that emerge are discussed and the practice of mindfulness-based meditation is proposed as a

way of enabling people to see more clearly what is taking place in their experience, and to choose their responses rather than responding habitually or automatically.

> It's like not having an immediate panic about every slight thing that I feel … If I get a pain somewhere, or a sensation somewhere I'm still aware of it … I'm still conscious of it, but it's just much more: 'It's a sensation. It's just a pain because your body's moving.'
>
> (MBCT for HA participant 'Ruth')

Sessions 5-8:

The remaining sessions focus on encouraging participants to deliberately allow emotional and physical experiences that they find difficult (usually fear or uncertainty) to stay in awareness. The educational aspects of the course draw out how maladaptive ways of reacting to fear or discomfort, such as avoidance or trying to control the experience by analysing or seeking reassurance, may lead to vicious cycles which exacerbate the feelings. Mindfulness practices provide participants with the opportunity to experiment with alternative ways of responding to fear and discomfort. The underlying aim is to reduce emotional avoidance and facilitate emotional processing, and for participants to extend their repertoire of ways of responding to health worries. Typical HA thoughts and images are discussed and meditation practices are used to enable participants to view the thoughts or images as events in the mind, which they can choose whether or not to engage with.

> My mind isn't just me. It's got its own agenda, and it goes off down its own avenues. And I can choose whether I want to follow those avenues ... I think I feel very aware of my thought patterns and how they function, and that there are ways not to react to my thoughts, to stop the anxiety.
>
> (MBCT for HA participant 'Ajay')

The meditation practices help people to spot the start of their typical patterns of responding, to acknowledge the distress with a sense of kindness, and then to consider whether there are alternative responses available to them. As in the standard MBCT programme for depression, there is also attention paid to the participants' broader life. Reducing stress generally may have a positive impact on health worries. Participants are encouraged to take a reflective stance to their current lifestyle – to pay attention to how they are spending their time, and what impact this has on them. Paying purposeful attention to moments which are experienced as pleasant or unpleasant can illuminate how many moments of potential joy are missed when people are continually absorbed by their thoughts, or how the appraisal of the experience influences the nature of the experience. Nourishing and depleting activities are monitored and participants are encouraged to reflect on the balance of activities in their life. Giving careful consideration to how one spends time can enhance feelings of calm and a sense of control over one's life.

> I can broaden my awareness and 'catch my peripheries' – there's more … suddenly I realise that there are good things around me and I'm not so caught up in the 'uugh'!
>
> (MBCT for HA participant 'Ben')

In summary, the MBCT core values and principles remain constant whichever client group or problem focus is being worked with, but the nature of the problem will affect the way in which the approach is implemented. While many of the exercises in MBCT for HA are modelled on those used in treating depressive relapse, the focus is on HA and the rationale and educational aspects relate to the cognitive-behavioural understanding of how HA is maintained.

> Before I did the classes, if I got the pain I'd be constantly thinking... 'Is it worse if I move like this? If I move like that? What's making it bad?' You know, I'd just be moving, touching my neck all the time. And I think now, I am just sort of more accepting of it, and I think through meditating I recognise it's there, but I'm not – it's almost like I used to aggravate it.
>
> (MBCT for HA participant 'Marie', who suffered from chronic neck pain and felt that MBCT had helped her adjustment to this)

Challenges in implementing MBCT with HA

There are a number of challenges that people with HA may face during the MBCT classes. Many use avoidance to cope with anxiety, so even having to focus on the concerns is daunting in itself. Initially some may find it difficult to engage with exercises such as the body scan that highlight bodily sensations they have previously been avoiding. Idiosyncratic concerns may also be triggered by specific exercises, such as the focus on the breath for those who have concerns about breathing difficulties. There may also be fear of letting go of attempting to control one's experience, or giving up previous coping strategies that have enabled participants to get by thus far. Similarly, MBCT's focus on

staying in the present is in stark contrast to the typically future-oriented concerns of HA patients[22] and some may fear the consequences of not attending to possible future disasters, or of anxiety escalating out of control if they give up avoidant coping strategies and simply observe the sensations in the here and now.

There may also be difficulties inherent in the group format. A common theme is a sense of shame about suffering from HA and the idiosyncratic concerns and associated behaviours (eg checking of one's stools for blood). In addition attending a group with others who share their HA concerns is daunting: participants may be all too aware that hearing about the experiences and concerns of others can trigger thoughts of illness and fuel their own fears (eg 'I sometimes get a buzzing noise in my ear too but I didn't realise that it could be a sign of a degenerative disorder…'). Wattar et al[23] report having to modify their group CBT protocol in order to address this process of 'symptom sharing' triggering exacerbations of HA. However, an initial qualitative study examining participants' experiences of MBCT for HA reported that participants found the group a validating and normalising experience, from which they derived benefit[17]. This may be because MBCT is 'class-based' rather than 'group-based', meaning that the environment is more focused on learning skills rather than discussing individuals' specific HA concerns.

> [I learned] a lot about being less tough on myself, and realised that a lot of other people experience similar things.
>
> (MBCT for HA participant 'Abraham')

Overcoming the challenges

It is usually possible to work with the difficulties outlined above. One of the attractive things about the MBCT approach is that it welcomes all experience and teaches participants the skill of gradually experimenting with allowing experience to be as it is, whilst fostering an approach of curiosity and compassion, rather than judgement. The teacher goes at the pace of the participant, encouraging exploration when possible and helping them to draw back if the experience becomes overwhelming. It is important to openly acknowledge that participants may be at very different stages and need different things.

Practices can be modified according to individual need. For example, for those with concerns about breathing, the focus on the breath can be discovered gradually by starting with a focus on other sensations, such as hands on the chair. For participants who find longer practices daunting, beginning with shorter practices may be useful. There is however a balance to be struck between having the time during practices to experience all the difficulties of impatience, boredom and other challenging emotional states, and finding the practice overwhelming. In this respect, the option of reducing the duration is preferable to not practising at all.

It may also be helpful to maintain contact (eg telephone contact) between classes to privately discuss participants' current struggles or difficulties. It is important throughout to acknowledge the participants' courage in coming at all, and in persevering when difficulties arise. Indeed, it has been our experience that it is through persevering in the face of difficulties that the most useful insights are gained – it is often the practices that are initially most difficult that ultimately prove most useful and become favoured practices.

> The attitude of being kinder to myself is something that has changed, now I realise I haven't been…
>
> (MBCT for HA participant 'Shiri')

Outcomes

Initial research has provided encouraging results for the efficacy of MBCT for HA. Two pilot evaluations reported significant improvements in HA and associated symptoms following MBCT[18, 19]. In both studies the treatment gains were maintained at three-month follow-up and all participants completed the course. Additionally, both studies reported that participants experienced more widespread benefits, including an increased ability to relax, reduced anxiety in other situations, improved mood and sleep, increased self- acceptance and desire to nurture the self, a more accepting attitude to life in general, and an increased ability to cope with everyday stressors[17-19]. Whilst research exploring the use of MBCT as a treatment for HA is in its infancy, these initial findings are promising and provide the basis for larger, more rigorous, controlled trials of MBCT for HA which are currently underway. Additionally, given that there is significant variation in the response across participants, future research could usefully look at which HA patients typically benefit most (and least) from MBCT interventions.

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