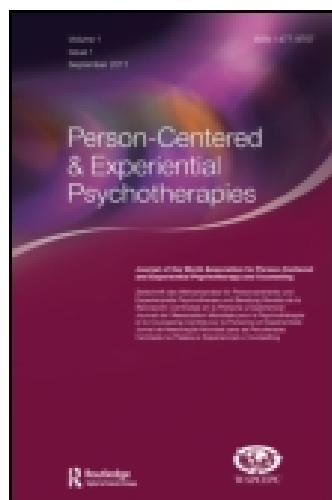


This article was downloaded by: [Swansea Metropolitan University]

On: 14 August 2015, At: 05:20

Publisher: Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: 5 Howick Place, London, SW1P 1WG



Person-Centered & Experiential Psychotherapies

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/rpcp20>

Moving on: a case analysis of process and outcome in person-centred psychotherapy for health anxiety

Kate Smith^a, Alison Shoemark^b, John McLeod^c & Julia McLeod^a

^a University of Abertay Dundee, School of Social and Health Science, Dundee, UK

^b School of Education, University of Aberdeen, Aberdeen, UK

^c Department of Psychology, University of Oslo, Oslo, Norway

Published online: 16 Apr 2014.



[Click for updates](#)

To cite this article: Kate Smith, Alison Shoemark, John McLeod & Julia McLeod (2014) Moving on: a case analysis of process and outcome in person-centred psychotherapy for health anxiety, Person-Centered & Experiential Psychotherapies, 13:2, 111-127, DOI: [10.1080/14779757.2014.886080](https://doi.org/10.1080/14779757.2014.886080)

To link to this article: <http://dx.doi.org/10.1080/14779757.2014.886080>

PLEASE SCROLL DOWN FOR ARTICLE

Taylor & Francis makes every effort to ensure the accuracy of all the information (the "Content") contained in the publications on our platform. However, Taylor & Francis, our agents, and our licensors make no representations or warranties whatsoever as to the accuracy, completeness, or suitability for any purpose of the Content. Any opinions and views expressed in this publication are the opinions and views of the authors, and are not the views of or endorsed by Taylor & Francis. The accuracy of the Content should not be relied upon and should be independently verified with primary sources of information. Taylor and Francis shall not be liable for any losses, actions, claims, proceedings, demands, costs, expenses, damages, and other liabilities whatsoever or howsoever caused arising directly or indirectly in connection with, in relation to or arising out of the use of the Content.

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden. Terms &

Moving on: a case analysis of process and outcome in person-centred psychotherapy for health anxiety

Kate Smith^{a*}, Alison Shoemark^b, John McLeod^c, and Julia McLeod^a

^aUniversity of Abertay Dundee, School of Social and Health Science, Dundee, UK; ^bSchool of Education, University of Aberdeen, Aberdeen, UK; ^cDepartment of Psychology, University of Oslo, Oslo, Norway

(Received 04 June 2013; final version received 18 January 2014)

This paper presents a systematic case-study analysis of a client who experienced debilitating symptoms of health anxiety. A substantial level of recovery was reported following five sessions of person-centred psychotherapy. Data on the process and outcome of therapy were analyzed using systematic team-based case study methodology. The main process factors that contributed to outcome included emotion processing, meaning-making, collaborative use of metaphor, and the person of the therapist. Implications for theory and practice are discussed.

Keywords: brief therapy; case study; health anxiety; Hermeneutic Single Case Efficacy Design (HSCED); person-centred; Ward method

Weitergehen: eine Fallstudie zu Prozess und Outcome bei Gesundheitsangst in einer Personenzentrierten Psychotherapie

Dieser Artikel stellt eine systematische Analyse einer Fallstudie zu einer Klient-Person vor, die behindernde Symptome einer Gesundheitsangst erlebte. Ein substantielles Niveau von Gesundheit wurde nach fünf Sitzungen mit Personenzentrierter Psychotherapie berichtet. Daten zu Prozess und Outcome der Therapie wurden analysiert mit dem Einsatz systematischer, team-basierter Fallstudien-Methodologie. Die Hauptprozessfaktoren, die zum Outcome beitrugen, beinhalteten das Verarbeiten von Emotionen, das Schaffen von Bedeutungszusammenhängen, den gemeinsamen Gebrauch von Metaphern und die Person des Therapeuten. Implikationen für Theorie und Praxis werden diskutiert.

Seguir adelante: análisis del proceso y los resultados de un caso en la psicoterapia centrada en la persona para la ansiedad

Este trabajo presenta un análisis sistemático de el caso de un consultante que experiencia debilitantes síntomas de ansiedad. Se informó un sustancial nivel de recuperación luego de cinco sesiones de psicoterapia centrada en la persona. Se analizó información del proceso y resultado de la terapia utilizando metodología sistemática basada en equipo para el estudio de casos. Los principales factores que contribuyeron al resultado incluyeron procesamiento de la emoción, construcción de significado, utilización colaborativa de la metáfora, y la persona del terapeuta. Discutimos implicaciones para la teoría y la práctica.

*Corresponding author. Email: kate.smith@abertay.ac.uk

Sur la route: une analyse de cas du processus et des résultats en psychothérapie centrée sur la personne pour l'anxiété concernant la santé

Cet article présente une analyse systématique de l'étude de cas d'un client qui fait l'expérience de symptômes débilissants d'anxiété concernant sa santé. Un résultat important est signalé après cinq séances de psychothérapie centrée sur la personne. Les données sur le processus et les résultats du traitement sont analysés en utilisant la méthodologie de l'étude de cas systématique en équipe. Les principaux facteurs de processus qui contribuent au résultat comprennent le traitement (processing) des émotions, la facilitation de l'émergence de significations, l'utilisation collaborative de métaphore et la personne du thérapeute. Implications pour la théorie et la pratique sont examinées.

Introduction

Health anxiety is defined as the persistent fear or belief that one has a serious undiagnosed medical illness. Up to 9% of patients in general medical practice and up to 5% of the general population meet diagnostic criteria for health anxiety (Creed & Barsky, 2004). People with health anxiety experience high levels of anxiety and fear responses to their perception of symptoms which are felt to indicate the presence of a serious, potentially fatal medical conditions. Formal (DSM-IV) diagnosis of health anxiety of hypochondriasis requires symptoms to have occurred over a period of more than 6 months (Magarinos et al., 2002). Within this "chronic" group recovery rates, even with treatment, are only around 30–50% (Olde Hartman et al., 2009). While treatment options include pharmacological anxiolytic and anti-depressive treatments, people who experience health anxiety have been found to prefer psychological rather than medical treatments (Walker et al., 1999).

The most widely used psychological treatments for health anxiety are based on cognitive and behavioral models (Warwick & Salkovskis, 1990). In a systematic review of controlled studies of the outcome of psychotherapy for health anxiety, Thomson and Page (2007) found the strongest evidence for the effectiveness of CBT, but noted important limitations within the existing literature, such as the possibility that client gains may have been due to nonspecific factors (regular contact with a therapist, for example), and the lack of long-term follow-up data. These issues were addressed in a recent trial carried out by McManus et al. (2012), in which encouraging results were found in CBT group therapy for health anxiety which included an additional element of mindfulness training. Williams et al. (2011) conducted qualitative interviews with clients who had taken part in the McManus et al. (2012) study, and found that positive outcomes were associated with specific mindfulness activities.

In an important early study, Kellner (1982) reported on 36 patients treated using an integrative model of individual psychotherapy, based on the use of a range of intervention strategies. Kellner (1982) argued that acceptance and empathy for the patient experience was reported to be important by several of the participants in this study. These findings suggest that a therapeutic relationship characterized by empathy, understanding and acceptance may be significant to people seeking help for health anxiety. At the present time, there is an absence of research into the role of person-centered and experiential approaches to psychotherapy in the field of health anxiety. However, there is some evidence for the efficacy of such approaches to psychotherapy in relation to the treatment of other anxiety disorders, such as social anxiety (Elliott, 2013).

The present study reports on the process of brief person-centred psychotherapy for a female client with long-term health anxiety. An intensive case study analysis was carried

out in order to examine in detail the processes that contributed to outcome, as a means of developing a preliminary model of person-centered psychotherapy for health anxiety that could be further refined and tested in subsequent research.

Method

The study made use of two methods of systematic single-case analysis: Hermeneutic Single Case Efficacy Design (HSCED) (Elliott, 2002), and the Ward method (Schielke et al., 2009). Multiple sources of data, quantitative and qualitative, were collected from each session throughout the course of therapy and assembled into a rich case record that was analyzed using procedures that ensured that alternative interpretations of the data were opened up for critical debate and dialogue.

The client

The client, Theresa, was aged 35 at the time of entering therapy. She had completed college-level education, and had a successful career as head of administration in a busy law office. Theresa had a son, Colin, age 5, who had just started school. In the year before entering therapy, there had been a period of separation from her partner, Alan – at the time of therapy he had only just returned to live with Theresa. Relationships with her mother, sister and other family members were reported as supportive and close. All names and identifying information have been altered to ensure confidentiality.

The therapist

The therapist (second author) is an accredited person-centered psychotherapist, supervisor and trainer with more than 25 years experience, with a prior background in nursing.

The therapy intervention

The therapist predominantly used a person-centered approach (Thorne et al., 2013) that highlighted the use of the core conditions of empathy, acceptance and congruence to create a relationship within which the client could begin to explore previously denied aspects of self. The therapy approach was influenced by a pluralistic model of practice (Cooper & McLeod, 2011) that emphasized the construction of a collaborative relationship between therapist and client, in which both work together to identify tasks and methods which can help the client work towards their goals for therapy. A pluralistic stance highlights the significance of the client's view on what is helpful and not helpful in therapy, with the result that meta-communication (Rennie, 1998) and the elicitation of client feedback are distinctive features of the approach. Therapist adherence to person-centered principles was confirmed by analysis of segments of session recordings using the Person-centred and Experiential Psychotherapy Scale (Elliott et al., 2012, Freire & Grafanaki, 2010; Hill, 2011). The therapeutic approach can be considered to be person-centered within a pluralistic framework, as potentially other methods of counseling could be used, and the therapy itself was guided by client feedback and the negotiation of goals (Cooper & McLeod, 2011). Therapy took place in a no-cost community counseling clinic (the Tayside Centre for Counselling) based in purpose-built premises within Abertay University. Each therapy session was 55 minutes in duration.

Procedure

Theresa had been advised to enter therapy by her GP (family doctor), who sent a referral form to the Tayside Centre for Counselling, and provided her with a leaflet about therapy. Theresa was then contacted by the center manager, who invited her to attend an initial meeting to discuss what was involved in therapy. This assessment meeting lasted for about 90 minutes, and encompassed a range of issues: collecting information about the client's personal and family life, health status and social network; identifying the goals of therapy; what was involved in therapy; discussing involvement in the research project; reviewing preferences around therapy approaches; explaining arrangements for appointment-making. Theresa was then given a first appointment with a therapist (who was not the person who had conducted the assessment interview). At the beginning and end of each therapy session, the client completed a set of brief questionnaires, to monitor perceptions of therapy and to track on-going change (see details below). The therapist reviewed the questionnaire responses during each session, and invited Theresa to reflect on this information in whatever way she felt was appropriate at that point.

Ethical considerations

The project received ethical consent from the University Research Ethics Committee and local Health Service Research Ethics Committee. Both client and therapist completed ethical consent procedures before therapy commenced. The client was given an information sheet at the pre-therapy meeting and agreed that information could be collected and used in a case study. Each session was recorded with the client's consent and she was informed that she could switch off the recorder at any point. Data were stored in a password protected file in a locked office.

Measures

The client completed a number of quantitative and qualitative measures at each therapy session.

Clinical Outcomes Routine Evaluation – Outcome Measure 34 (CORE – OM 34)

A self-completed scale, yielding four sub-scales (well-being, psychological symptoms, functioning and risk) and total score; it has been validated and widely used in research into the outcomes of counseling and psychological therapies (Evans et al., 2000).

Goals/Target Complaints Rating (TC)

A self-completed form through which clients describe up to three problems for which they are seeking help, and rate each of them on a ten-point scale of severity (Deane et al., 1997).

Working Alliance Inventory – Short Form (WAI-SR)

A self-completed 12-item scale which measures three dimensions of the relationship between counselor and client: bond, task and goal (Hatcher & Gillaspy, 2006).

Helpful Aspects of Therapy (HAT) form

A two-page instrument, in which the client is invited to describe the most helpful and most hindering events that took place during the preceding counseling session (Llewelyn, 1988). In addition, further case data were collected through the following instruments:

Client Pre-Counseling Interview (CPCI). A semi-structured interview, conducted prior to entering counseling, that explored: (a) reasons for seeking counseling/description of problems; (b) previous assistance sought for problems; (c) length of time suffered from problems; (d) theory of change: “what do you believe will help you best with the difficulties and problems you have at present?”; (e) social network/participation in social life/use of community resources – family, work, other (leisure, religion, etc); (f) feelings about taking part in research; and (g) perceptions of the counseling center environment.

Change Interview. A semi-structured counseling follow-up interview, widely used in counseling and psychotherapy case study research. It invites the client to identify changes that have occurred as a result of counseling, and to explore the extent to which these outcomes might have occurred in the absence of therapy. Further questions invite the client to identify helpful and hindering aspects of the therapy (Elliott et al., 2001).

Structured therapist session notes. The therapist made a weekly record of the themes and issues addressed in therapy, helpful factors and events, and evaluated overall progress.

Therapist interview. The therapist was interviewed by a member of the research team, around her experience of working with Theresa. This interview was recorded and transcribed.

Session recordings. All therapy sessions were recorded and transcribed.

Data analysis was based on scrutiny of a bound volume that contained all the information that had been collected on the case.

Data analysis

The analysis of the information collected on this case focused on two questions: (i) what was the outcome of therapy?, and (ii) what was the process of therapy: were there specific therapeutic factors that could be identified as contributing to change? The procedures for data analysis were informed by the principles of systematic case-based inquiry identified by McLeod (2010). In particular, a rich case record was constructed that was analyzed by multiple researchers who were mandated to generate as wide as possible a range of interpretations of the case, and to engage in dialogue with the objective of arriving at a reasoned consensus. The issue of outcome was primarily addressed through the use of a modified Hermeneutic Single Case Efficacy Design (HSCED, Elliott, 2002) procedure, while the identification of helpful factors and therapy process was primarily addressed using the Ward method (Schielke et al., 2009). However, both analytic strategies generated valuable insights in respect of both research questions.

The HSCED procedure, developed by Elliott (2002), is a method for systematic critical interpretation of single case data, in order to determine the level of confidence with which the case can be considered as a good or poor outcome. A central aspect of this method is the adoption of a quasi-judicial perspective, in which independent arguments are constructed from an affirmative stance (the client benefitted from therapy and these gains can be attributed to the action of therapy) and a sceptic stance (the client did not benefit, and/or any gains can be attributed to factors other than therapy). In this study, a 6-hour workshop was held in which 16 experienced psychotherapy researchers worked in small groups to assemble affirmative and sceptic readings of the case, and then compose rebuttals. Three further psychotherapy researchers, reflecting different theoretical orientations, acted as observers during the workshop and provided judgements at the end of the event regarding their views around the confidence with which the case could be described as a good or poor outcome.

The Ward method (Schielke et al., 2009) offers a structure for democratic, person-centered group problem-solving. A small team is provided with fixed terms of reference (in this instance, to arrive at an agreed analysis of the process of therapy within this case). Each member of the team independently develops a response to the brief (that being the response to the research aims and guidelines, i.e. what they were asked to do, for example, a response to the question of whether the outcome of counseling was good), and presents it in the group. There is no debate within the group – only questions of clarification are allowed. The members of the group then work independently on revised individual responses, that take into account the ideas presented by other members. These versions are then presented to the group. This sequence continues until a sufficient level of agreement has been reached. In the present study, a team of three members was convened (the first three authors, KS, JM and AS), with one member (KS) taking responsibility for keeping a record of what was discussed. Three iterations of the cycle were required, with a period of around 3 weeks between each meeting.

The researchers

The study was carried out by the first three authors, Kate Smith, a post-graduate counseling student, and John McLeod, Professor of Counseling both of Abertay University, and Alison Shoemark, a lecturer in counseling at Aberdeen University, the latter each having over 20 years of counseling experience, the former having 2 years.

Results

The findings of the case analysis are presented in the following sections. An overview of the case is presented, in terms of a brief account of the situation in Theresa's life when she began therapy, and a summary of what happened in each session. This contextualizing information provides a backdrop for more detailed analysis of outcome and process.

The situation at the start of therapy

Theresa presented as an attractive, well-organized and professionally successful woman who was undergoing a period of severe crisis in her life. She had a satisfying family life, good health, and no reported issues in areas such as alcohol and drug misuse, eating disorders, debt or suicidality. Alongside these strengths and accomplishments, Theresa described an adult life that had been at times significantly affected by periods of severe anxiety. Over the previous decade, she had received medication for anxiety problems and depression on at least two occasions, and a brief course of counseling on one further occasion. Since the birth of her son, 5 years earlier, these anxieties had centered on the belief that she had developed life-threatening illnesses that would lead to an early death and leave her son alone in the world. The intensity of these worries was exhausting and had resulted in panic attacks and paramedical attention. In the period before beginning therapy, Theresa had consulted her GP on a range of ailments and symptoms that she believed to be signs of cancer or heart disease. The GP had prescribed anti-depressant medication, which Theresa had commenced 4 months before the referral for therapy. She described the medication as having been moderately helpful. In the initial assessment meeting at the counseling center, she reported that "I am a hypochondriac – I am constantly wondering whether I have cancer or heart disease, or having a brain haemorrhage," and recounted a story of woman who had facilitated a training event in her workplace and then gave a talk at the college and then died the following day. The statements made by Theresa in the assessment interview mapped on to the extreme end of almost all of the items in the Health

Anxiety Inventory (Salkovskis et al., 2002), a standard screening instrument for health anxiety. The level of desperation exhibited by Theresa during assessment meant that she was prioritized for immediate access to a therapist, and allocated to the most experienced therapist in the clinic team. When asked about her coping strategies and sources of pleasure, Theresa replied that she did not have time for hobbies, exercise or outdoor pursuits, and tried to deal with her fears through self-control: “I give myself a good talking to – don’t be so stupid.” On the problem rating scale used in the study Theresa described the main problem/goal to be worked on in therapy as: “I feel that there is something that is seriously wrong with me in a medical sense, for example cancer, heart problems that are lying undetected. I fear that I am not going to be around to see my 5-year-old son grow up” and gave this statement a rating of 9 (“couldn’t be worse”) on a scale of 0–9.

The process of therapy

The interaction between client and therapist consistently followed a person-centered approach characterized by an open, personal and exploratory style on the part of the therapist, with frequent empathic reflection and high levels of therapist sensitivity to the implicit emotional and personal meaning of the client’s description of events in her life. Working Alliance Inventory ratings made by the client after the first session indicated a moderate level of relationship factors, with several items rated at 4 on a scale of 1–7 where 7 indicates a positive alliance. All items had shifted to 6 by the end of the second session, and remained at that level throughout therapy. There was a limited amount of discussion within sessions of routine monitoring data, and no use of structured in-session activities (e.g. two-chair work or mindfulness practices). The process of therapy did not incorporate any interventions that might be considered as typical of a CBT approach, such as identification of negative automatic thoughts, relaxation skills training, psycho-education, scaling, homework assignments, or problem formulation and treatment planning. The client completed an outcome scale and therapy goals rating form before the start of each session. These forms were handed to the therapist, who read them, invited the client to comment on any issues highlighted in the questionnaires that she felt might be relevant to the session. The therapy therefore reflected a core principle of pluralistic practice, in being explicitly anchored in a shared understanding of the client’s goals.

The first session began with Theresa providing examples of many areas in which she felt that she was developing serious illnesses, and occasions when she had experienced panic as a result of these possibilities. By the middle of the session, she started to talk about the death of her father, and to express feelings of loss and grief. Sessions 2–4 consisted of on-going recounting and reflection on similar themes, and making connections between family life, unexpressed feelings, and health worries. In session 3, Theresa talked in detail, and with deep feeling, about the events surrounding the death of the father, and what he had meant to her. The final session, which occurred just before a vacation period, consisted of a review of these themes.

Analysis of outcome

There were four sources of outcome data available to the inquiry teams: quantitative ratings from CORE and goals scales (Table 1), the Change Interview conducted with the client, the post-therapy interview with the therapist and statements made by the client within sessions. The information from these sources was highly consistent, in pointing

Table 1. Summary of quantitative outcome data.

Time	CORE raw score	Problem rating
Assessment	50 (mild/moderate level)	9 (maximum)
Start of session 1	Not available	Not available
Start of session 2	44 (high mild)	7
Start of session 3	28 (normal range – low level of symptoms)	6
Start of session 4	12 (healthy)	4
Start of session 5	1 (healthy)	2
Following session 5	1 (healthy)	2
7-month follow up	4 (healthy)	2 (note: 1 = “not bothering me at all”)

toward a substantial shift in the client by the end of therapy, in the direction of a life that was no longer dominated by health fears.

In her Change Interview, Theresa described how therapy had made a difference to her life:

I wouldn't say it (the anxiety/panic) has gone completely. No, I would say it's manageable now whereas when we first met it was as far from manageable as possible, it was real and this was happening to me.... Now it's OK to feel like that at times and know that, I don't get palpitations anymore I still sometimes get the feeling in the throat... but I can move on from it; when we first met there was no moving on; it was dragging me down and down and down even further, so it's the realisation that it will pass, it will pass...It's that being able to move on whereas before I would have sat and not moved and burst into tears, and gone to bed early because my throat was sticking...get up in the morning and think 'uh! That food was sticking last night', it's the ability to move on now....I'm more of myself again, more assertive again, happier, happier in myself which has obviously got a knock on effect with the family and the work life. Happier within myself, which makes it easier, makes life a lot easier, not a constant battle all the time.

At several points in the interview, Theresa attributed these changes to therapy, rather than other factors. For example, in relation to her antidepressant medication she stated that “...obviously I had to get the anti-depressants to kick in before the doctor realised no we have to take this a wee bit further...anti-depressants alone just isn't working....” During a follow-up interview the therapist independently described her perception of the outcome of Theresa's therapy in similar terms: “my sense of the outcome was that it was good, she moved quickly from major panic attacks to having very few. She now has resources to cope.”

The analysis of outcome conducted within the HSCED procedure yielded a consensus across all adjudicators that Theresa had largely recovered from her health anxiety problems. The adjudicators also observed that there were a number of additional factors that had probably also played some part in recovery:

- the development of a more supportive relationship with her partner;
- anti-depressant medication;
- support from her GP, who encouraged her to view her problems as psychological in nature;
- Theresa reported that completing weekly questionnaires helped her to monitor progress, and that visiting the counseling center was a “relaxing experience;”
- time of year – attending therapy coincided with the beginning of summer.

In addition, it was noted that there had been previous cycles of stress/crisis followed by recovery in Theresa's life, and that it would only be possible to determine the lasting value of the present course of therapy at a longer follow-up. Taking all these factors into account, adjudicators came to a view that the gains demonstrated by Theresa were primarily attributable to participation in therapy, although other factors had also made a contribution. Adjudicators were influenced by the fact that clear linkages were evident between in-therapy events and change in symptoms, while the health anxiety issues experienced by the client had remained problematic for an extended period of time prior to entering therapy.

Analysis of the change process

Theresa used therapy to talk about many aspects of her problem. It seems likely that the lack of an explicit agenda, allied to the therapist's acceptance of whatever Theresa wanted to discuss, made an important contribution to the therapy process by allowing Theresa to give voice to ideas and feelings that were elusive and hard for her to define. However, it was possible to identify a line of development that threaded its way through this rather open and free-flowing conversation. This thread appeared to comprise distinct themes:

- (1) Accepting what was happening;
- (2) Beginning to see something else "behind" these worries and panic attacks;
- (3) "Opening the box": exploring new emotions and memories that then came into awareness;
- (4) Re-authoring: developing a new life-story.

Although these themes initially emerged in that order, by the third session all four themes were in play during each session.

The ways in which *accepting what was happening* and *beginning to see something else* operated within this therapy are illustrated in the following excerpt from near the beginning of the second session. In other opening minutes of the session, Theresa and her therapist had talked about different occasions when panic and anxiety had been most intense, and what Theresa had done to control these frightening events. In the excerpt below, the therapist's words are in italics. Some portions of the conversation have been omitted to make it easier to follow, and to maintain confidentiality.

...rather than spending time worrying about what might or might not ever happen, I'm just getting on and doing things. And it's only when like last night it happened, when I sat down, that the panic came back...

... too much time to think or else it's kind of like these..the feelings, whatever they are, are in there and you can kind of, I dunno, I suppose, mark, put them aside or something when you're really really busy but when you're not busy it's like the things that are upsetting you they kind of come out in physical ways and you start feeling panicky

Uhuh

... and I remember you talking about your dad dying and the kind of feelings and your grief and you kind of

uuuuh cough

umm that's kind of onset, maybe that kind of sits there

mmm

and like like

and never goes away

yeh

and it's, that's what it's like it's like it's always there in the background

yeh, and if you're really busy you can kind of keep it in the back ground

keep it in the background, yeh

and when you're not busy you can kind of

it's like it come forward

uhuh

yeh, that's what it's like hmm

hmmm

because that I remember that this this fluttery panic thing that happened there

yeh

and it obviously was you know a panic, a type of panic....and it was like, no there's something wrong with me, something seriously wrong....and it just seemed to build and build and build every week that there was more and more and more things wrong with me...

uhuh

and it seems strange for me again that we've come back into the lighter night and we're getting more busy again. So it's like, like a little box, you know, tidy up and put it away

uhuh

because we're busy, and then I'm sitting down...

yes

and it comes out of the box, it's that sort of feeling

uhuh

no, I'm busy I don't need to think about it, or I can think about it and..dismiss it.

Kind of put the lid on the box

we'll kind of just put it away again just now but in times of just sitting.. in sometimes in sitting it's just like it all spills out again

Yeh

And it's dealing with umm when it all spills out

Uhuh

That I need to cope with

Yes yeh uhuh I was just staying with that, with that in my mind that image of the box and it's kind of like you can put the lid on the box but it kind of feels a wee bit like the lid pops up quite easily,

Mm

And it's uh what's in the box is actually really really important

Ahuh

And needs to be heard...met in some kind of a in some kind of a way...doesn't want to stay in the box.

In this episode, Theresa spontaneously created a metaphor *the box*, that allowed both participants to have a shared understanding, and which also acted as an opening into a further phase of the therapeutic work: finding out what was in the box. Session 4 almost immediately began with what might be considered to be the *opening of the Box*.

Yeh uhuh, I mean like the reason that I'm here just now with the, what I've got on my sheet (goals form) with the life-threatening illness and the and all that I.I.b..believe that in this I wouldn't be sitting here saying this if my dad hadn't have died and I think it just

Yeh

Brings home just how precious life is and how short life can be

Uhuh, yeh and that feels very I don't know maybe I'm just hearing you differently but it's like you're saying how precious life is and there's something really really strong in that, and you have had that experience of how short life can be like, somebody's there and then they're not and it's a shocking experience I think but it can it opens up all sorts of other things

Hmm

- Two sides of the same thing, how precious life is and how transient it is as well

- How precious it is to you and how devastating it is to others, once, when your presence isn't there anymore something about me there...I think it was the Saturday night before he got, he died I think it was a week the following Sunday, it was the Saturday night before and I'd phoned my mum and dad it was something daft like he used to want me to pick up that steak pie out of Tesco's or something

Uhuh

And right when she answered the phone you could tell right away that she'd been crying and I was like, what is it? Panic, what is it what's wrong? 'Nothing nothing I'm alright' and uh no there's something wrong with you and at that time because it was the last couple of weeks of my Dad's illness he was a bit...my mum truly didn't believe, my mum believed that he was getting better and that my dad was dying never entered her mind and..

Had it entered your mind?

Yeh uhuh, because of the secondary cancer and all of that, once we got told it was secondary cancer my mum yeh uhuh...uhh so I knew

uhuh

...what had happened was they had been talking and dad started crying and got quite upset with my mum which my dad had never shown her, he'd show me ...he wasn't worried, he wasn't worried about dying, his worry was..

about how you would be

..... how we would cope and how we would deal with him not being here any more

and that touches...?

(cries) yeh uhuh, I mean obviously pause, I'm not saying he wasn't worried about dying because he

how you feel

he wasn't worried about dying it was just, obviously he would prefer not to and prefer that none of this ever happened to him but in the back of his mind he knew he was dying and

(pause) where would (pause, cries) .what would happen to my mum and me and my sister cos it's (pause, sobs)....and that hurts as well ...because... he was such a good strong man ..(sobs)... how do you cope knowing that, how did he manage to cope knowing that that he was on such borrowed time? How did he manage to get through it ...(sobs)... and that's what scares me now ...if I was ever to be diagnosed with something how would I cope?

You just really cannot imagine how it's possible

(Sobs)

All this feels like you're kind of awestruck with how your dad coped, like he was able to do that and you see that somehow it was really sad and hard... Is that how you imagine you would feel..

Yeh sobs

Just want to give up

Sobs, just...

.. something like that's going to happen

you'd be so scared

now and

so scared (sobs)

are you frightened

uhuh

and the thought of it's really frightening

uhuh.. (long pause – sobbing).

This part of the session was highly emotional, the box was being opened and the contents were being expressed. From this point, Theresa appeared to begin a process of narrative assimilation of her emotional experience; she was able to say out loud and for the first time, how awful her experience of death had been, how scared she felt, and how much she loved and missed her father. In the follow-up interview, she reflected on this episode by stating that: “*not until I started speaking about it...made me realize I actually felt the way I did.*”

Once Theresa had acknowledged and expressed some of the painful emotions surrounding her bereavements (her father, and both of her grandmothers) she appeared able to take on new aspects of self-understanding. Theresa had initially presented a somewhat idealized narrative of her early family life, and was unable to integrate her experience of her “perfect” former (birth) family with her current situation. Living up to the “family rules” of this former family had been difficult at times. There seemed to have been an emphasis on self-sacrifice, being brave, not breaking down, *burying* things and also feelings of responsibility – “we looked after each other.” Her perception of the way her father felt responsible for the family is reflected in her own attitude toward her son, her concerns are around what would happen to him if she wasn't around anymore. Her current family life was “good” but clearly could not live up to her idealized “good life.” In the follow-up interview she stated that:

when I was young there was always a family circle...that was the perfect circle...so it was like the break-up of this circle to start this new circle...

the realization that I wasn't doing anything wrong, there wasn't any badness in hankering for it (the old circle/family) accept both of them together rather than having them fighting against each other.

An important process for Theresa seemed to be that she was able to talk about her father's death and not protecting anyone by keeping quiet about it. The new acceptance of her experience allowed her to accept the suppressed aspects of her emotions around the death of her father (and other earlier deaths of close attachment figures). This was a significant shift from the "family rules" which she had been trying hard to live by. By acting as an accepting audience to this new narrative, her therapist encouraged self-acceptance and allowed Theresa's own meaning-making process to unfold.

By the end of therapy, Theresa appeared to be on the way to developing an identity as someone who "had been through it;" by acknowledging the pain and distress of bereavement she was better able to take on this new identity and deploy it in helping others. For example, in the follow-up interview Theresa recounted events where she had been able to help colleagues who had experienced loss, or were experiencing loved ones with terminal illness. Also in the follow-up interview, she commented that she had appreciated the way that her therapist had been able to talk in a way that indicated that she "actually knew" about what happened when people are dying. The significance of this aspect of the process was reinforced in the follow-up interview with the therapist, who reflected that "working with loss and bereavement strengthened something in our work together, because it doesn't make me anxious or nervous."

Discussion

It is important to acknowledge the limitations of single case research. Compared to other methodologies, case study inquiry is particularly well-suited to investigating complex processes that unfold over time, and to the task of exploring the ways in which contextual factors can shape these processes. A single case can only provide a glimpse of what is *possible*, what *can* happen. In order to arrive at an understanding of the general applicability of the findings of a single case, either a case series, or a "large n" study needs to be conducted. Analyses of single cases can generate ideas and theory that may be articulated further in these other forms of inquiry. Within the present study, considerable effort has been made to establish points of connection between the case of Theresa and other instances of psychotherapy for health anxiety, for example by using standard outcome and process measures, and by carefully describing what happened in therapy. At the same time, it is necessary to be clear that the material presented in this paper represents a condensed summary of Theresa's experience in therapy; a balance always needs to be achieved between offering a rich description of a case, and safeguarding the identity of the client.

The main aim of this section of the paper is to explore the theoretical and practical implications of what emerged from this case analysis. As a preliminary to theoretical reflection, it is useful to consider what this case tells us about the phenomenon of health anxiety. For Theresa, and undoubtedly for many other individuals who worry too much about the possibility of life-threatening illness, the experience of health anxiety is multifaceted, encompassing cognitive, emotional, behavioral, existential and social dimensions. We live in a medicalized culture in which we are urged to take symptoms seriously. Chest pain could be an indicator of heart disease, throat constrictions could be an indication of throat cancer. We are advised to see a doctor as soon as possible if we observe these signs in our body. Seeing a doctor is, however, an extended process –waiting for an

appointment, being tested, waiting for the results of tests. There is therefore an extended time of uncertainty, when it is natural to be alert and concerned. As the process of medical consultation unfolds, there are many opportunities for pre-existing cognitive habits to enter the scene: rumination, denial, arbitrary inference, catastrophizing. In turn, these ways of thinking invite self-criticism: “don’t be so stupid” and perhaps also criticism from others. Running alongside these cognitive and cultural processes, at some level there is a reminder of the existential necessity of death, and the possibility that these pains may be the first steps on a road to an early death. Also running alongside are implications for social relations and attachments: what will happen to my child if I get ill and die? And, for people such as Theresa, there is also a trigger for remembering the illness and deaths of close attachment figures and wondering about the quality of their relationships with current attachment figures.

It is in the context of an appreciation of the complexity of health anxiety that it becomes possible to assess the value of different theoretical frameworks for making sense of health anxiety. The classical CBT model of health anxiety, formulated by Warwick and Salkovskis (1990) suggests that this form of anxiety is ultimately grounded in previous experience of illness in self and family members, which come to be associated with a set of “dysfunctional assumptions” such as “I should *always* be able to find an explanation for my symptoms” (p. 111). It is within this life history context that a specific critical incident occurs, such as a series of days marked by headache, leading to an activation of dysfunctional assumptions that function as negative automatic thoughts that then in turn have a wide range of effects, such as increased emotional and bodily arousal, sleep disturbance, rumination, discounting positive information, repeated self-monitoring and self-inspecting, and so on. Cognitive-behavioral intervention seeks to cut through this escalating cycle of worry and panic by the use of two main strategies (Warwick & Salkovskis, 1990): modification of automatic thoughts and dysfunctional assumptions through cognitive therapy techniques such as reframing and testing alternative hypotheses, and initiating behavior change activities and experiments in order to minimize dysfunctional behavior sequences such as compulsive monitoring of symptoms. The recent addition of mindfulness training to this set of CBT interventions (McManus et al., 2012; Williams et al., 2011) introduces an additional strategy, in helping the client to develop a set of cognitive and self-awareness skills that encourage acceptance of symptoms, bodily sensations and thoughts, as an alternative to being drawn into a cycle of rumination and worry.

It seems clear that the therapy received by Theresa was successful without involving any attention to dysfunctional assumptions, negative automatic thoughts or behavioral sequences. How, then, can the change processes observed in this case be understood in theoretical terms? Person-centered and experiential theory around the topic of anxiety has received relatively little attention in recent years (Elliott, 2013). However, there appear to be at least two sets of ideas within current experiential theory that may be of some value in explaining what happened in this case. McGavin and Cornell (2008) have suggested that anxiety can be understood as a *stopped process*. In other words, when a person is functioning well, he or she is engaged in an on-going process of being aware of what he or she is feeling at a bodily level, and is able to symbolize the meaning of these implicit processes in ways that guide action. Sometimes the symbolization can be verbal and conceptual (“I am aware in this moment and through this feeling, of how much I got from my father and how much his loss means to me”). Alternatively, symbolization can take the form of action (“for some reason, it seemed important to phone my sister right at that moment”). By contrast, a stopped process arises from a failure to allow the implicit meaning of a bodily “felt sense” to unfold. Over time, the person develops a sense of

being a *partial self*, as if there is some part of them that is missing and incomplete. These ideas seem to correspond well with the process of therapy experienced by Theresa. The empathic acceptance and intense presence of her therapist allowed Theresa to stay with what she was feeling in the moment, rather than veering off into medical explanations and threads of rumination. This “staying with” what was there, seemed to enable a previously stopped process to begin to move, for example through the appearance of the image of the “box” and then the activity of “opening” the box to see what was there.

While the McGavin and Cornell (2008) model serves well as an account of the moment-by-moment process of therapy, it does not offer a way of understanding the nature of the shifts that then occurred once this process was underway. Recent theoretical developments around the role of narrative and emotion in experiential psychotherapy may be relevant in this context. In general terms, emotion-focused theory posits that it is only by going into and *through* the feelings and emotions that a person can discover his or her core relatedness to an issue (example: “I worry a lot but when I get beneath that there is just such a lot of sadness and loss”). At the moment of contacting and expressing that emotion, the person is being who he or she is, and has agency rather than being acted-upon or spoken-through. Angus (2012) and Angus and Greenberg (2011) point out that this process always occurs in the context of a narrative: “all significant emotions are embedded in important stories, and all significant stories revolve around important emotional themes” (Angus, 2012, p. 376). From this perspective, the situation described by Theresa at the start of therapy can be regarded as an “untold story” (Angus, 2012). She had never talked openly and in detail about the death of her father, and she had not made connections between her worrying bodily sensations and symptoms, and the story of her life as a whole. From the narrative experiential perspective outlined by Angus and Greenberg (2011), shifting into states of feeling, and then into story-telling, and then back into feeling, would be regarded as characteristic of effective therapy. This process then led to two outcomes: feeling better, and constructing a new story. As Angus (2012) points out, this way of understanding therapy makes use of ideas that were originally developed within the field of narrative therapy (White & Epston, 1990). Indeed, the therapeutic journey undertaken by Theresa can be understood as comprising a process of “re-authoring” as described within the narrative therapy tradition.

The image and metaphor of “moving on,” used by Theresa in the follow-up interview, captures the lived experience of these experiential processes. Theresa became able to move on in a “micro” sense, in respect to the moment-by-moment ability to accept her bodily feelings and symptoms as not necessarily catastrophic in nature. She was also able to move on in terms of her life story, and in terms of having a clearer picture of the life she wished to create for herself.

The findings of this case study have a number of implications for practice and research. In terms of the process of psychotherapy in health anxiety, it would appear that there are at least four distinct change processes that can be identified within the literature: (a) challenging negative automatic thoughts and irrational beliefs; (b) behavior change around dysfunctional activities such as compulsive self-monitoring of symptoms; (c) adoption of a “mindful” awareness that promotes acceptance and self-compassion; and (d) meaning-making that enables symptoms, emotions and memories of life events to be integrated into a more coherent narrative. It may not be particularly helpful to adopt a position that any one of these change processes is more valid than any of the others. It may be that different mechanisms of change are more effective for different clients, or for the same client at different points in their recovery (Cooper & McLeod, 2011). In relation to the conduct of case study research in psychotherapy, the

procedures used in the present study suggest that the Ward method (Schielke et al. 2009) represents a rigorous yet flexible means for a team of researchers to arrive at a nuanced consensual analysis of rich case data, particularly in relation to developing an understanding of the process of change. It is also worth noting that the transcripts of therapy sessions proved to be an invaluable source of evidence about both the process and outcome of therapy.

References

- Angus, L. (2012). Toward an integrative understanding of narrative and emotion processes in emotion-focused therapy of depression: Implications for theory, research and practice. *Psychotherapy Research*, 22(4), 367–380.
- Angus, L., & Greenberg, L. (2011). *Working with narrative in emotion-focused therapy: Changing stories, healing lives*. Washington DC: American Psychological Association.
- Cooper, M., & McLeod, J. (2011). *Pluralistic counselling and psychotherapy*. London: Sage.
- Creed, F., & Barsky, A.J. (2004). A systematic review of the epidemiology of somatisation disorder and hypochondriasis. *Journal of Psychosomatic Research*, 56, 391–408.
- Deane, F.P., Spicer, J., & Todd, D.M. (1997). Validity of a simplified target complaints measure. *Assessment*, 4, 119–130.
- Elliott, R. (2002). Hermeneutic single case efficacy design. *Psychotherapy Research*, 12, 1–20.
- Elliott, R. (2013). Person-centered-experiential psychotherapy for anxiety difficulties: Theory, research and practice. *Person-Centred and Experiential Psychotherapies*, 12, 14–30.
- Elliott, R., Freire, B., & Westwall, G. (July 2012). Person centred and experiential psychotherapy scale. Field trial results and next steps. *Proceedings of the 10th World Conference for Person-Centred and Experiential Psychotherapy and Counseling*, Antwerp, Belgium.
- Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on Psychotherapy: Alternative strategies. In J. Frommer, & D.L. Rennie (Eds.), *Qualitative psychotherapy research: Methods and methodology* (pp. 69–111). Lengerich, Germany: Pabst Science Publishers.
- Evans, C., Mellor-Clark, J., Margison, F., Audin, K., Connell, J., & McGrath, G. (2000). CORE: Clinical outcomes in routine evaluation. *Journal of Mental Health*, 9, 247–255.
- Freire, E., & Grafanaki, S. (2010). Measuring the relationship conditions in person-centred and experiential psychotherapies: Past, present, and future. In M. Cooper, J.C. Watson & D. Hoeldampf (Eds.), *Person-centered and experiential therapies work: A review of the research on counseling, psychotherapy and related practices* (pp. 188–214). Ross-on-Wye: PCCS Books.
- Hatcher, R.L., & Gillasp, J.A. (2006). Development and validation of a revised short form of the working alliance inventory. *Psychotherapy Research*, 16, 12–25.
- Hill, A. (2011). *Curriculum for counselling for depression*. Lutterworth, Leicestershire: British Association for Counselling and Psychotherapy.
- Kellner, R. (1982). Psychotherapeutic strategies in hypochondriasis: A clinical study. *American Journal of Psychotherapy*, 36(2), 146–157.
- Llewelyn, S. (1988). Psychological therapy as viewed by clients and therapists. *British Journal of Clinical Psychology*, 27, 223–238.
- Magariños, M., Zafar, U., Nissenon, K., & Blanco, C. (2002). *Epidemiology and treatment of hypochondriasis*. New Zealand: Adis International. doi:10.2165/00023210-200216010-00002
- McGavin, B., & Cornell, A.W. (2008). Treasure maps to the soul. *Folio: A Journal for Focusing and Experiential Therapy*, 21(1), 41–60.
- McLeod, J. (2010). *Case study research in counselling and psychotherapy*. London: Sage.
- McManus, F., Surawy, C., Muse, K., Vazquez-Montes, M., & Williams, J.M.G. (2012). A randomized clinical trial of mindfulness-based cognitive therapy versus unrestricted services for health anxiety (hypochondriasis). *Journal of Consulting and Clinical Psychology*, 80(5), 817–828. doi:10.1037/a0028782
- Olde Hartman, T.C., Borghuis, M.S., Luccasen, P.L.B.J., van der Laar, F.A., Speckens, A.E., & van Weel, C. (2009). Medically unexplained symptoms, somatisation disorder and hypochondriasis: Course and prognosis. A systematic review. *Journal of Psychosomatic Research*, 66(5), 363–379.
- Rennie, D.L. (1998). *Person centred counselling: An experiential approach*. London: Sage.

- Salkovskis, P.M., Rimes, K.A., Warwick, H.M.C., & Clark, D.M. (2002). The health anxiety inventory: Development and validation of scales for the measurement of health anxiety and hypochondriasis. *Psychological Medicine*, 32, 843–853.
- Schielke, H.J., Fishman, J.L., Osatuke, K., & Stiles, W.B. (2009). Creative consensus on interpretations of qualitative data: The ward method. *Psychotherapy*, 19, 558–565.
- Thomson, A.B., & Page, L.A. (2007). Psychotherapies for hypochondriasis. *Cochrane Database of Systematic Reviews*, 4, 1–43.
- Thorne, B., Mearns, D., & McLeod, J. (2013). *Person-centred counselling in action*. London: Sage.
- Walker, J., Vincent, N., Furere, P., Cox, B., & Kjernisted, K. (1999). Treatment preferences in hypochondriasis. *Journal of Behavior Therapy and Experimental Psychiatry*, 30, 251–258.
- Warwick, H.M.C., & Salkovskis, P.M. (1990). Hypochondriasis. *Behavior Research and Therapy*, 28(2), 105–117.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.
- Williams, M.J., McManus, F., Muse, K., & Williams, J.M.G. (2011). Mindfulness-based cognitive therapy for severe health anxiety (hypochondriasis): An interpretative phenomenological analysis of patients' experiences. *British Journal of Clinical Psychology*, 50, 379–397.