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Abstract
Worries about one's health, while ubiquitous, can for some become quite distressing. Health anxiety occurs when one becomes focused on symptoms and fears they may become ill or die. This often overtakes their life due to continued worry. They often spend an inordinate amount of time and effort to seek answers. Other aspects of their life are placed in the periphery or abandoned. Traditional approaches are aimed at symptom relief. While effective for some, others continue to struggle. A more novel approach that aims to look at the client both holistically and individualistically can address much more than symptom amelioration.

Counseling clients with health anxiety (HA) can be challenging. To begin, it is considered a treatment resistant condition (Ansari & Siddiqui, 2014). Additionally, many HA clients can have poor insight, often believing symptoms are attributable to a medical rather than a psychological issue (Abramowitz et al., 2010). HA drives clients to overestimate the severity of symptoms and illness (Weck & Höfling, 2014). Data suggests those with HA report lower quality of life and more functional impairment (Doherty-Torstrick et al., 2016). These factors, along with often seen co-occurring disorders (Starcevic, 2014) can make HA concerns difficult for counselors. With this in mind, the aim of the present article is to provide counselors a way of approaching clients with HA. It is hoped the approach outlined and demonstrated in the accompanying case illustration will afford counselors the confidence and competence to address health anxious clients.

Overview of Health Anxiety

A majority of Americans regard their personal health as very important. In fact, a national survey found that almost 60% of respondents were "…paying more attention to personal health than in the past…" (Friedman, 2013). Health equates to security, the ability to care for one's self and family (Furer et al., 2007). Websites such as WebMD, MedlinePlus, and Mayo Clinic have become popular access points to address health concerns.

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A Pew Research Center survey found more than a third of Americans used a medically focused website to explore one or more medical concerns (Fox & Duggan, 2013). Two studies conducted in Germany found about 20% of those in the general population as well as those presenting in primary care settings presented with concerns related to their health absent any physiological cause (Hiller et al., 2006; Steinbrecher et al., 2011). One's health, good or poor, is inexorably tied to relationships, occupation, income, and of course quality of life (Kansky & Diener, 2017). Furthermore, anxiety about one's health can, for some, become a significant source of distress (Sunderland et al., 2013). This chronic and persistent worry can develop in some to such an extent that it causes clinically significant distress (American Psychiatric Association [APA], 2000, 2013).

The previous iteration of the Diagnostic and Statistical Manual of Mental Disorders (DSM) listed those with having health anxiety as hypochondriasis (APA, 2000). The most recent DSM replaced hypochondriasis with two separate disorders. Illness anxiety disorder (IAD) and somatic symptom disorder (SSD) (APA, 2013). Illness anxiety disorder is characterized by excessive worry about having or developing a potentially life-threatening medical illness. Actual symptoms may or may not be present. If they are present, the symptoms are not significant. IAD results in substantial maladaptive thoughts and behaviors to address the fear of becoming ill. Some individuals with IAD may overutilize medical professionals while others may eschew medical professionals for fear of a negative report (APA, 2013). Neither of these strategies are particularly effective in addressing their distress. Additionally, IAD clients may often avoid activities they feel may exacerbate a feared illness.
Somatic symptom disorder refers to concerns associated with somatic complaints (APA, 2013). Often, there are several physical ailments. Those with SDD evaluate their symptoms as dangerous and even potentially fatal. They become preoccupied with their symptoms and perseverate on symptom meaning. Other activities may be crowded out due to excessive thoughts and persistent anxiety (APA, 2013). The prevalence rate for those with IAD is 0.1% (Newby et al., 2017). For those with SDD, it is 5% to 7% of the general population (APA, 2013). IAD and SSD are included in the section titled "Somatic Symptom and Related Disorders" in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (APA, 2013, p. 309). A diagnosis of hypochondriasis often carries significant stigma (Brakoulias, 2014). There is some thought that replacing the word hypochondriasis, as well as separating the symptomology into IAD and SSD, may lead to better understanding and possibly treatment of both (Brakoulias, 2014; Newby et al., 2017).

However, it should be noted that Newby et al. (2017) reported that IAD or SSD diagnoses share common features such as health worry, maladaptive thoughts and behaviors, chronicity, and age of onset.

Furthermore, Bailer et al. (2016) found more similarities than differences between the two disorders. Research indicated co-morbidity for IAD and SSD with panic disorder and generalized anxiety disorder for SSD (Bailer et al., 2016) and major depressive disorder (Newby et al., 2017). IAD had co-morbidity with major depressive disorder, although less so than with SSD (Bailer et al., 2016; Newby et al., 2017). Haug et al. found SSD co-morbidity with both depression and anxiety (2004) as well as HA and substance use (Jeffers et al., 2015). Furthermore, HA may be implicated in the development of obsessive-compulsive disorder (Furer et al., 2007).

Due to the overlap in symptomology of IAD and SSD, the term health anxiety (HA) will be used to refer to symptoms of either disorder for the remainder of this article. "Health anxiety is a term for mild-severe presentations of illness worries…" (Doherty-Torstrick et al., 2016, p. 391). We respect the decision to split the previous diagnosis of hypochondriasis into IAD and SSD and acknowledge the differences between the two diagnoses. However, we find the overarching distress over one's health, the impact HA has on one's level of functioning, and their quality of life to be most relevant to the present article.

Implications of Health Anxiety

Clients who suffer with HA can present with a variety of complaints. For example, HA clients may overutilize medical services such as emergency departments, community health clinics and their personal physicians. In fact, these individuals utilize both inpatient and outpatient services at twice the rate as those without HA (Barsky et al., 2005). Tyrer et al. (2011) found that across numerous medical disciplines, almost 20% of those presenting for medical care also demonstrated HA concerns. Additionally, the healthcare costs and service utilization for those with HA can be significant (Barsky et al., 2001; Fink et al., 2010; Lipsitt, 2015). However, for medical providers who may not able to reassure patients, this can lead to poor doctor-patient relationships (Noyes et al., 2010).

The use of the internet for health information is also significant. Almost 90% of Americans utilize the internet (Anderson et al., 2018). As mentioned previously many of those utilize health-based websites. For many, this access to health information is quick and convenient. Though for others who struggle with HA, this can be problematic. A study conducted by Doherty-Torstrick et al. found that distress actually increased during and after health-related online searches (2016b). In fact, the term cyberchondria has entered the literature related to HA (Doherty-Torstrick et al., 2016; Muse et al., 2012; Poel et al., 2016).

Paradoxically, avoidance has also been seen in those with HA (Doherty-Torstrick et al., 2016a). Specifically, HA clients may avoid activities and engage in safety behaviors to assuage anxiety and fears. Among these may be physical exertion, visiting friends who may have an illness, routine medical check-ups

(Abramowitz & Braddock, 2011; Bouman, 2014; Doherty-Torstrick et al., 2016a).

Standard Heath Anxiety Approaches

Approaches for those suffering with IAD/SSD most cited in the literature are cognitive-behavioral therapy (CBT) (Allen et al., 2006; Barsky & Ahern, 2004; Kroenke, 2007), short-term psychodynamic (STPD) approaches (Abbass et al., 2009), exposure therapy (ET), and exposure and response prevention (ERP) (Asmundson et al., 2010; Weck et al., 2015a). Several small studies using a variety of medications have also shown some efficacy (Asmundson et al., 2010). However, CBT, STPD, ET, and ERP are based on research that assumes commonality across participants and groups. Additionally, in spite of these evidence-based approaches, many clients do not get better (Lovas & Barsky, 2010).

Empirically based approaches may not always be the best for those with complicated needs such as those with HA (Haynes & Williams, 2003). Furthermore, the aforementioned approaches are largely based upon DSM criteria for IAD and SSD alone. We assert that those with HA have other potential diagnoses that may need attention. Among these are anxiety, depression, obsessive-compulsive disorder and substance use (Jeffers et al., 2015; Starcevic, 2014; Scarella et al., 2016). Lastly, HA clients often have concerns, histories, and assets that may contribute, exacerbate, and possibly even mitigate their symptoms. These additional factors may make standard approaches inadequate for counselors working with HA. For these reasons, we think a more individualized and holistic approach may prove beneficial.

Nomothetic Versus Idiographic Approaches

Nomothetic and idiographic approaches have been the subject of deliberation for quite some time (Salvatore & Valsiner, 2010). While it is beyond the scope of the present article to settle the debate, some basic information may prove valuable. Nomothetic knowledge and approaches focus on taking data on sample populations and generalizing it to larger populations. Essentially, those who develop, and practice nomothetic approaches seek to put a disorder into remission. In other words, these types of approaches are "disorder-focused treatments" (Persons, 2013, p. 3). Furthermore, nomothetic approaches tend to assume homogeneity, or common to all (Robinson, 2011). Most empirically supported treatments (ESTs) fall into the nomothetic category and tend to be protocol or manualized (Persons, 2013). These approaches allow for uniformity and consistency towards individual clients presenting with the same disorders. This is not to disparage them or challenge their efficacy. However, this is not to assume that nomothetic approaches are the only option or for that matter, best.

Idiographic knowledge, and hence approaches, begin from a decidedly different perspective. It is person-specific and assumes heterogeneity (Beltz et al., 2016). Idiographic refers to "…the aspects of

subjective experience that makes each person unique" (Pagnini et al., 2012, p. 1). It also explores differences within an individual over time (Beltz et al., 2016). When looking through an idiographic lens at clients and their problems, counselors can get a much more detailed and richer picture. In addition, it allows for a more tailored and client problem-specific approach as opposed to standardized approaches such as cognitive-behavioral therapy. Finally, coming from an idiographic perspective may be beneficial for clients with complex presentations. In fact, the DSM-5 states, "…case formulation for any given patient must involve a careful clinical history and concise summary of the social, psychological and biological factors that may have contributed to developing a given mental disorder" (APA, 2013, p. 19).

Idiographic Case Formulation with Health Anxious Clients

Many struggling with HA are in persistent distress (Asmundson et al., 2010; Hiller et al., 2006). As mentioned previously, HA symptoms and their consequences can have deleterious effects on clients. As with many anxiety disorders, if not addressed the anxiety can become tenacious. Furthermore, HA clients may fuse various aspects of past, present and future, and thus have difficulty moving forward. Importantly, given the inherent differences in clients and the dynamism of client's lives, a nomothetic approach may not be the best course. We propose an idiographic approach that focuses on more than symptoms. This design permits a holistic and multidimensional picture of those with HA. This in turn allows for a very individualized approach to addressing HA clients. For clients with HA who often are defined by symptoms, an approach that examines clients from multiple perspectives may provide a less pathological and more empowering path towards wellness. Furthermore, as Bolton (2014) points out, an approach to a problem should, among other actions, "…encourage us to tell better, thicker stories" (p. 182).

Five Ps Approach to HA

Weerasekera (1993) developed a four-factor model of case formulation for use in psychiatry. This model includes (1) predisposing, (2) precipitating, (3) perpetuating, and (4) protective factors. It examines clients from multiple perspectives; biologically, psychologically, and systemically. System, in this context, refers to "…areas outside the individual that have a significant impact on day-to-day life" (Weerasekera, 1993, p. 351-352). This approach to addressing clients encompasses the whole person, their environment, and any other factors that may impact their lives. It allows for a more dimensional view, rather than a categorical view. This multidimensional view looks at not only symptoms, but various aspects related to HA client's expressed concerns (Furer et al., 2007).

Macneil et al. (2012) expanded upon the four-factor model (Weerasekera, 1993) and developed the Five Ps. The Five Ps' approach is a short expansion on

Weerasekera's model of case formulation. It is comprised of (1) presenting problem, (2) predisposing factors, (3) precipitating factors, (4) perpetuating factors, and (5) protective factors, (Macneil et al., 2012). The addition of presenting problem as the first P works especially well with HA clients. Their singular and overriding concern is often worry over their health. This becomes the natural starting point for exploring subsequent factors. The remaining factors, along with the presenting problem, permit the counselor and client to formulate a plan of action that can be tailored to the client's needs.

In addition to symptoms, the Five Ps examines areas that can impact their symptoms and quality of life. Standard HA approaches addresses symptomology related specifically to that disorder (Persons, 2013). They may not address the previously cited co-morbid disorders. The Five Ps' approach takes a much larger view of the client. It examines several dimensions and how they intersect with, potentially contribute to, and even exacerbate clients' distress. It also explores factors that can mitigate against the anxiety of their health status and accompanying distress. Most important, this approach allows flexibility and adaptability of strategies, where most nomothetic approaches do not. Approaches such as the Five Ps has been discussed in psychiatry and psychology literature but has yet to be explored for use in counseling specific literature (Macneil et al., 2012; Persons, 2013). To better understand the Five Ps' utility for HA clients, we present the following case illustration. It shows how counselors can examine and intervene at any factor deemed relevant to clients' needs. It should be noted this particular case conceptualization is a composite of several clients who have presented with HA.

Case Illustration

Nan is a 32-year-old married mother of two children. She presents to counseling with symptoms suggestive of health anxiety. These include intense worry and fear related to some stomach problems, fatigue, and occasional headaches. Nan has seen numerous healthcare professionals, undergone various diagnostic tests, and searched many medical websites with no answers or relief. She seems convinced there is an undiagnosed illness that if not addressed, will cause her eventual death. These concerns have caused her to curtail and at times, cease physical activities with family and friends for fear of exacerbating her health issues. Nan has gone on an extended leave of absence from her employment and has increased her alcohol consumption to alleviate her fears. Her husband and children are "fed up" and there is often tension in the home, thus exacerbating her anxiety. In fact, she often seems to be defined by her symptoms and concomitant fears.

Presenting Problem

The presenting problem is what the client sees as currently most pressing and distressing. For Nan, it is perseverating on her health issues and fears she may become so ill that it will be too late for any medical

intervention. She has difficulty sleeping, concentrating, and her appetite has decreased. She finds it almost impossible to shake off her worries for more than a short time. The counselor validates and normalizes her concerns. The counselor then provides basic psychoeducation about anxiety such as its causes, its prevalence and some breathing techniques. The counselor allows Nan to express her worries without judgment and Nan experiences some relief as the counselor stays in the present with her.

Predisposing Factors

The focus here is on those aspects that may put the client at risk for developing HA. Nan has a family history of anxiety. She also reports a childhood illness that included minor complications; specifically having measles that led to nausea, vomiting, and a middle ear infection. Nan also reports a father who was very suspicious of modern medicine and often used home remedies to treat illnesses. The counselor provides some additional psychoeducation on anxiety and the hereditary and environmental links. Nan and the counselor discuss the impact of past experiences on the present and how familial influences have carried into adulthood. Nan reports that she had never considered this connection and that it helps her make sense of her experiences.

Precipitating Factors

Precipitating factors explores significant occurrences that preceded or triggered the presenting problem. In the case of Nan, after visiting healthcare professionals, she would seek out information on various medical websites, which would increase her anxiety and fears. She also reached out to her mother for some information on her childhood illnesses which increased her distress due to her mother's past history of anxiety and high emotionality. The counselor shares with Nan that seeking out answers to perceived health concerns can often increase the very concerns one is trying to address. Nan and the counselor discuss how her family's response can exacerbate her anxiety and Nan tells the counselor about past unhelpful conversations she has had with family members. The counselor offers to engage in some brief role plays to help Nan express to her family what she needs from them in order to freely express to them, for her, what are legitimate concerns.

Perpetuating Factors

Perpetuating factors are features that continue the presenting problem that are unique to each individual. For Nan, this involves isolating herself, her increased use of alcohol, her ruminations about past relatives who developed serious illnesses, and her very real fears of dying. The counselor and Nan discuss the challenges and potential implications of alcohol use. Nan reports that when she drinks, she experiences temporary relief from her health anxiety, but afterword experiences increased anxiety when she considers the potential impact on her liver. Nan and the counselor explore her isolation. Nan acknowledges the more she isolates herself, the more she

ruminates about her death and the more strained her familial relationships become. The counselor explores with Nan the transient effects of alcohol and the potential reinforcing effects of alcohol, which may actually increase her use. In addition, the counselor explores the notion of attentional bias as instrumental in her ruminations. Furthermore, the counselor uses mindfulness techniques to help Nan just 'notice' her health anxiousness and move towards valued goals. The counselor also engages in a logical analysis of the evidence that her symptoms, while real and distressing to her, leads to death.

Protective Factors

The counselor begins to investigate resources and/or supports that may alleviate or temper Nan's distress. The counselor inquiries about Nan's support system. Nan reports that when she spends time doing activities with her children, she does not spend as much time worrying about her health. She reports that she has a good friend that encourages her and lifts her up. Nan mentions that she wants to schedule a weekly coffee meeting with her friend to maintain and strengthen that connection. The counselor invites Nan to explore how she has overcome other anxiety-provoking situations in the past. Nan reports that after the death of a long-time friend, she found comfort in a grief support group. Nan tells the counselor that when she attended the support group, she realized how resilient she was, a strength she had not considered before. Nan considers the possibility of attending a local anxiety support group. The counselor and Nan explore previously enjoyable activities. Nan explained that she used to enjoy bicycling and the benefits she received from this activity. Nan reported that she stopped bicycling due to her fear of being in an accident and injuring herself. The counselor invites Nan to develop alternative options and Nan considers attending a stationary cycling class. Nan reports that she feels a bit hopeful as she and the counselor discuss her strengths and assets instead of perseverating on her liabilities.

Interventions

After addressing the 5 Ps, the counselor now has a thorough and very individualized way of conceptualizing and addressing Nan's HA. The counselor implements strategies and interventions that are tailored to Nan's experiences, allowing for flexibility in counseling sessions. It allows for movement in and across a wide variety of strategies or combining a variety of therapies (Weerasekera, 2013). The counselor considers Nan's consuming HA is amenable to an overall narrative approach. The counselor considers Nan's alcohol use and assesses the severity of her use. Nan's use indicates a slight problem and the counselor utilizes motivational interviewing techniques to address this concern. The counselor and Nan consider the possibility of a family session if familial discord persists. The strategies can be used upon completion of the Five Ps. In the case presented, strategies such as psychoeducation, acceptance and commitment therapy, and cognitive-

behavioral therapy, and solution-focused therapy could be seen.

Discussion

Implications for Counselors

Counselors working with HA clients may find this approach beneficial. To begin with, it allows the counselor to get both a broader and deeper picture of HA clients. While the presenting concern is likely to be the HA and symptoms, counselors can examine the various factors that contribute, exacerbate, and mitigate HA suffering. Addressing those factors many alleviate some of the HA symptoms. Highlighting the protective factors may help empower clients. Using the Five Ps approach does not require any advanced training and can be used by novice or seasoned counselors. Using the Five Ps to a challenging population such as those with HA may both increase counselor competence and counselor alliance. These are two factors positively correlated with HA outcomes (Weck et al., 2015b).

The Five Ps is very intentional in its' presentation. As each factor is explored and information shared by the client, the counselor develops a deeper, thicker and more individual picture of their client. In addition, the Five Ps allow counselors to intervene at any point and utilize a variety of strategies as they see fit to best meet the needs of their client.

Limitations and Recommendations for Further Study

It should be noted that this approach to HA clients has not been empirically tested. Research on its efficacy and practicality would most certainly provide valuable information. A potential approach would be to initially administer a measure such as the Short Health Anxiety Inventory (SHAI)(Abramowitz et al., 2007). Once completed, then using the Five Ps as clients are engaged in counseling, they can be administered another SHAI to measure progress. Another potential area of inquiry would be to utilize the SHAI to participants and compare the Five Ps to other stand-alone interventions.

Those who struggle with HA can present challenging issues and their concerns often impact virtually every aspect of their life. HA clients have often seen numerous healthcare professionals, searched medical websites, and likely met with mental health professionals. Treating the symptoms via standard approaches such as CBT may be helpful. However, coming from an idiographic perspective allows for flexibility and modifications as necessary. It affords a way to approach the client that does not simply focus on symptoms, but the client holistically. It can be used in conjunction with any other approach. The idiographic nature of this approach may fit well with this population who are often considered very difficult to treat (Ansari & Siddiqui, 2014; Asmundson et al., 2010).

Finally, HA clients may present with additional concerns related to the current

COVID-19 pandemic. Guidelines such as mask wearing, social distancing, and attention to hygiene practices may reinforce and possibly exacerbate HA symptomology. Furthermore, the significant focus on COVID-19 via social media and the 24-hour news cycle may increase HA distress. Consequently, counselors should be mindful of these added stressors as they implement the Five Ps into their practice with HA.

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