CBT for Health anxiety
("Hypochondriasis")
Prevalence of health anxiety and functional somatic symptoms

No reliable estimate of the prevalence of health anxiety, but it has been estimated that between 30% and 80% of patients who consult physicians present with symptoms for which there is no physical basis
The main problem is defined as a preoccupation with either
the fear of having, or
the belief that one already has,
a serious physical illness.

The preoccupation with health is based on the person’s misinterpretation of bodily sensations. The problem persists despite medical examination and reassurance.
Health anxiety

Anxiety resulting from perceived health threat

Clinical diagnosis: “Hypochondriasis”, a term almost universally disliked by patients and misunderstood by professionals.

– “I’m not just a hypochondriac”
– “It’s not an imaginary problem”
Health anxiety

• Key features of clinical health anxiety:
  – Misinterpretation of the meaning of symptoms
  – Misinterpretation of the meaning of medical information (from health professionals and the media)
  – Reassurance seeking from health professionals;
  • sometimes very extreme
  – Reassurance can be subtle and unseen
  – Patients able to elicit not only reassurance, but also
  • multiple (expensive) unnecessary referrals and investigations
The problem of reassurance

- Reassurance tells the patient what is NOT wrong with them.
- Sometimes reassurance backfires

The emergency doctor responded to Katie’s description of her symptoms by saying “That’s not MS... that’s not MS.... that’s not MS either... These symptoms would only indicate MS in some very unusual, difficult to diagnose cases.”
Why might the patient distrust reassurance?

• History: try to understand how the person came to believe what they now believe about their symptoms
• Identify assumptions about reassurance and the medical consultation
• Consider the personal meaning of the person’s present symptoms
If reassurance doesn’t work, what does?

• Disconfirmation is not usually an option because of the timescale
• Katie says: “I just know that this is the first sign of MS, too early for the doctors to detect; it’s just creeping up on me”
• Patients are grateful if they find out what the problem is not; but they really want to know what the problem IS
Engagement requires empathy: helping the patient to feel understood

- First, the therapist has to understand
Health anxiety and threat

- I might have Multiple Sclerosis X
- I will end up crippled and a burden on those I love, unable to reach my dreams
- Above
- I will fall apart, my family will have to look after me. I will be a basket case PLUS
- Anything the Doctors do will just make things worse
Negative appraisals: other examples

• I have AIDS
• I have cancer
• I am about to die
• I have a serious brain disease
• I have heart disease
• I have a serious illness the doctors haven’t diagnosed yet
Assumptions: examples

Bodily changes are always a sign that something is wrong.
If I don’t worry about my health, something will go wrong.
Detailed tests are the only way to really rule out an illness.
If the doctor sends me for any tests, this is because he or she is convinced that there is something wrong.
Treatment of Health Anxiety: general issues

• Treatment should not begin when the patient is currently receiving seriously ambiguous cross referral
• Exclusion of a physical condition is, however, NOT a requirement
• Audiotape of session: helps memory and processing
• Involvement of others helpful - 8-16 sessions, sessions up to one hour long
Engagement problems

• General resistance arising from
  • – Fear
  • – Avoidance
  • – Misunderstanding psychological approach
• • “Not all in the mind”
• • “I’m not mad”
• • “My childhood was fine”
• – Previous responses from clinicians
• Investment issues
Preventing treatment from making things worse

Hypochondriacal patients are particularly likely to misinterpret health relevant information as indicating they may be ill: therefore, they may misinterpret the information discussed during therapy sessions. Ask the patient to summarise at the end of each therapy session. If the patient has misinterpreted what was discussed, turn this to therapeutic advantage.
**Treatment: Cognitive-behavioural therapy: “information, information, information, information”**

1. Agree on main target problem/s
2. Specific assessment
3. Formulation and shared understanding
4. Identify the formulation as an alternative, less threatening account of the person’s problems
5. Discussion techniques: intended to help the person understand how the alternative explanation works
6. Behavioural experiments intended to allow the person to gather new information which allows them to extend their understanding of how the alternative explanation works.
Validating the patient’s experience:
“I have pain in my legs, intense tingling and I think I have multiple sclerosis”

The best way to decrease belief in a highly threatening idea which cannot be disproved is to build up belief in an alternative explanation. The alternative explanation does not have to be completely incompatible with the threatening belief; initially, it probably helps if it is not.

This type of reattribution will proceed best if the patient feels understood. The formulation therefore is best done as a “shared understanding”
Assessment: history can help

Helps establish a rapport, helps the person to “feel understood”.
Can help the therapist to understand the person’s distrust of reassurance.
Can establish aspects of the “Developmental Formulation”.
Development of depression and demoralisation.
Can help establish the personal meaning of illness.
Often gives particularly vivid examples of the key processes in action.
Assessment tools

- BAI
- BDI
- Cognitions Scale
- Attitudes/Assumptions
- Responsibility cognitions
- (Health anxiety thought records)
HAI

- Health anxiety inventory
- 1. Six months or last two weeks
- 2. Scales: Symptoms, “cost”, Avoidance,
- Reassurance
- 3. Brief (12/4) item version available
Assessment: identifying a specific instance

1. A recent and relatively well remembered episode is identified.

2. Situation and time are primed: where and when was it? What were you doing just before it? What was the first sign of trouble?

3. Step through the situation and the person’s reactions

4. “Emotion is the guide”

5. Slow things down if steps are skipped
Assessment: guided discovery

• Guided discovery is main method: aims to lead to a
• “vicious flower” formulation
• Pay attention to sequencing of questions
• “When you noticed your fingers tingling, what seemed to you, at that time, was the worst thing this could mean?” [belief ratings 95%]
• “When you thought this tingling meant you had Multiple Sclerosis, how did that affect you? [how did it make you feel.....what did you do......what did you pay attention to.......how did you try to deal with it.....]
Assessment: guided discovery again

• “What did that do?”; “At that time, what was the effect of.......on the belief that you had multiple sclerosis?”

• “When you felt terrified, what did that do to your thinking....did it increase it or decrease it?”

• “What did you notice when you checked your body for symptoms?”
Shared understanding and formulation

• The shared understanding provides the basis for explicit discussion of two different ways of understanding their problem
• Guided discovery aiming to explore the treatment rationale, not didactic
• Help patient to understand
• • (1) why they experience severe health anxiety
• • (2) why it persists
• Panic attacks?
• Obsessional type presentation?
Treatment elements (1): Engagement and socialisation

• The necessary first step in treatment (and sometimes in assessment) is **engagement**
• Issues surrounding engagement:
  • “Are you saying its all in my mind?”
  • “What guarantees can I have?”
  • “I’ll be dead by then”
• Pros and cons of being anxious about health.
• • Forward time projection;
  • “You are 80 years old and looking back on your life.....”
• The engagement deal: theory A / theory B
Treatment elements (2)

• Treatment involves a range of other components, including:
  • Self monitoring
  • Specific re-attribution
  • Discussion and behavioural experiments, aimed to help the patient to evaluate the alternatives.


Treatment elements (3)

• Discussion and behavioural experiments are linked and interwoven.
• Discussion and verbal techniques usually help the patient to draw upon their past experience to understand the alternative explanation which they are considering.
• Behavioural experiments are used to gather new information to feed into the discussion. “Don’t trust me, test it for yourself”
Treatment elements (4)

- Discussion techniques
- Reviewing the evidence: for and against both ways of looking at things
- Using the alternative explanation/framework to understand the significance of old information
- Specific discussion techniques:
  - Challenging beliefs
  - Pie charts
Pie chart in health anxiety

- Identify the distorted belief
- Multiple Sclerosis >>> muscle weakness and shakiness
- Therefore
- Muscle weakness and feeling shaky >>> Multiple Sclerosis
- Belief rating (90%)
- Encourage the patient to make a list of all possible causes of muscle weakness in this town today; begin with Multiple Sclerosis.
- When the list is complete, the pie chart is divided up into percentages starting at the bottom of the list
- Re-rate belief: 40%
- What if anxiety is not included?
Pie charts: in people with multiple serial concerns

- Patient repeats exercise with a previous symptom-illness link
- Finally, repeats exercise with a possible future symptom-illness link.
Treatment elements (5)

• Dealing with reassurance and medical consultation seeking
• “How helpful is reassurance?”
• Promising large amounts of reassurance; for a price......
Treatment elements (6)

• Dealing with the “cry wolf” worry
• (i) programmed postponement
• (ii) worries about emergencies
Behavioural experiments: what do you want to achieve?

1. To help the person to discover that the things which they fear will not happen
2. To help them discover the importance of maintaining factors
3. To help them discover the importance of negative thinking
4. To help them find out whether using an alternative strategy will be of any value
5. To discover the “truth” about beliefs
The present status of treatment for Hypochondriasis

Good evidence that CBT and cognitively-based psycho-educational interventions are effective

Some evidence that the effects of CBT are not solely due to non-specific factors

Some evidence that Behavioural Stress Management (a composite treatment which includes the engagement elements of CBT) is effective

Some unpublished evidence that SRIs are effective