

### **Cognitive-Behavioral Treatment (CBT)**

CBT and related interventions are effective in treating health anxiety and hypochondriasis. Specific components of CBT include psychoeducation, exposure and response prevention, and stress management. Clark and Salkovskis (Clark et al., 1998) and their colleagues conducted the first large-scale, randomized, controlled study that found both CBT and stress management more effective for treating hypochondriasis than a list control. Barsky and Ahern (2004) reported similar findings in a large, randomized, controlled trial

of CBT for hypochondriasis in which a largely psychoeducational approach targeted the amplification of benign bodily symptoms, faulty health and disease beliefs, and maladaptive illness behaviors. In another smaller controlled study, patients with hypochondriasis and multiple somatoform symptoms were compared to patients with somatic symptoms only; CBT was equally effective for both groups (Bleichard et al., 2005). Bouman and Visser (1998; Visser & Bouman, 2001) conducted two studies that compared cognitive therapy to behavior therapy with exposure methods. Both treatments were equally effective relative to wait-list controls.

The primary task facing the therapist treating a patient with health anxiety is to make these treatments acceptable to the patient and help the patient consider that his or her health worries, ruminations, obsessional thinking, and illness behaviors may be as much a source of the patient's difficulties as the physical discomfort or undiagnosed medical illness. When a patient enters a specialized clinic that utilizes CBT (such as the Houston OCD Treatment Program), the first step is to complete a psychiatric and medical assessment. No matter how thorough, this assessment is often experienced as not comprehensive enough because patients with health anxiety and hypochondriasis tend to be overinclusive in the information provided. Patients believe, for example, that if they could only be clearer or more thorough, then a solution to their difficulties could be found. The belief that the assessment is too brief can seriously hinder the formation of the necessary therapeutic alliance. In addition, the therapist, like previous health care professionals, can easily get mired down in the minutiae of the patient's symptoms. A therapist needs to begin by fostering trust with the patient by showing empathy and understanding for the patient's problems. The therapist provides the assurance that even though the psychological aspects are going to be explored, the patient's physical health will not be neglected. Additional assurance should be given that any physical discomfort will be taken seriously. Many patients feel accused that their complaints are "all in their head" or that they are merely imagining their symptoms. Purely medical approaches in the past have failed for these patients, and it is likely that an overly aggressive psychological approach may be doomed for failure as well (Lautenbacher & Rollman, 1999).

Through the assessment process the therapist will gain a better perspective of the patient's experience. Whether a patient fears getting a disease, fears that he or she already has a disease, or is convinced that she or he has a disease greatly influences the treatment planning. It is important to identify the patient's beliefs, assumptions, and behavior patterns involving her or his health and illness concerns. Family members can be interviewed to get other perspectives on the patient's struggles. Self-monitoring also can be used to gather information. The patient is instructed to keep written track of when symptoms occur, what the thoughts were at that time, a description of the emotional experience, and what the behaviors were.

An initial stage in the treatment for health anxiety and hypochondriasis is psychoeducation. Mild forms of the problem may be helped with psychoeducation alone, such as learning real and appropriate medical facts and the role of stress (Taylor & Asmundson, 2004). Many health anxious patients, particularly those who are disease phobic, are woefully underinformed about health and illness. Psychoeducation also can involve providing information about the connection between thoughts and beliefs in anxiety and other emotional experiences, the misinterpretation of noisy body sensations, the role of selective attention in amplifying symptoms, and how various forms of checking and reassurance seeking are factors in maintaining health anxiety. In addition, the role that stress and loss play in physical problems can also be explained as well as the consequences of falling into the "sick role."

Through group and individual sessions, patients are encouraged to challenge their prevailing beliefs and assumptions. Initially, patients are asked to at least consider a new, competing hypothesis that psychological factors can account for at least some of their physical discomfort and that firmly held beliefs that there is something medically wrong may not be absolute facts. Since patients have been struggling with trying to find medical answers, in some cases for several frustrating years, they may be ready for a new strategy. Patients are then asked to begin challenging their thoughts and behaviors, generating more adaptive thought patterns, and engaging in more useful activities. Patients will be asked to generate evidence for and against the possibility that they have a diagnosable medical illness. The evidence itself may be in need of critical scrutiny, and further challenges may need to be made. The patient could be asked the following questions: "How do you know your assumption is true?" "What other assumptions could be true?" "What would you do if it were true?" These questions can be useful in helping to generate more effective and adaptive responses. There are a variety of other CBT techniques that help patients reframe ineffective thoughts into healthy and more productive ways of looking at things (see Salkovskis & Warwick, 2001; Taylor & Asmundson, 2004).

Exposure and response prevention (E-RP) is used in a similar fashion as with OCD. The process of E-RP exposes patients to increasingly stressful triggers and helps them prevent safety behavior or ritual-like responses. During exposure to triggers, patients' distress (usually anxiety) will increase dramatically. Without the safety behaviors (e.g., escape, avoidance, checking, reassurance seeking) to reduce distress, patients learn that they *habituate* to their distress over time. Through habituation, patients find a new source of information that begins to disconfirm their beliefs that a catastrophic result will occur if they face a feared situation while relinquishing their safety behaviors. They will also start to accumulate evidence that disconfirms their beliefs in their inability to tolerate negative emotional states. Patients develop a hierarchy of fears through which they will work up to challenging themselves to habituate to their most feared situations. When it is difficult to arrange actual feared situations, an imaginal exposure can be set up through repeatedly writing out fears or listening to a recorded message that describes the fear until habituation occurs.

Another component of CBT for hypochondriasis is the behavioral experiment. In a behavioral experiment, the patient and the therapist agree to a set of behaviors or a goal, after which the results will be analyzed to determine what has been learned. For instance, a patient who fears having a heart attack may be asked to exercise for 10 minutes then record how many times he checks his pulse the rest of the day. In the same situation, a behavioral experiment could be used to help the patient gather disconfirming evidence that a heart attack will occur if he exercises and does not check his pulse. Behavioral experiments can be short exercises (e.g., asking the patient to hold his breath to increase heart rate) or maybe of longer duration (e.g., negotiating with patient to not take his blood pressure for 1 week). The patient and the therapist should assess each behavioral experiment to determine what was learned and what further experiments need to be conducted.

In addition to CBT, family therapy, relapse prevention, and stress management can be helpful in getting patients out of the sick role. Families need to learn, for example, how to give reassurance without reinforcing obsessive ruminations and dysfunctional behaviors. Family therapy also can be an essential part of relapse prevention to support patients in maintaining treatment gains. In many cases, it can be beneficial to work with the primary physician whether the physician is a psychiatrist, a family doctor or a specialist who is well informed and understanding of the patient's health anxiety in helping a patient in recovery make good decisions about future health care. For instance, a patient may make a contract not to seek further evaluation or treatment without a collaborative decision with the designated medical professional. The designated professional will help a patient contain the excessive seeking of unnecessary and expensive medical tests and specialty consultations. This must be a person with whom the patient has a trusted relationship and has agreed in advance to accept reasonable and appropriate medical reassurance despite thoughts and feelings to the contrary. Regular appointments for a period of time with this trusted professional to help reduce "doctor shopping" and excessive reassurance seeking from friends and family might be warranted. Since symptoms of health anxiety and hypochondriasis often increase in difficult times, stress management can be a useful auxiliary to patient recovery. Components of a stress management program will typically consist of self-monitoring of stressful situations and reactions, increasing problem-solving skills, and applied relaxation.

### **Pharmacological Treatments**

Several antidepressants have been studied for effectiveness in treating health anxiety and hypochondriasis. Medications with demonstrated efficacy include the tricyclic medications clomipramine and imipramine, and three SSRIs: fluoxetine, fluvoxamine, and paroxetine (Fallon, 2004). Precisely why these medications work on health anxiety and hypochondriasis is speculative. A reasonable assumption is that the antianxiety and antidepressant effects of these medications are effective for reducing the amplification of bodily symptoms. SSRIs also help with pain syndromes in patients who do not have reported anxiety and depression (Taylor & Asmundson, 2004).

There are pitfalls, however, to using pharmacotherapy in treating patients with health anxiety and hypochondriasis. Because no medication works for everyone in the same way, there is some trial and error in the process, as is the case with most psychiatric problems. This trial-and-error aspect can be troubling to patients with health anxiety because they can often be impatient and want to switch medications frequently. In addition, some patients' health anxiety is related to past side effects from previous medication trials. The phenomenon of the "nocebo effect" which is the opposite of the placebo effect, is frequently encountered in all forms of the pharmacological treatment of patients with health anxiety and hypochondriasis. The nocebo effect is experienced when a patient expects to experience negative side effects, similar to a self-fulfilling prophecy (Barsky, Saintforth, Rogers, & Borus, 2002). As a result, a medication may be prescribed in an effort to give relief to a patient, but the potentially unfortunate result is an increase in more distressing symptoms that generate more problematic self-focused rumination and worry.