

## CBT for Health Anxiety ("Hypochondriasis")

Jon Wheatley  
(with thanks to Paul Salkovskis)

## How psychological treatments work

- People suffer from anxiety because they think situations as more dangerous than they really are.
  - Treatment helps the person to consider alternative, less threatening explanations of their problem
- If the alternative explanation is to be helpful:
- It has to fit with your past experience
  - It has to work when you test it out

Good therapy is about two (or more) people working together to find out how the world really works  
It involves two experts working on the problem in close collaboration.

## 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"

**"No one ever believes you when you tell them your fears"**

## DSM IV Hypochondriasis

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

## DSM IV Hypochondriasis

- The fear of having a serious physical illness:
  - "I want you to help me with my fear of cancer"
- The belief that one already has a serious physical illness:
  - "I don't need psychological help. My problem is that I have cancer."
- *These are quite different presentations, with different implications for engagement in therapy*

## Cognitive theory of panic

- Patients with recurring panic attacks have an enduring tendency to misinterpret certain bodily sensations as a sign of *imminent disaster* (thinking palpitations are a sign of a coronary)
- Acute panic attacks result from the misinterpretation of bodily or mental sensations as signs of imminent personal disaster. (Clark, 1986 & 1988; Salkovskis, 1988, 1998)

### Cognitive disturbance in health anxiety (1)

- Similar to panic, in that the misinterpretation of bodily sensations commonly occurs.
- However, health anxious patients also misinterpret other things, including bodily variations, medical information from doctors and from the media, and the results of health screening and tests.

### Cognitive disturbance in health anxiety (2)

#### Key differences

- Relatively delayed time course in terms of the feared catastrophe
- Different behaviours (checking and reassurance seeking are prominent)
- Alternation of “dwelling” and avoidance
- Assumptions concerning health prominent

### Bodily sensations & misinterpretations

Heart racing, palpitations	I'm having a heart attack
Lumps under skin	I've got cancer
Loss of sensation & tingling in arms and legs	I've got multiple sclerosis
Feeling dizzy, faint, weak	I've got HIV, AIDS
Feeling dizzy, tight chest	I'm dying

### Interpretations questionnaire: sample health anxiety item

- Your heart is beating quickly and pounding
- Why?
1. Because you are excited
  2. Because you are having a heart attack
  3. Because you have the early signs of heart disease
  4. Because you have been exercising

### Negative appraisals: other examples

- I have a serious brain disease
- I have heart disease
- I have a serious illness that the doctors haven't diagnosed yet

### DSM or Dimension?

OCD      “Hypochondriasis”      Panic Disorder

Selective attention  
 Safety seeking behaviours  
     Reassurance  
     Avoidance  
     Counter-productive strategies  
 Somatic sensations  
 Delay or imminence of threat

- Where Panic attacks are present, deal with this first

### Prevalence of health anxiety “Medically Unexplained 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

### Prevalence of Hypochondriasis

#### Cross national study in primary care (Gureje, Ustun and Simon, 1997)

Outpatient primary care clinics in 15 sites in 14 countries, screened using the GHQ 12; second stage used the CIDI.

ICD10 Hypochondriasis: **0.8%**

“Unrestricted” hypochondriasis: **2.2%**

Higher rates of Major Depression & GAD.

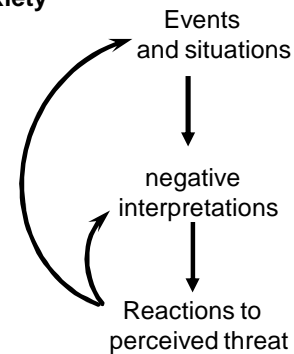
high rates of health care usage.

### Health anxiety: Phenomenology

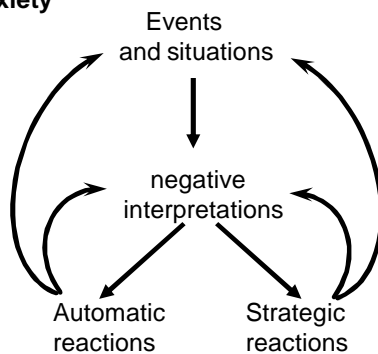
Key features of clinical health anxiety:

- 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
- Patients able to elicit not only reassurance, but also multiple (expensive) unnecessary referrals and investigations

### Simplified Cognitive model of the persistence of anxiety

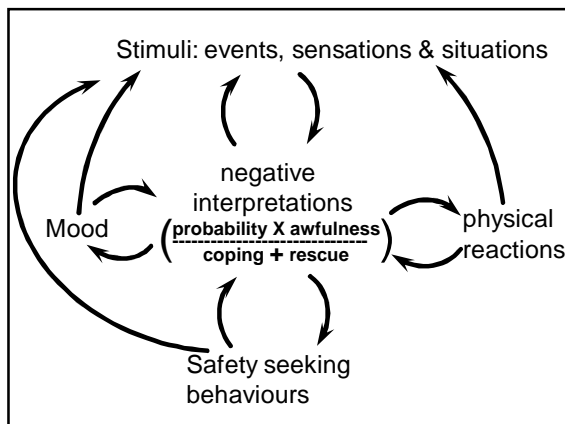


### Simplified Cognitive model of the persistence of anxiety



### 4 main processes

- Information-processing biases
  - selective attention
- Physiological reactions
  - E.g. heightened experience of bodily sensations
- Safety-seeking behaviors
  - E.g. avoidance, checking, and reassurance seeking
- Affective changes
  - particularly anxiety and depression



## Health anxiety and threat

<p><b>I might have Multiple Sclerosis</b></p>	×	<p><b>I will end of crippled, a burden on those I love, unable to reach my dreams</b></p>
<p><b>I'll fall apart My family will have to care for me. I'll be a basket case</b></p>	+	<p><b>Anything the doctors do will just make things worse</b></p>

- ### 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

- ### Treatment: underpinnings
- Engage with the person: **May have had a history of health problems, family illnesses & death, not being taken seriously**
  - Validating the patient's experience:
    - "I have pain in my legs, intense tingling and I think I have multiple sclerosis"*
    - "That must be terrifying..."*
  - General clinical assessment (Pt may not expect this...)
  - Goal setting (short, medium and long term): help the person to engage with their life.

- ### Engagement problems
- General resistance arising from
    - Fear
    - Avoidance
    - Misunderstanding psychological approach
      - "Not all in the mind"
      - "I'm not mad"
      - "My childhood was fine"
  - Investment issues

Engagement requires empathy:  
helping the patient to feel understood

## First, the therapist has to understand

## 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”
- Insurance metaphor
- 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: general

The main element of treatment is **re-attribution**: based on the fact that the best way to decrease belief in a highly threatening belief which cannot be disproved is to build up belief in an alternative explanation.

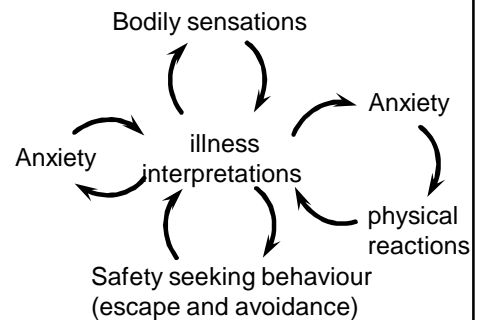
The alternative explanation does not have to be completely incompatible with the threatening belief; initially, it probably helps if it is not (why?)

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

## 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?

## Cognitive model of the persistence of anxiety: a validated multi-component model



## Negative appraisals: 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

## 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 (14/4) item version most commonly used
  4. Available in the IAPT 'disorder specific measures' pack

## Assessment: identifying a specific instance

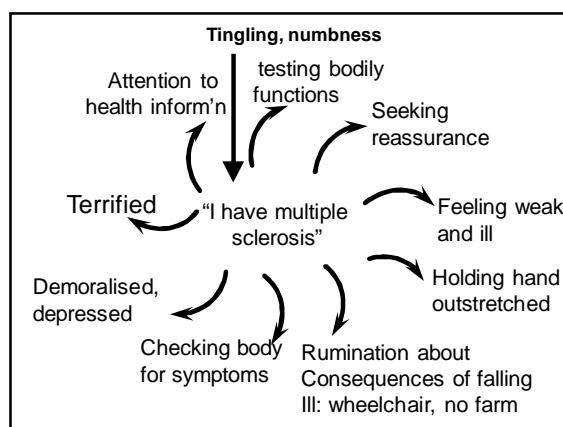
- A recent and relatively well remembered episode is identified.
- Situation and time are primed: where and when was it? What were you doing just before it?
- What was the first sign of trouble?
- Step through the situation and the person's reactions
- "Emotion is the guide"
- Slow things down if steps are skipped

## Assessment: guided discovery

Guided discovery is main method: aims to lead to a "vicious flower" formulation

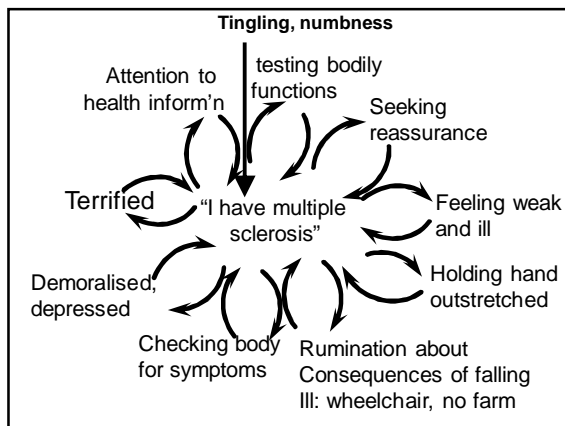
Pay attention to sequencing of questions

- "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?"



### Common problems when working with health anxiety

- Misinterpretation of content of therapy
  - Cognitive distortions
  - Assumptions about health
- Reassurance seeking
  - Managing genuine health scares

### Misinterpretation of therapy

- 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

### Assumptions about self/others

- I am weak and vulnerable
  - E.g. "there's heart trouble in the family", "I've had weak lungs since I was a baby"
- Doctors should have all the answers
- Others are unable to help
  - or Others are responsible for my health

### Common assumptions about signs/sensations of illness

- Bodily changes are always a sign that something is wrong
- If you don't go to the doctor as soon as you notice anything unusual then it will be too late
- If I don't worry about my health, then 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

### Critical incidents might activate assumptions

- Unfamiliar bodily sensations
- Hearing details of illness in a friend of a similar age
- Hearing new information about illness
- Further bodily sensations may then be noticed as a consequence of increased vigilance arising from anxiety

## Examples of cognitive distortions

- **Jumping to conclusions**  
'I'm sweating more than I should in this hot spell. I must be ill.'
- **Catastrophising**  
'This must be cancer'  
'Nobody is ever really cured of cancer'
- **Superstitious thinking**  
'If I think I'm well, I will tempt fate'

## Examples of cognitive distortions

- **All or nothing thinking**  
'Unless I am entirely free from symptoms, then I must be unwell'  
'I must always know I am completely well'
- **Selective attention and memory**  
'The doctor said he might arrange for another test in a few months time – he must think there is something wrong' (ignoring the fact that he had said there was no abnormality on the test)

## The problem of reassurance

- Reassurance tells the patient what is *NOT* wrong with them.
- Sometimes reassurance directly backfires
- It will almost always indirectly backfire: it is functionally identical to OCD checking

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
- Only discuss reassurance in session 3 or later?

## 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*

## Reassurance & Therapists

- Patients may ask us for reassurance
- May create anxiety in the therapist
- Rule of thumb: when patient is very distressed, imagine they have just come in for a routine check-up with same symptoms, but not anxious about them
- Therapist can promise large amounts of reassurance, for one day only...

### Responsibility for consultation questionnaire example items:

It would be wrong not to mention every symptom, even the most minor symptoms in case they are important.

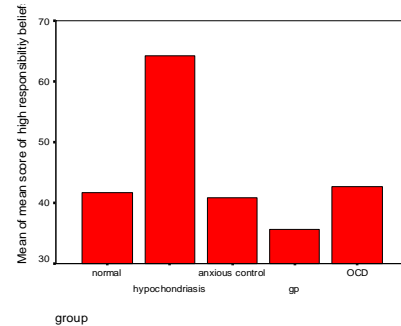
The doctor may fail to realize that I am seriously ill if I miss out any details about my symptoms.

I'll only worry if I haven't told my doctor exactly what my symptoms are and how I feel.

I need to be sure that I get the right diagnosis.

Hypochondriasis, Healthy controls, Anxious controls, OCD : plus GPs

### Responsibility for consultation



### Treatment elements (2)

Treatment involves a range of other components, including:

- Self monitoring (very important)
- Specific re-attribution
- Discussion and behavioural experiments, aimed to help the patient to evaluate the alternatives.

### Example health anxious thoughts diary

- Situation: In a playground with the children
- Trigger: Saw a bruisy mark on my leg
- Negative Automatic Thought: I've got leukaemia
- Anxiety (0-100): 90
- Action taken: Thought back to see if I'd knocked myself, checked myself for other bruises, and constantly checked this mark to see if it was getting bigger.

### Reattribution: General

- Emotional engagement: essential!
- The therapist's job is to help loosen the disease-based interpretations and build an alternative understanding of the problem.
- Language:
  - Signs and symptoms
  - Sensations and variations

### Reattribution 1:

- Help the patient to identify thinking errors in their interpretation of bodily sensations and health-related information.
- Frequent errors include
  - Jumping to conclusions
  - catastrophizing
  - Selective abstraction.
- Generate alternative, less-threatening interpretations using questions
  - "What evidence do I have for this belief?"
  - "What alternative explanations could there be?"
  - "What are the advantages and disadvantages of thinking in this way?"

## Reattribution 2:

- Ensure that the patient generates their own alternative response and that they continue to use reattribution techniques between treatment sessions.
- "Rational response" is viewed as a hypothesis, to be tested out in behavioral experiments.
- Logging evidence (how what has happened fits with "I have cancer" and "I have a lot of health anxiety"): collated in therapy
- Beware the development of reassurance

## 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 health-related information
- Specific discussion techniques:
  - Socratic questioning of beliefs
  - e.g. "How helpful is reassurance? How long does it last?"
  - 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%**

## Pie chart in health anxiety

- Identify the problematic belief  
(e.g. brain tumour >>> headaches  
*Therefore* headaches >>> brain tumour)
- Belief rating (0-100)
- Encourage patient to make a list of all possible causes of headaches in your town today, beginning with brain tumours
- When the list is complete, divide the pie chart into percentages *starting at the bottom of the list*
- Re-rate belief

## Example of an inverted pyramid

- No. of people in London with a headache this morning: 2000
- No. still with a headache this evening: 1000
- No. who still have it tomorrow: 300
- No. who still have it after 3 days: 50
- No. who go to GP and are sent for tests: 20
- No. who are told that its serious: 3
- No. who are told its a brain tumour: 1
- No. who are not successfully treated: .001

*How sure are you now that your headaches are a life threatening brain tumour? Are you JTC?*

### Treatment elements (5)

- Dealing with reassurance and medical consultation seeking
- Reassurance alternatives: moving to support. Reassurance involves the person focussing on theory A: support is about emphasising theory B as an alternative
- Relationship issues: what else are they going to do? How? Planning it.

### Treatment elements (6)

- Dealing with the “cry wolf” worry
- ‘programmed postponement’
- ‘reassurance agreements’
- Overestimating ill-health

### 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

### Behavioural experiments

#### Testing Predictions

- Predictions about specific symptoms indicating imminent catastrophe are tested in sessions.
- Examples include tensing muscles to bring on pain, or running up and down stairs to bring on breathlessness and chest pain.
- If the exact or similar sensations to those involved in the patient’s concerns can be reproduced, it helps to disconfirm a catastrophic interpretation and thus build up belief in the alternative explanation.
- Best if the process of bringing on symptoms matches patients naturally occurring safety seeking behaviours

### Behavioural experiments

#### Selective-Attention Experiments

- In selective attention experiments, patients are asked to focus on a specific body part for several minutes
- Choose an area/symptom that is not a current focus of health anxiety
- Then: ask to describe any bodily sensations they notice.
- Most will detect sensations that they were unaware of before the experiment—for example, tightness in throat, tingling in fingers.
- This exercise is helpful as a demonstration of the effects of symptom monitoring and bodily checking.

### Behavioural experiments

#### Dropping Safety-Seeking Behaviours.

- Safety seeking behaviours (checking, avoidance, reassurance seeking) that maintain health anxiety.
- Patients can test out the effects of these behaviours for themselves using an alternating treatment experiment.
- 1: Establish monitoring (anxiety, sensations, strength of belief)
- 2: Increase the target behaviour for a while e.g. bodily checking and information seeking
- 3: Next interval the patient has to completely refrain from the target behaviour while still monitoring anxiety, symptoms and strength of belief
- 4: Resulting data is reviewed and graphed.
- Patients are often surprised at how much worse they feel on the day in which the target behaviour is increased and this experiment can be used to help them to decide to drop the target behaviour completely.

## Behavioural experiments

### Worry and rumination

- In-session patients are asked to identify ruminations/imagery then run through these by talking out loud for a period (or closing their eyes and rehearsing).
- Assess impact on mood, symptoms awareness, and disease conviction.
- "What do you make of that?"
- Review advantages and disadvantages of rumination

## Imagery in health anxiety

(Wells & Hackmann 1993)

- Images of blood vessels bursting, body riddled with cancer, family at funeral etc
- Imagery more closely linked to emotion than verbal thoughts
- May attempt to suppress distressing images – patients typically block images before they reach the worst point: try to run it on.

## Catastrophobic thoughts & images

- |   |  |
|---|--|
| • I've got heart disease                      | • Self as rotting corpse & parents distressed    |
| • I could have AIDS                           | • Dead and trapped in body, helpless             |
| • This might be cancer                        | • Son & husband happy & she is forgotten         |
| • I'm seriously ill & will end up in hospital | • Kept in hospital against will with no visitors |
| • I'll have to give up work                   | • Family destitute                               |

## Meanings of the images

- To be dead means to be alone & aware of self as corpse & distress of significant others
- To be dead means to be alone & trapped in your body forever
- To be dead would be to be completely forgotten, even by her husband & son
- To be ill would be to be admitted to hospital, kept there against will & abandoned by relatives
- To be ill would mean incapacity & financial ruin

## Imagery modification

- Explain how suppression maintains emotional significance of image
- Discuss evidence & alternatives
- Incorporate new info. into the image
- Example: rescripting image of self getting the all clear & healthy in 10 years time with family

## Relapse prevention

- Discuss idea of "setback" rather than relapse
- Seek to confront all possible situations in the course of therapy (no red areas on map)
- Emphasise the setback as positive experience
- Blueprint and relapse pack (action plan)
- Anticipate problems
- Build positives

## The present status of treatment for Hypochondriasis

- Good evidence that CBT and cognitively-based psychoeducational interventions are effective
- **Danish Study: Ulla Wattar, Morten Birket-Smith, Per Soronsen and Paul Salkovskis (in press)**
  - Compared CBT, psychodynamic therapy & wait list control
- 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

## Effects of Mindfulness based CBT (McManus, Muse & Williams)

- MBCT helps people to relate differently to thoughts & images
  - They are just images, not indicative of reality
- MBCT groups had an indirect effect on the frequency, associated distress & ability to 'let go' of negative images of future
- Reduced unhelpful responses of avoidance or rumination

## Selected references

- Salkovskis, P. & Bass, C. (1997). Hypochondriasis. In D. Clark & C. Fairburn (eds.) *Science and Practice of Cognitive Therapy*. Oxford, OUP.
- Sanders, D. & Wills, F. (2003). Health Anxiety. Chapter in Sanders and Wills, *Counselling for Anxiety Problems*. (2<sup>nd</sup> ed.) London: Sage.
- Wells, A. (1997). Health anxiety. Chapter in *Cognitive Therapy of Anxiety Disorders. A Practice Manual and Conceptual Guide*. Chichester: Wiley.
- Wells, A. & Hackmann, A. (1993). Imagery and core beliefs in health anxiety: content and origins. *Behavioural and Cognitive Psychotherapy*, 21 (3), 265-274.