

the client willingly explore the possibility that their illness beliefs might be better accounted for by explanations other than physical illness. This is a necessary first step that must be successful before cognitive modification, response prevention, and exposure can be initiated. Given Mrs. A.'s presentation, it is likely that our approach, or something along these lines, will be successful. Indeed, treatment strategies derived from the CB model of health anxiety have recently been shown to be effective in randomized controlled trials (e.g., Clark, Salkovskis, et al., 1998). On a case-by-case basis, review of personal monitoring and reapplication of relevant self-report instruments (as described above) can be used to evaluate treatment progress. Preventing relapse, however, will involve not only additional follow-up contact with Mrs. A. but also restructuring of the style in which her physician and significant others respond to her illness concerns.

### References

- Asmundson, G. J. G., Taylor, S., Sevgur, S., & Cox, B. J. (2001). Health anxiety: Conceptual, diagnostic, and epidemiological issues. In G. J. G. Asmundson, S. Taylor, & B. J. Cox (Eds.), *Health anxiety: Clinical and research perspectives on hypochondriasis and related disorders* (pp. 3–21). London: Wiley.
- Clark, D. M., Salkovskis, P. M., Hackman, A., Wells, A., Fennell, M., Ludgate, J., Ahmad, S., Richards, H. C., & Gelder, M. (1998). Two psychological treatments for hypochondriasis. *British Journal of Psychiatry*, *173*, 218–225.
- Derogatis, L. R. (1975). *SCL-90-R: Administration, scoring and procedures manual—II for the revised version and other instruments of the psychopathology rating scale series*. Towson, MD: Clinical Psychometric Research.
- Fava, G. A., & Grandi, S. (1991). Differential diagnosis of hypochondriacal fears and beliefs. *Psychotherapy and Psychosomatics*, *55*, 114–119.
- First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1996). *Structured Clinical Interview for Axis-I DSM-IV Disorders—Patient Edition (SCID-I/P Version 2.0)*. New York: Biometrics Research Department, New York State Psychiatric Institute.
- Furer, P., Walker, J. R., & Freeston, M. H. (2001). Approach to integrated cognitive-behavior therapy for intense illness worries. In G. J. G. Asmundson, S. Taylor, & B. J. Cox (Eds.), *Health anxiety: Clinical and research perspectives on hypochondriasis and related conditions* (pp. 161–192). Wiley: New York.
- Hadjistavropoulos, H. D., Hadjistavropoulos, T., & Quine A. (2000). Health anxiety moderates the effects of distraction versus attention to pain. *Behaviour Research and Therapy*, *38*, 425–438.
- Kellner, R. (1986). *Somatization and hypochondriasis*. New York: Praeger-Greenwood.
- Kellner, R., Abbott, P., Winslow, W. W., & Pathak, D. (1987). Fears, beliefs, and attitudes in DSM-III hypochondriasis. *The Journal of Nervous and Mental Disease*, *175*, 20–25.
- Lucock, M. P., & Morley, S. (1996). The Health Anxiety Questionnaire. *British Journal of Health Psychology*, *1*, 137–150.
- Marks, I. M. (1987). *Fears, phobias, and rituals*. New York: Oxford University Press.
- McCabe, R. E., & Antony, M. M. (2004). Challenges in the assessment and treatment of health anxiety: The Case of Mrs. A. *Cognitive and Behavioral Practice*, *11*, 102–106.
- Noyes, R., Jr. (2001). Hypochondriasis: Boundaries and comorbidities. In G. J. G. Asmundson, S. Taylor, & B. J. Cox (Eds.), *Health anxiety: Clinical and research perspectives on hypochondriasis and related disorders*. London: Wiley.
- Pilowsky, I. (1967). Dimensions of hypochondriasis. *British Journal of Psychiatry*, *113*, 89–93.
- Rief, W., Hiller, W., & Margraf, J. (1998). Cognitive aspects of hypochondriasis and the somatization syndrome. *Journal of Abnormal Psychology*, *107*, 587–595.
- Salkovskis, P. M. (1989). Somatic problems. In K. Hawton, P. M. Salkovskis, J. Kirk, & D. M. Clark (Eds.), *Cognitive therapy for psychiatric problems: A practical guide* (pp. 235–276). Oxford: Oxford University Press.
- Salkovskis, P. M., & Warwick, H. M. C. (2001). Making sense of hypochondriasis: A cognitive model of health anxiety. In G. J. G. Asmundson, S. Taylor, & B. J. Cox (Eds.), *Health anxiety: Clinical and research perspectives on hypochondriasis and related disorders*. London: Wiley.
- Speckens, A. E. M., van Hemert, A. M., Spinhoven, P., & Bolk, J. H. (1996). The diagnostic and prognostic significance of the Whiteley Index, the Illness Attitude Scales, and the Somatosensory Amplification Scale. *Psychological Medicine*, *26*, 1085–1090.
- Stewart, S. H., & Watt, M. C. (2001). Assessment of health anxiety. In G. J. G. Asmundson, S. Taylor, & B. J. Cox (Eds.), *Health anxiety: Clinical and research perspectives on hypochondriasis and related disorders*. London: Wiley.
- Taylor, S., & Asmundson, G. J. G. (2004). *Treating health anxiety: A cognitive-behavioral approach*. New York: The Guilford Press.
- Walker, J. R., Vincent, N., Furer, P., Cox, B. J., & Kjernisted, K. D. (1999). Treatment preference in hypochondriasis. *Journal of Behaviour Therapy and Experimental Psychiatry*, *30*, 251–258.

Address correspondence to Gordon J. G. Asmundson, Ph.D., Anxiety and Illness Behaviours Laboratory, University of Regina, Regina, SK Canada S4S 0A2; e-mail: gordon.asmundson@uregina.ca

Received: May 24, 2001

Accepted: June 29, 2001



### Response Paper

## Understanding and Treating Health Anxiety: A Cognitive-Behavioral Approach

Steven Taylor

University of British Columbia

Mrs. A. presents with a textbook case of hypochondriasis. An additional diagnosis of OCD does not enhance our understanding or treatment of her problems, and is not indicated according to DSM-IV. Cognitive-behavior therapy (CBT) is effective in treating hypochondriasis, although it is necessary to devise a case formulation for each patient to determine which interventions to use and how to best implement them. A detailed cognitive and behavioral assessment is essential to successful treatment. In this commentary, I describe the important assessment areas that need to be covered to better understand Mrs. A.'s problems and the obstacles to assessment that might be encountered. A tentative case formulation is presented, based on the available information, and a tentative CBT protocol is derived. Likely obstacles to successful treatment, such as Mrs. A.'s poor insight into her disorder, need to be more thoroughly assessed in order to devise strategies for circumventing these difficulties.

**Cognitive and Behavioral Practice 11, 112–123, 2004**

1077-7229/04/112-123\$1.00/0

Copyright © 2004 by Association for Advancement of Behavior Therapy. All rights of reproduction in any form reserved.

**A**NXIETY ABOUT HEALTH is something we all experience at various times in our lives. In its mild forms health anxiety is adaptive, serving as a motivator for seeking appropriate health care and for avoiding things that are harmful to health. Severe forms of health anxiety are less common in the general population, but are often encountered in clinical practice, particularly by clinicians working in anxiety disorder clinics and in consultation-liaison services in general hospitals. The case of Mrs. A. is useful because it raises many of the important issues that clinicians encounter when assessing and treating people with severe health anxiety.

Mrs. A. presents with long-standing health anxiety, which has worsened in recent years. Her main problems are as follows: various somatic symptoms (e.g., pain in various bodily regions), numerous health-related fears (e.g., fears of having serious, undiagnosed diseases), chronic anxiety and health-related worries (e.g., worry that doctors are not sufficiently competent to make a correct diagnosis), and health-related safety behaviors. That is, behaviors intended to avoid or escape aversive stimuli (e.g., walking slowly up the stairs in order to avert a heart attack; seeking reassurance from doctors to allay her health concerns; avoiding air travel because of the perceived risks of breathing “recycled air”). She also seeks out various safety signals to reduce her health concerns. That is, stimuli she associates with the absence of health-related danger (e.g., carrying nitroglycerin spray that she could use in the event of a heart attack). Extensive medical testing has been unable to explain her somatic symptoms and has not reduced her health anxiety. She has poor insight into the excessive nature of her concerns.

### Diagnostic Issues

A diagnostic formulation is insufficient for understanding the causes of Mrs. A.’s problems and is insufficient for planning treatment. Nevertheless, the process of making a diagnosis is an important first step for understanding and treating her problems. The task of assessing *DSM-IV* Axes I and II encourages the clinician to look beyond the patient’s most salient problems. This helps the clinician identify psychiatric problems that might otherwise be missed. Diagnoses also facilitate communication among health-care professionals. That is, diagnoses represent a common language that can be used to communicate information about the patient’s primary problems. In the case of Mrs. A., diagnoses are important for communicating whether her problems are due to a general medical condition in need of a surgical or pharmacological intervention, or whether her problems are psychological in nature and therefore in need of some kind of psychotherapeutic or psychopharmacological intervention.

I agree with much of the diagnostic formulation offered by McCabe and Antony (2004). The authors make a good case for ruling out various disorders such as specific phobia and generalized anxiety disorder. I agree that Mrs. A.’s primary problem is hypochondriasis. In fact, she has a textbook case hypochondriasis. But is it useful or necessary to assign an additional diagnosis of obsessive-compulsive disorder (OCD)? McCabe and Antony believe so. These authors point out that Mrs. A. has symptoms suggestive of OCD: i.e., recurrent intrusive thoughts, rumination and doubting, and compulsions. But all of these symptoms are health-related. Her intrusive thoughts are about death and dying, her rumination and doubting are about health-related threats (e.g., doubts about the accuracy of medical tests), and her compulsions involve the search for reassuring health-related information or efforts to avoid health risks (even her concern about a gas leak at home is health-related). Mrs. A. does not appear to have any nonhealth-related obsessions or compulsions.

An additional diagnosis of OCD does not enhance our understanding of Mrs. A.’s problems or facilitate treatment planning. Her putative OCD symptoms are commonly associated with hypochondriasis (Asmundson, Taylor, & Cox, 2001; Kellner, 1986). In fact, inventories designed to measure the major facets of hypochondriasis include subscales and items assessing these symptoms; e.g., subscales assessing recurrent thoughts of death, doubts about medical tests, and excessive reassurance seeking (Asmundson et al., 2001). Contemporary cognitive-behavioral therapy (CBT) for OCD is in many ways similar to contemporary CBT for hypochondriasis (compare, for example, the hypochondriasis protocols in Taylor & Asmundson, 2004, with the OCD protocol in Taylor, Thorndarson, & Söchting, 2001). So, for Mrs. A., an additional diagnosis of OCD does not indicate any interventions that we would not already use in the treatment of hypochondriasis. In fact, a diagnosis of OCD may be more hindrance than help. Such an additional diagnosis carries the implication that Mrs. A. has nonhealth-related obsessions or compulsions, thereby misleading clinicians who receive information about her disorders. An additional diagnosis of OCD is also inconsistent with *DSM-IV*. According to *DSM-IV* (and the text revision, *DSM-IV-TR*), Mrs. A. does not qualify for an additional diagnosis of OCD because all her symptoms are health-related:

Individuals with Hypochondriasis may have intrusive thoughts about having a disease and also may have associated compulsive behaviors (e.g., asking for reassurances). A separate diagnosis of Obsessive-Compulsive Disorder is given only when the obsessions or compulsions are not restricted to concerns about illness (e.g., checking locks). (American Psychiatric Association, 2000, p. 506)

متن کامل مقاله

دریافت فوری ←

**ISI**Articles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات