



# Acceptance and commitment group therapy for health anxiety – Results from a pilot study



T. Eilenberg, L. Kronstrand, P. Fink, L. Frostholm\*

*The Research Clinic for Functional Disorders and Psychosomatics, Aarhus University Hospital, Barthsgade 5.1, 8200 Aarhus N, Denmark*

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## ABSTRACT

Health anxiety (or hypochondriasis) is prevalent, may be persistent and disabling for the sufferers and associated with high societal costs. Acceptance and Commitment Therapy (ACT) is a new third-wave behavioral cognitive therapy that has not yet been tested in health anxiety.

34 consecutive Danish patients with severe health anxiety were referred from general practitioners or hospital departments and received a ten-session ACT group therapy. Patients were followed up by questionnaires for 6 months.

There were significant reductions in health anxiety, somatic symptoms and emotional distress at 6 months compared to baseline: a 49% reduction in health anxiety (Whiteley-7 Index), a 47% decrease in emotional distress (SCL-8), and a 40% decrease in somatic symptoms (SCL-90R Somatization Sub-scale). The patients' emotional representations and perception of the consequences of their illness (IPQ) improved significantly, and 87% of the patients were very or extremely satisfied with the treatment.

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## 1. Introduction

Health anxiety or hypochondriasis is common with a prevalence of 0.8–9.5% in primary care (Creed & Barsky, 2004; Fink, Ørnboel, & Christensen, 2010; Fink, Ørnboel, Toft et al., 2004; Gureje, Ustun, & Simon, 1997), and spontaneous remission is rare in severely ill patients (Fink et al., 2010; Fink et al., 2004b). Health anxiety is seldom diagnosed and has traditionally been considered a chronic disorder that is difficult to treat (Barsky & Ahern, 2004). Health anxiety and hypochondriasis are often classified in different ways, and in this study, we have used the empirically established positive criteria for health anxiety published by Fink et al. 2004b. The essential features of health anxiety are exaggerated rumination with intrusive worries about harboring a serious illness and persistent preoccupation with ones health leading to significant decrease in health-related quality of life. Thus, health anxiety is mainly characterized by cognitive and emotional symptoms, which distinguishes it markedly from other somatoform disorders.

Psychotherapeutic treatments of health anxiety have primarily used various forms of cognitive behavioral therapies (CBTs) (Thomson & Page, 2007). Previous randomized, controlled trials (RCTs) have shown that treatments such as explanatory therapy (Fava, Grandi, Rafanelli, Fabbri, & Cazzaro, 2000), cognitive therapy (Greeven et al., 2007; Visser & Bouman, 2001), cognitive behavioral

therapy (CBT) (Barsky & Ahern, 2004; Clark et al., 1998; Sorensen, Birket-Smith, Wattar, Buemann, & Salkovskis, 2010; Warwick, Clarke, Cobb, & Salkovskis, 1996) and mindfulness-based cognitive therapy (MBCT) (McManus, Surawy, Muse, Vazquez-Montes, & Williams, 2012) are associated with decrease in symptoms of health anxiety.

Central to cognitive models of health anxiety is that patients with health anxiety have negative beliefs about health and illness and therefore misinterpret common symptoms as a sign of undiagnosed serious illness (Abramowitz, Schwartz, & Whiteside, 2002; Marcus & Church, 2003).

Since these misinterpretations entail physiological arousal and anxiety that may further intensify the physical sensations and worries, the focus in traditional CBT is on breaking this “vicious circle”. CBT specifically aims at challenging the content of the dysfunctional beliefs, conducting behavioral experiments, graded exposure, and possibly relaxation training.

However, a new generation of cognitive behavioral treatment methods commonly called “the third wave” is less focused on changing the form or frequency of inner experiences such as symptoms, but rather seeks to change the patients' way of relating to the experience. Acceptance and Commitment Therapy (ACT) is one of the new third wave therapies. The overall aim of ACT is to increase “psychological flexibility” defined as the ability to know and act upon personal life values, even when faced with difficult thoughts, emotions, and bodily sensations. Therefore, for example mindfulness is used to increase the individual's ability to recognize and gently allow unwanted inner experiences, rather than

\* Corresponding author. Tel.: +45 78464334; fax: +45 78464340.  
E-mail address: [lifro@rm.dk](mailto:lifro@rm.dk) (L. Frostholm).

suppressing, controlling, or ruminating about these. The human tendency of wanting to control or get rid of difficult thoughts, feelings, and sensations is called “experiential avoidance” in ACT terms and is assumed to be a key element in the development of psychological pathology (Fledderus, Bohlmeijer, & Pieterse, 2010; Hayes, Villatte, Levin, & Hildebrandt, 2011).

Third wave therapies are gaining more and more attention, both in research and clinical practice (Hofmann, Sawyer, & Fang, 2010; Ost, 2008). It is found that RCTs on ACT have an overall moderately strong effect size (Ost, 2008). ACT has not yet been tested in patients with health anxiety, but has shown a positive effect in the treatment of a range of disorders, among others depression, anxiety disorders, chronic pain, drug abuse, and psychotic symptoms (Bach, Hayes, & Gallop, 2011; Dahl, Wilson, & Nilsson, 2004; Dalrymple & Herbert, 2007; Forman, Herbert, Moitra, Yeomans, & Geller, 2007; Lundgren, Dahl, Melin, & Kies, 2006; Lundgren, Dahl, & Hayes, 2008; Lundgren, Dahl, Yardi, & Melin, 2008; Pull, 2009; Twohig, Hayes, & Masuda, 2006; Zettle & Rains, 1989; Zettle, 2003).

There are reasons to hypothesize that ACT may be applicable in the treatment of health anxiety as health anxiety phenomenologically is similar to anxiety disorders in some aspects, e.g. dysfunctional cognitions and rumination leading to misinterpretations of internal or external cues resulting in anxiety (Taylor & Asmundson, 2004). ACT has been applied specifically in RCTs on anxiety disorders, e.g. OCD (Twohig et al., 2010) and mixed anxiety disorders (Arch et al., 2012a; Forman et al., 2007) providing preliminary evidence that ACT may be an effective treatment for anxiety disorders. Furthermore, authors have stressed a relationship between anxiety sensitivity and the ACT term “experiential avoidance” (Arch, Wolitzky-Taylor, Eifert, & Craske, 2012; Berman, Wheaton, McGrath, & Abramowitz, 2010).

In this uncontrolled pilot study, we wished to examine the effect and acceptability of ACT group therapy on severe health anxiety as well as assess the study design in terms of assessment procedure, outcome measure, and treatment manual before initiating a randomized, controlled trial.

We hypothesize that for patients with severe health anxiety, ACT group therapy is (1) associated with significant reductions in self-reported health anxiety symptoms, somatic symptoms, and emotional distress 6 months after treatment compared to before treatment, (2) acceptable, and (3) associated with significant improvements in the patients’ illness perceptions 6 months after treatment compared to before treatment.

## 2. Methods

### 2.1. Subjects and setting

This study was carried out at the Research Clinic for Functional Disorders and Psychosomatics, Aarhus University Hospital, Denmark. Information about the study (e.g. referral procedure and inclusion and exclusion criteria) was sent to general practitioners in the catchment area and was also available on the clinic’s webpage. Treatment was free of charge for the patients, and they did not receive compensation for participation. Patients were consecutively referred from general practitioners or hospital departments. Between April 2009 and May 2010, patients referred to the clinic were screened for study eligibility (Fig. 1). Patients were invited to undergo a thorough clinical assessment using a modified version of the semi-structured psychiatric interview, Schedules for Clinical Assessment in Neuropsychiatry (SCAN) (WHO, 1998; Fink, Ørnbøl, Toft et al., 2004) performed by either a psychologist or a medical doctor. Psychologists consulted a medical doctor in case of unclear medical history. The eligibility criteria were: (1) the Whiteley-7 Index (scale 0–100 score points) score >21.4, (2) severe health

anxiety (Fink, Ørnbøl, Toft et al., 2004), (3) 20–60 years old, (4) of Scandinavian origin, and (5) in case of comorbid mental disorder, health anxiety is dominant. Patients were excluded if they (1) were at risk for suicide, (2) had current or previous episodes of psychosis, (3) had abuse of alcohol, drugs, or medication, (4) were pregnant, or (5) did not give informed consent to the study.

### 2.2. Study design and measures

Patients completed questionnaires at baseline, at the end of treatment, and at 3- and 6-month follow-up.

#### 2.2.1. Primary outcome

The primary outcome measure was the Whiteley-7 Index (Fink et al., 1999) – a 7-item measure on symptoms of health anxiety. The Whiteley Index (WI) has been widely used in assessing health anxiety and has demonstrated excellent psychometric properties in primary care samples with good sensitivity and specificity for screening DSM-IV somatization disorder and hypochondriasis/health anxiety (Conradt, Cavanagh, Franklin, & Rief, 2006; Fink et al., 1999).

Each item on the WI was Likert scored from 1 to 5, and the patients’ scores are shown as a sum score of these seven ratings. Scores were transformed from a 7–35 score point scale to a 0–100 score point scale (a higher score indicating more symptoms) to facilitate comparison with other studies using another version of WI.

The WI does not have a clearly defined cut-off in terms of identifying clinical cases. Therefore, the cut-off score >21.4 was established based on data from a primary care follow-up study on health anxiety. The study showed that at 24-month follow-up, 10% (the 90% percentile) of the patients with a well-defined medical condition had a Whiteley-7 score above 21.4 (scale 0–100 score points) (Fink et al., 2010).<sup>1</sup> We therefore chose this as the upper limit for natural worry about illness in a medical population and on this background defined patients scoring above this cut point as potential cases of health anxiety.

Furthermore, response status on the WI was determined according to the criteria of clinically significant improvement (Jacobsen & Truax, 1991). A clinically significant improvement was defined as an SD for change equivalent to 25 score points (scale 0–100 score points). The SD of the changes was assessed based on existing data from the clinic and has shown to vary quite a lot ranging from 15 to 25 (Fink et al., 2010). We have thus chosen a quite conservative estimate for the SD.

#### 2.2.2. Secondary outcome

Secondary outcome measures were severity of anxiety and depression measured with the SCL-8 scale (Fink et al., 2004a), physical symptoms measured with the SCL-90-R Somatization Subscale (Derogatis & Cleary, 1977), and illness perception measured with a Danish condensed version of the Illness Perception Questionnaire (IPQ) (Frostholm, Fink, Christensen et al., 2005; Frostholm, Fink, Oerboel et al., 2005; Frostholm et al., 2007). Four components of the IPQ hypothesized to be important in health anxiety were included: Negative consequences (e.g. ‘My illness will have negative consequences for how I perceive myself’), Uncertainty (e.g. ‘It is hard to figure out what’s wrong’), Long timeline perspective (e.g. “my symptom are a sign of a long-lasting illness”), and negative emotional representations (e.g. “My illness makes me feel depressed”).

<sup>1</sup> Further information on how the cut-off score for the WI was established can be obtained from the corresponding author.

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