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# The treatment of hypochondriasis: exposure plus response prevention vs cognitive therapy

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## Abstract

In this study (1) exposure in vivo plus response prevention, (2) cognitive therapy and (3) a waiting-list control condition were compared on their efficacy on the treatment of hypochondriasis. Seventy-eight patients with a DSM-IV diagnosis of hypochondriasis were randomly assigned to one of these conditions. Patients in both active treatment conditions improved significantly on all the measures, whereas the patients in the waiting-list control condition did not improve. The improvements were clinically significant. Exposure in vivo plus response prevention and cognitive therapy were equally effective. The improvements were maintained at the 7 months follow up. © 2001 Elsevier Science Ltd. All rights reserved.

*Keywords:* Hypochondriasis; Cognitive therapy; Behaviour therapy; Exposure; Treatment outcome

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## 1. Introduction

Hypochondriacal patients suffer from the fear or conviction of having a serious disease, and their fear or conviction is based on a misinterpretation of bodily symptoms (DSM-IV; American Psychiatric Association, 1994). Although appropriate medical examination has given no support to their ideas, the fear or conviction remains. Patients develop a characteristic behavioural and cognitive pattern, in which they gradually seek more reassurance, but nevertheless become more and more anxious. Due to the persistent, sometimes delusion-like preoccupation, therapists and researchers were not optimistic about the treatment of this disorder (Fallon, Klein & Liebowitz, 1993; Kellner, 1986). Recently, however, researchers and clinicians developed new models and

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treatment protocols (Salkovskis, 1989; Warwick & Salkovskis, 1990; Visser & Bouman, 1992; Speckens, 1995; Bouman & Visser, 1998). In a cognitive-behavioural model, bodily sensations are conceived as the main triggers for the catastrophic interpretations. It is hypothesized that these interpretations elicit emotional distress and anxiety, that in turn lead to hypochondriacal behaviour, such as reassurance seeking, checking and avoidance of disease related stimuli. The patients become strongly focused on their bodily symptoms and on disease related information, which may lead to selective attention and a confirmatory bias with respect to their catastrophic misinterpretations. The increase of emotional distress and anxiety often causes more bodily symptoms, so that the patients become caught in a vicious circle.

Many case studies and some uncontrolled studies have been published on the treatment of hypochondriasis, but only two controlled studies. The first study was conducted by Warwick, Clark, Cobb and Salkovskis (1996). Patients meeting the DSM-III-R criteria for hypochondriasis ( $n=32$ ) were randomly assigned to a cognitive-behavioural treatment or a waiting-list control condition. The patients in the active treatment condition received 16 individual treatment sessions, spread over 4 months. The results indicated that the active treatment group was improved compared to the waiting-list control group on all the measures. The improvements were retained at the 3 months follow-up. The authors concluded that cognitive behaviour therapy is an acceptable and effective treatment for hypochondriasis, but also mentioned a number of limitations of their study. All treatments were carried out by only one therapist (the first author), so it is unclear whether other therapists will obtain similar results. The follow-up period — 3 months — was relatively short in order to draw firm conclusions about the long-term efficacy of the treatment. Finally, standardized assessment was used for depression and anxiety only; hypochondriasis was assessed by visual analogue scales. The second controlled study was conducted by Clark et al. (1998). In this study patients with the DSM-III-R diagnosis hypochondriasis ( $n=48$ ) were randomly assigned to either cognitive therapy, behavioural stress management or a waiting-list control group. The cognitive therapy consisted of a mixture of cognitive and behavioural techniques: modification of the patients beliefs, behavioural experiments, response-prevention of repeated bodily checking and reassurance seeking. Behavioural stress management consisted of identification of stressors, applied relaxation procedures, stress management procedures like problem-solving, assertiveness and time management skills, and stimulus control procedures. The results showed that both treatments were effective, but that cognitive therapy was significantly more effective than behavioural stress management. However, at 1 year follow-up both treatments were almost equally effective — only on one of the ten measures cognitive therapy was more effective.

Some other studies have been conducted on the treatment of hypochondriacal patients. Avia et al. (1996) compared cognitive group treatment ( $n=9$ ) with a waiting-list control condition ( $n=8$ ). The results indicated a significant reduction in hypochondriacal attitude and dysfunctional health beliefs in the active treatment group compared to the control group, as well as a significant decrease in somatic symptoms. Eighty-four per cent of the patients in the cognitive group treatment estimated the frequency of their somatic symptoms lower than before treatment. A limitation of this study was that only eight of the 17 patients met the DSM-III-R criteria (American Psychiatric Association, 1987) for hypochondriasis.

Speckens et al. (1995a) treated patients with medically unexplained physical symptoms with cognitive behaviour therapy. Patients were randomly assigned to two treatment conditions: cognitive behaviour therapy ( $n=39$ ) and optimized medical care ( $n=40$ ). The number of sessions in the

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