



Cognitive-behavioral therapy for hypochondriasis/health anxiety: A meta-analysis of treatment outcome and moderators



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ABSTRACT

The present investigation employed meta-analysis to examine the efficacy of cognitive-behavioral therapy (CBT) for hypochondriasis/health anxiety as well as potential moderators that may be associated with outcome. A literature search revealed 15 comparisons among 13 randomized-controlled trials (RCTs) with a total sample size of 1081 participants that met inclusion criteria. Results indicated that CBT outperformed control conditions on primary outcome measures at post-treatment (Hedges's $g = 0.95$) and at follow-up (Hedges's $g = 0.34$). CBT also outperformed control conditions on measures of depression at post-treatment (Hedges's $g = 0.64$) and at follow-up (Hedges's $g = 0.35$). Moderator analyses revealed that higher pre-treatment severity of hypochondriasis/health anxiety was associated with *greater* effect sizes at follow-up visits and depression symptom severity was significantly associated with a *lower* in effect sizes at post-treatment. Although effect size did not vary as a function of blind assessment, smaller effect sizes were observed for CBT vs. treatment as usual control conditions than for CBT vs. waitlist control. A dose response relationship was also observed, such that a greater number of CBT sessions was associated with *larger* effect sizes at post-treatment. This review indicates that CBT is efficacious in the treatment of hypochondriasis/health anxiety and identifies potential moderators that are associated with outcome. The implications of these findings for further delineating prognostic and prescriptive indicators of CBT for hypochondriasis/health anxiety are discussed.

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The central feature of hypochondriasis is a preoccupation with the inaccurate belief that one has, or is in danger of developing, a serious medical condition based on misinterpretations of benign (or minor) bodily sensations (American Psychiatric Association [APA], 2000). Research has shown that up to 9% of patients in general medical practice clinics and up to 5% of the general population meets diagnostic criteria for hypochondriasis (Creed & Barsky, 2004; Gureje, Ustun, & Simon, 1997). The heightened prevalence in medical practice may reflect the fact that hypochondriasis is also characterized by a strong “disease conviction” that persists despite appropriate medical evaluation. This preoccupation with medical illness often focuses on specific signs or symptoms (e.g., sore throat), diseases (e.g., cancer), organs (e.g., heart), or vaguely defined somatic phenomena (e.g., “my aching veins”). Typically, patients with hypochondriasis attribute

unwanted bodily sensations to possible disease (e.g., “this headache means I have a brain tumor”) and are highly concerned with their authenticity. Perhaps the most readily observable sign of hypochondriasis is the persistent attempt to seek reassurance about the feared symptoms or illness. Individuals with this condition may repeatedly contact doctors, seek additional tests, scour Internet sites and medical texts, and seek reassurance from significant others about bodily sensations which have been appropriately evaluated and judged to be benign. This preoccupation with disease can be disruptive to social, occupational, and family functioning, and is associated with substantial economic costs (Katon & Walker, 1998).

Although hypochondriasis has historically been viewed as a somatoform disorder (APA, 2000), the validity of this categorization has not been without debate. It has been argued that hypochondriasis may be best conceptualized as an anxiety disorder (Olatunji, Deacon, & Abramowitz, 2009). This view suggests that health anxiety represents a continuous dimension (ranging from no health anxiety to severe health anxiety) with ‘hypochondriasis’ at its

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clinical endpoint (Marcus, Gurley, Marchi, & Bauer, 2007). This argument is based largely on empirical observations that symptoms of hypochondriasis overlap with certain anxiety disorders: namely, panic disorder (PD) and obsessive-compulsive disorder (OCD). Like those with hypochondriasis, patients with PD are hypervigilant to benign, arousal-related body sensations and often erroneously attribute them to organic causes such as heart attacks, strokes, and other serious medical conditions (Abramowitz, 2005; Barsky, Barnett, & Cleary, 1995). Similarities have also been observed between hypochondriasis and OCD in terms of preoccupation with health and disease, and the repetitive and pervasive nature of such preoccupation (Abramowitz, 2005; Fallon, Javitch, Hollander, & Liebowitz, 1992). Much like PD and OCD, cognitive-behavioral models (Abramowitz, Schwartz, & Whiteside, 2002; Warwick & Salkovskis, 1990) posit that hypochondriasis is an extreme form of health anxiety that emerges from the misinterpretation of benign and normally occurring experiences that lead to anxiety and the use of safety behaviors which paradoxically maintains the anxiety (Abramowitz & Moore, 2007; Abramowitz, Olatunji, & Deacon, 2007).

The cognitive-behavioral model of hypochondriasis is depicted in Fig. 1 (Abramowitz, Deacon, & Valentiner, 2007). This model suggests that dysfunctional beliefs about bodily symptoms and illness play a significant role in the development of hypochondriasis. Such beliefs often increase the likelihood of having catastrophic cognitions when exposed to benign bodily symptoms or health-related information. Once concerned about the possibility of acquiring an illness, the person becomes vigilant for any signs of being ill and is motivated to reduce their worry by gaining certainty

about their health status. It is important to note that this process in hypochondriasis is driven largely by mistaken beliefs about illnesses. According to the cognitive-behavioral model, mistaken beliefs in hypochondriasis are maintained (despite contradictory information and repeated reassurance of good health from medical professionals) by maladaptive strategies used to cope with health-related anxiety. These strategies include attempts to prevent the feared illness, avoidance, and attempts to attain certainty about health status. These safety behaviors prevent individuals with hypochondriasis from acquiring information that would disconfirm their mistaken beliefs about illnesses. This cognitive-behavioral model of hypochondriasis has been empirically supported and proven to be clinically useful (Taylor & Asmundson, 2004). Based in part on these observations, the newly published DSM-5 has replaced the diagnosis of hypochondriasis with “illness anxiety disorder” (APA, 2013).

Based on the findings of early, predominantly psychodynamic interventions, hypochondriasis has historically been regarded as resistant to psychological treatment (Taylor, Asmundson, & Coons, 2005). In fact, treatments were initially considered to be of limited value for hypochondriasis (Ladee, 1966). Extreme interventions were considered and some clinicians even employed prefrontal lobotomies for the treatment of hypochondriasis (Bernstein, Callahan, & Jaranson, 1975). Fortunately, the emergence of a cognitive-behavioral model of hypochondriasis has paved the way for the application of a more appropriate approach to treatment. The cognitive-behavioral approach is derived largely from the observation that symptoms of hypochondriasis — at both a topographical *and* functional level — overlap remarkably with certain

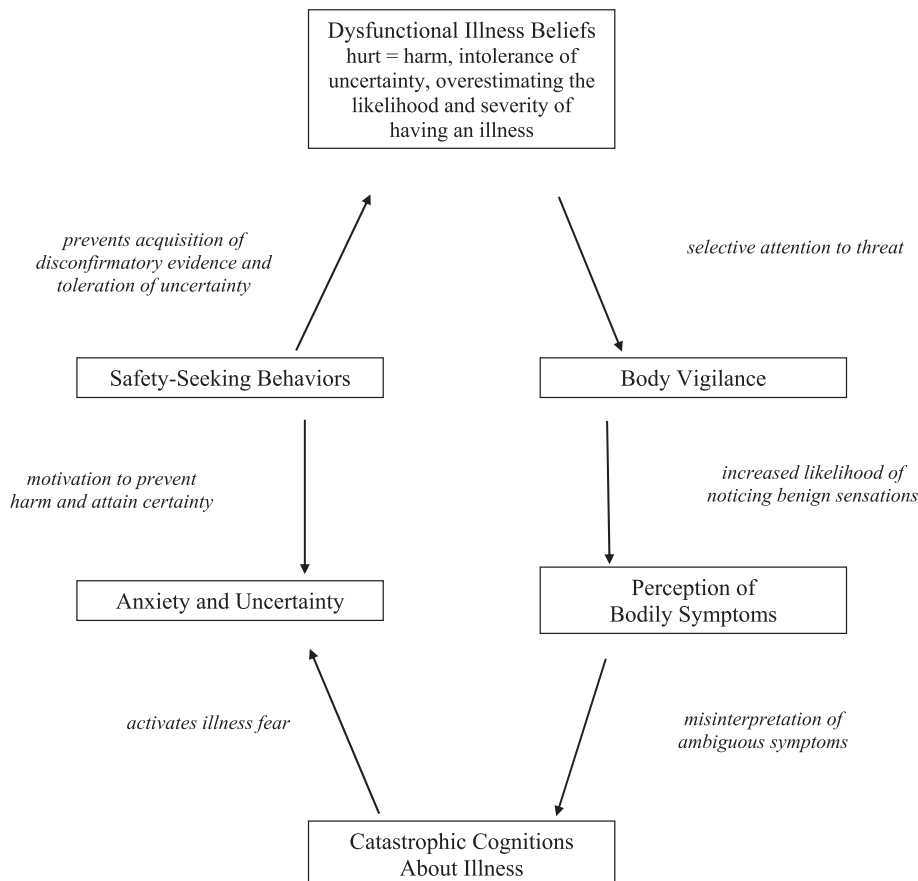


Fig. 1. Cognitive-behavioral model of hypochondriasis outlined by Abramowitz, Deacon, et al. (2007).

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