



Cognitive behavioural therapy for health anxiety

A randomised controlled trial indicates that cognitive behavioural therapy is effective at reducing excessive health anxiety in patients in hospital, and total healthcare costs including the cost of the therapy are roughly the same as with standard care.



Overview: [Health anxiety \(hypochondria\)](#) is a somatoform disorder characterised by obsessive worrying about health, often to the point where it causes great distress and affects functioning. In many cases, this worrying is coupled with a fear or conviction of having a disease despite medical reassurance.

Studies in the general population and in primary care estimate that the prevalence of health anxiety is between 0.02% and 8.5%, with the population prevalence potentially as high as 10.7% when abridged diagnostic criteria are used ([Creed and Barsky 2004](#)). Somatoform disorders such as health anxiety are associated with increased healthcare resource use and costs, independent of psychiatric and medical comorbidity ([Barsky et al. 2005](#)).

Previous studies have suggested that psychological interventions, such as cognitive therapy and behavioural therapy, may be effective at reducing symptoms of health anxiety ([Thomson and Page 2007](#)). Cognitive behavioural therapy (CBT) has been shown to be an effective treatment for health anxiety in primary care ([Barsky and Ahern 2004](#)).

Current advice: The NICE guideline on [depression in adults](#) (currently [being updated](#)) recommends individual guided self-help based on the principles of CBT, and computerised CBT, for adults with persistent subthreshold depressive symptoms or mild to moderate depression. Individual non-facilitated self-help based on the treatment principles of CBT, and CBT, are also recommended for [people with generalised anxiety disorder and panic disorder](#). No NICE guideline advises specifically on management of somatoform disorders such as health anxiety.

New evidence: A randomised controlled trial by [Tyrer et al. \(2014\)](#) assessed the clinical and cost effectiveness of a modified form of CBT for excessive health anxiety in outpatients at UK hospitals. Patients attending cardiology, endocrine, gastroenterology, neurology and respiratory medicine clinics at 6 hospitals in the UK were screened. Those who scored 20 or more in the short form of the Health Anxiety Inventory (HAI) and satisfied diagnostic criteria for hypochondria were eligible for the study. A total of 5769 patients satisfied these criteria; 444 agreed to take part and were randomly assigned to CBT plus standard care (n=219) or standard care only (n=225).

The CBT comprised 5–10 sessions with a therapist (range 0–22 sessions) aimed at helping patients understand the factors that drive and maintain health anxiety. The sessions were delivered by specifically trained graduate research workers, nurses or other health professionals who otherwise had little previous experience in CBT. Standard care, as described separately in the study protocol ([Tyrer et al. 2011](#)), was largely a combination of clinical assessment, appropriate tests and

reassurance. The primary outcome was change in health anxiety symptoms measured by the HAI at 12 months.

Among patients followed up at 12 months, those in the CBT group (n=194) had a significantly greater reduction in health anxiety than those in the standard care group (n=193; difference in HAI score=-2.98, 95% confidence interval [CI] -4.33 to -1.64, p<0.0001). In addition, more patients in the CBT group than the standard care group had normal levels of health anxiety at 12 months (HAI score of 10 or less; 7% versus 14%, odds ratio=2.15, 95% CI 1.09 to 4.23, p=0.0273). The beneficial effect of CBT was maintained at 24 months (difference in HAI score=-2.05, 95% CI -3.41 to -0.70, p=0.003).

The average cost of the CBT intervention was £422 per patient for a mean of 6 sessions. Other healthcare costs, such as GP contacts and medication, were lower in the CBT group than in the standard care group. Among the 342 patients for whom complete data were available, total health and social care costs including the cost of the intervention were also lower in the CBT group (£7314 versus £7727). However, this difference shrank to £156 in analyses adjusted for baseline cost (95% CI -£1446 to £1758, p=0.848), indicating no significant difference in costs between the two groups.

Limitations of the study included that most of the patients screened as eligible did not take part and the cost analyses may have been underpowered because data were available on only 73% of the total number of patients needed to demonstrate equivalence.

Commentary: “People with health anxiety and somatoform disorders are high users of healthcare and have poorer quality of life. Many people with health anxiety are reluctant to see a psychologist; the overwhelming fear of having an unaddressed medical problem means that their focus is on receiving medical attention and investigation. The novel approach used by Tyrer et al. (2014) of training existing staff in CBT and then supervising delivery is appealing because it may improve treatment uptake. For example, people reluctant to see a therapist may be willing to receive an intervention from a clinic nurse. However, only 7.7% of patients with identified significant health anxiety entered the trial, the majority either declining to participate or being considered unsuitable. This suggests that one approach does not suit all.

“For hospitals with established psychological medicine departments, the approach used in this study could contribute to a stepped care approach alongside specialist services for more complex cases, and consultation or multidisciplinary review for people who decline referral. For hospitals that are yet to develop psychological medicine services, it helps to make the economic argument for CBT. By evaluating both the effectiveness and cost effectiveness of CBT, this study adds to existing evidence that psychological treatments for health anxiety can improve quality of life and cover their own costs by reducing unnecessary investigations and consultations.” – **Dr Alex Thomson, Consultant Liaison Psychiatrist, Central and North West London NHS Foundation Trust**

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