Psychoeducational treatment for hypochondriasis.
Buwalda, Femke Marrit

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version
Publisher's PDF, also known as Version of record

Publication date:
2007

Link to publication in University of Groningen/UMCG research database

Citation for published version (APA):

Copyright
Other than for strictly personal use, it is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), unless the work is under an open content license (like Creative Commons).

Take-down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Downloaded from the University of Groningen/UMCG research database (Pure): http://www.rug.nl/research/portal. For technical reasons the number of authors shown on this cover page is limited to 10 maximum.

Download date: 30-12-2018
Chapter 2

A Psychoeducational Approach to Hypochondriasis: Background, Content, and Practice Guidelines.

Theo K. Bouman & Femke M. Buwalda

This chapter is based on Bouman, T.K., & Buwalda, F.M. (accepted pending revisions). A psychoeducational approach to hypochondriasis: background, content and practice guidelines. Cognitive and Behavioral Practice.
Abstract

Patients suffering from hypochondriasis are difficult to engage in a psychological treatment, although it has now been empirically established that cognitive-behavioural treatments are beneficial for many of these patients. A first important step is to change their orientation from a biomedical to a biopsychosocial perspective. One way of promoting this change is to provide focused psychoeducation. A number of studies showed that group psychoeducation for patients with hypochondriasis results in a reduction in hypochondriacal concerns, depression and medical services utilisation.

The purpose of this chapter is to describe the background, content and implementation of a course entitled ‘Coping with health anxiety’. The empirical support, as well as the potentially active ingredients of this approach are discussed.
Psychoeducation for Hypochondriasis / 33

Introduction

Many patients who suffer from hypochondriasis tend to stick to a biomedical conceptualisation of their problems, seek refuge in medical care, and are reluctant to accept or even consider a more fruitful biopsychosocial perspective. The reasons for their reluctance are quite diverse, such as unfamiliarity with psychological treatments, the dualistic vision that the problem is in their bodies rather than in their minds, and the social stigma that being in psychotherapy means being insane. These attitudes and misconceptions prevent people from being motivated to engage in a potentially beneficial treatment. This is an unfortunate situation, as the efficacy of cognitive-behavioural therapy (CBT) has now been established in a number of controlled studies (Barsky & Ahern, 2004; Bouman & Visser, 1998; Clark, Salkovskis, Hackman, Wells, Fennell, Ludgate, Ahmad, Richards, & Gelder, 1998; Visser & Bouman, 2001; Warwick, Clark, Cobb, & Salkovskis, 1996; see Taylor & Asmundson, 2004, for an overview).

However, patients involved in these treatment studies seemed to be willing to be referred for psychological treatment, suggesting that they are a subsample of all patients with hypochondriasis in the community at large. Reaching a larger number of people and transferring knowledge about (psychological) treatments for their excessive health concern seems to be problematic and poses a challenge for the delivery of adequate and evidence based mental health care. On the other hand, in a small scale study Walker, Vincent, Furer, Cox and Kjernisted (1999) found 74% of patients with hypochondriasis to prefer psychological treatment over pharmacological treatment once they decided to be referred for non-medical treatment.

It seems that many patients suffering from hypochondriasis are contemplating to change their situation but are not sure what action to undertake. It may be argued that there is a need for an approach to health anxiety that (a) has a low threshold, (b) is without psychotherapeutic connotations, (c) is time limited, (d) is cost-effective, (e) is highly acceptable to participants, and (f) is available to a large portion of the community. This can be realised by providing a brief, structured and problem oriented approach, which is psychoeducational rather than psychotherapeutic in nature, and can be delivered in group format. The costs of such an approach can stay low by employing specifically trained instructors, rather than more expensive and less available psychotherapists or physicians who more often than not can only be reached via waiting lists. Barsky (1996, p. 55) already stated that “the need for such treatments will only grow with the growing imperative to contain medical care costs and to curtail undue medical utilisation”.

Psychoeducational treatment could be a useful tool within a stepped care treatment program. Stepped care, according to Bower and Gilbody (2005), deploys several treatments of differing intensity. It has two main features: a) the recommended treatment in a stepped care model should be the least intense and time-consuming of those available, but still likely to provide significant health gain, and b) it is a model that is self-correcting, meaning that the results of treatments, and decisions about treatment provision, are monitored systematically. Progression to the next step in the model is considered when current treatment is not achieving significant health gain. Professional care is
Psychoeducation for Hypochondriasis / 34

stepped in intensity, starting with limited professional input and systematic monitoring and is then augmented for patients who do not achieve an acceptable outcome (Van Korff, Glasgow, & Sharpe, 2002). From a stepped-care point of view it is desirable to reach people who on the one hand have not (yet) been admitted to (mental) health settings, but who on the other hand recognise that they are suffering from persistent health concerns such as hypochondriasis. Psychoeducational interventions might provide one of the first steps in a stepped care program.

The purpose of the present paper is to describe the background, content and empirical evidence of a psychoeducational approach to hypochondriasis and health anxiety (as a factor prominent in hypochondriasis and its subclinical manifestations).

**Psychoeducation and hypochondriasis**

Psychoeducation refers to an educational model of care delivery, in contrast to a medical model (Authier, 1977; Brown, 1998; Lukens & McFarlane, 2004). Broadly speaking, it is characterised by the provision of focused information about mental health problems. The roles of patients and doctors (and other health care professionals) are redefined in terms of pupils and teachers. In clinical practice it is considered important to engage health anxious patients as active participants, rather than as passive recipients of care (cf. Asmundson & Hadjistavropoulos, 2004). Furthermore, the patients’ predicament is not described in terms of abnormality or disease, but rather as dissatisfaction with a current dysfunctional situation. This leads to the formulation of goals, coping, and problem solving (cf. Authier, 1977; Barsky, 1996). The beneficiaries from psychoeducation can be very diverse, ranging from the general public, to caregivers, family members, and patients themselves.

Psychoeducation in itself may take many forms, from being a phase in a treatment, to an explicit component of such a treatment, to being an intervention in its own right. A recent review (Lukens & McFarlane, 2004) shows psychoeducation to be effective for many disorders, and qualifying as Category II (i.e. ‘probably or possibly efficacious intervention’) in terms of the criteria for evidence based interventions (Chambless & Hollon, 1998).

Cognitive-behavioural therapists are familiar with psychoeducation as they use the explanation of the treatment rationale in the early stage of treatment. Typically, part of a session is devoted to the aim of socialising the individual patient into the cognitive-behavioural model of his or her particular problem(s). Usually in somatoform and related disorders, this involves broadening the patient’s perspective from a biomedical to biopsychosocial orientation. Salkovskis (1989) proposes the dual hypotheses approach to invite the patient to test whether the complaints are only somatic, or a mix of somatic and mental components (such as concern and worry about disease). In general, there seems to be consensus about the need for broadening the patient’s perspective and for providing a plausible alternative model for somatic complaints early in treatment.
Empirical support

From a cognitive-behavioural perspective, stand-alone psychoeducation can be regarded as a specific form of reattribution, namely the delivery of an illness theory and a treatment rationale (i.e. a certain perspective on hypochondriacal symptoms) without the ensuing formal treatment. The primary goal is a modification of the interpretation of the disorder itself (i.e. a more accurate understanding about the nature of hypochondriasis), rather than the reduction of physical and mental symptoms. A number of authors have studied this particular form of psychoeducation for hypochondriasis. Barsky, Geringer and Wool (1988) proposed a groupwise cognitive-behavioural educational approach in which information regarding the maintaining factors of hypochondriasis are presented. The original authors have not empirically tested this approach, although many of its features emerge in the waiting list controlled CBT study by Barsky and Ahern (2004).

Earlier small scale studies testing the applicability of group psychoeducation were conducted by Stern and Fernandez (1991) \((n = 6)\) and by Avia and her colleagues (1996). The latter concerned a small waiting list controlled study involving 14 participants who were mainly university students, part of them not fulfilling DSM-criteria for hypochondriasis. Fava, Grandi, Rafanelli, Fabbri and Cazzaro (2000) randomised 20 patients with hypochondriasis into either 8 sessions of explanatory therapy (along the lines of Kellner, 1986) or a waiting list condition, and found a reduction in hypochondriacal symptoms and medical services utilisation. These studies however, suffer from a number of methodological flaws, such as the use of small sample sizes, and diagnostic ambiguity.

A series of outcome studies investigated the feasibility and efficacy of group psychoeducation for hypochondriasis. A pilot study involving 21 DSM-IV patients with hypochondriasis (Bouman & Van den Broek, 1997; Bouman, 2002) showed that this approach resulted in a significant decrease of the level of hypochondriacal symptoms, as well as general anxiety and depression. Quite remarkable was the substantial reduction (around 40%) of the number of GP and medical specialist consultations.

In a second study \((n = 53)\) cognitive-behavioural psychoeducation was compared with a waiting list control group (Bouman & Polman, submitted). The results demonstrated no reduction on relevant variables in the waiting list period, whereas the decrease in hypochondriacal symptoms, anxiety and depression from the pilot study was replicated in the active psychoeducation condition.

Next, the efforts concentrated on the question whether the content or the format of the psychoeducation is the active ingredient. For that purpose cognitive-behavioural psychoeducation about hypochondriasis was compared to a similar format aimed at teaching participants a general problem-solving model. The idea in the latter condition was to focus on contingent factors assumed to maintain hypochondriasis (such as relational problems, perfectionism, general lack of social problem solving), rather than on the mechanisms of the disorder itself, as described in the cognitive model of hypochondriasis (Bouman & Visser, 1998; Warwick & Salkovskis, 1990).
Buwalda, Bouman and Van Duijn (in press) included 48 participants satisfying DSM-IV criteria for hypochondriasis and randomised them into either of the two conditions. Results showed again a significant reduction in hypochondriacal symptoms, anxiety and depression. Interestingly, the problem-solving course performed equally well as the cognitive-behavioural course did. This study is described in chapter 3 of this thesis.

Overall, it can be concluded, both from the literature and from our own experiences, that a brief focused psychoeducational approach is a feasible way of reducing hypochondriacal symptomatology.

The course ‘Coping with health anxiety’

General background

Model

Inspired by Barsky's format (Barsky et al., 1988) we have developed an educational course aimed at providing its participants insight into the mechanisms of hypochondriasis. In order to lower the subjective threshold for potential participants, the term 'treatment' or 'therapy' was avoided and replaced by the word 'course'. The course was baptised as 'Coping with health anxiety'. The Dutch colloquial equivalent of the latter term (i.e. 'ziektevrees') was chosen because it has a less stigmatising connotation than 'hypochondriasis'. ‘Coping’ carried the suggestion of management rather than cure. People who signed up for this course were not considered 'patients' or 'clients', but rather 'participants'. Our approach is paradigmatic and departs from an explicit cognitive-behavioural model (see Figure 2.1), which is an adaptation from Warwick and Salkovskis (1990).

The model focuses on the various concepts that are assumed to maintain health anxiety: the misinterpretation of bodily sensations, anxiety, selective attention for bodily sensations, and safety behaviour.
Aim

The aim of this course is to provide insight into the mechanisms of hypochondriasis from a cognitive-behavioural point of view, rather than cure participants from their fear of serious disease. The course was designed to provide a low threshold to treatment, because it was meant for people who did not immediately consider getting referred to a mental health facility for whatever reason. This aim was explicitly communicated to potential participants, so as to provide them with realistic expectations.

Indication

Although in clinical practice one may adopt rather loose inclusion criteria, we feel that this type of approach is not a priori considered appropriate for severe cases that need more intensive and individual attention. For that reason we aimed at participants who, on the one hand, were not formally under psychological / psychiatric treatment, but on the other hand did suffer from fear of, and preoccupation with, serious disease to the extent that it influenced their everyday life.

Aspiring participants were screened for psychopathology during a structured 30 minute telephone interview, which is a condensed version of the Anxiety Disorders Interview Schedule (Bouman, De Ruiter & Hoogduin, 1997; DiNardo, Brown, & Barlow, 1994). This instrument screens for DSM-IV (APA, 1994) somatoform, anxiety, and mood disorders. Participants were also asked about previous psychological treatment. The interview led to an evaluation of the presence or absence of any of the disorders mentioned above. The main
Psychoeducation for Hypochondriasis

inclusion criterion is the presence of a DSM-IV diagnosis of hypochondriasis. In addition, both literacy and the willingness to contribute to a group are considered important. Exclusion criteria are the primacy of other psychopathology (such as depression, OCD and panic disorder), a serious somatic disease being the focus of the health anxiety, and previous or concurrent cognitive-behavioural treatment for hypochondriasis. Although many participants did suffer from comorbid anxiety and depression, they were included in the course since their primary complaint was hypochondriasis.

Format of the course
The course consists of six weekly two-hour sessions and one or two booster sessions, with two facilitators per group. Sessions are held during the evening, so as to not interrupt participants’ occupational life.

Components
Each session comprises mini-lectures, demonstrations, brief exercises, and focused group discussions. In order to emphasize the educational nature of the course, use is made of various audiovisual facilities, such as whiteboards, transparencies, video fragments and other course material (see below). Following the mini-lecture, specific exercises are undertaken to provide the participants with hands-on experience with the topics discussed (see below).

The facilitators try to elicit many examples and opinions from the participants, in order to engage them as much as possible. This is generally no problem since most participants are eager to be engaged in discussion, and are usually very willing to speak about their experiences. At the end of the sessions participants are encouraged to do some brief homework assignments during the coming week, which never takes more than about 30 minutes of the participant’s time. The homework’s content is described in the course manual, which is described in more detail below.

General structure
Every session has roughly the same structure. The facilitators open the session with the presentation of the agenda and a motto that summarises the idea of the session. At the start of every session, the vicious circle (see Figure 2.1) is shown, and the role of this session’s component in the circle is discussed. Previous week’s homework is discussed at the beginning of the sessions to check its level of difficulty and the participants’ understanding.

Next, a mini-lecture is held on the theme of the present session. The first five sessions focus on one component of the vicious circle described in Figure 1, and the sixth session integrates the previous sessions into the entire circle. During the lecture, the facilitators explain: a) the nature of the component, b) why the component is important in hypochondriasis (for example ‘how does selective attention maintain hypochondriacal complaints’), and c) how one can alter this particular component’s impact on hypochondriacal complaints. In this final part of the lecture, the practical application of what is learned is very important. One of the course’s aims is that participants gain more control over their anxiety. By showing them ways of taking action, participants become empowered.
At the end of each session the main points are summarised and an easy-to-
remember slogan is provided. Finally, homework of the week to come is
explained, and then the session is closed.

**Interactional style**

The interactional style used by the facilitators relies on Socratic questioning,
leading to questions such as: “Could anyone give an example of . . . ?”, “How
would that fit into the model?”. This facilitator attitude is very important
because we have experienced that this group of participants is very eager to
share their difficulties with the group and the facilitators, and thereby supply a
great deal of information. Guided discovery as to the meaning and functions of
sensations and experiences has proven to be more helpful than providing the
‘right’ answer. During the entire session, the facilitators make sure they leave
room for questions, and they try to engage the participants in the session as
much as possible. In this way the atmosphere is one of a group of active
participants, rather than passive consumers. Some participants have to be
explicitly invited to take this role, since they have developed into passive
medical patients, who wait to hear what the doctor has to offer. The facilitators
are explicitly instructed to provide a non-threatening, relatively relaxed
atmosphere in which the use of humor has its place.

**Materials**

At the beginning of the course, the participants receive a 25-page course
booklet including a summary of the sessions, a description of the model, and
homework assignments. There is ample room for taking notes, and the relevance
of this is explicitly emphasised, again contributing to an active attitude.

The facilitators use a 50-page course manual describing each session. This
provides them with suggestions for mini-lectures, group discussions, and
demonstrations and exercises. The manual is intended to be a guide throughout
the course, rather than a must-do. For each session the general goal is
formulated, example text is provided, as well as a number of exercises. The
explicit instruction is to elicit responses and examples from the participants,
rather than to provide them with an overload of information. In addition,
throughout each session the most important information is projected on a screen,
or written on the whiteboard, all underscoring the educational approach.

**Facilitators**

Each group is run by two facilitators who take turns and complement each
other in the presentation of information and structuring the discussion in
subgroups. In our studies these were usually graduate students of clinical
psychology, with some previous experience of individual cognitive-behavioural
treatment for hypochondriasis. At least one of the facilitators has previous
experience with coaching this particular course. They have received the
facilitator manual as well as a brief two-hour introduction into the course’s
content and into basic didactic skills. While coaching the course, all the
facilitators receive weekly supervision by either one of the authors of this
chapter, both of whom have extensive experience as facilitators. It is important
to mention that outside our studies, some groups have been run by nurses and other paramedical staff with equally beneficial effects. It appears that the facilitators feel very confident in using the manual, and in their reliance on Socratic questioning.

**Content of sessions**

Table 2.1 summarises the courses general outline.

Table 2.1. The Outline of the Course's Content

<table>
<thead>
<tr>
<th>Session</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>What is health anxiety?</td>
</tr>
<tr>
<td>2</td>
<td>The role of your thoughts</td>
</tr>
<tr>
<td>3</td>
<td>Attention and health anxiety</td>
</tr>
<tr>
<td>4</td>
<td>Behaviour and health anxiety</td>
</tr>
<tr>
<td>5</td>
<td>Stress and bodily symptoms</td>
</tr>
<tr>
<td>6</td>
<td>Your own vicious circle</td>
</tr>
<tr>
<td>7</td>
<td>Booster session</td>
</tr>
</tbody>
</table>

**Session 1: 'What is health anxiety?''**

In this session participants and facilitators are introduced to each other. During the first part of the session, the participants are invited to describe the nature of their health anxiety. Participants often state that they felt as if they were the only one suffering from this anxiety, and hearing others 'tell their story' is an eye-opener to them right from the start. Next, it is explained that the purpose of the course is to offer the participants specific guidelines through which they can learn to cope with the anxiety they are currently experiencing. It is emphasised that the approach is no substitute for psychotherapy, but rather a first way to gain insight into hypochondriacal complaints, and control over anxiety.

During the first session, participants are informed that in each of the future sessions, one theme will be elaborated on, based on the health anxiety model described in Figure 2.1 (Bouman & Visser, 1998b; Warwick & Salkovskis, 1990). Participants are invited to discuss their thoughts about the model and to link their own experiences to its different components. The model's various components (bodily sensations, cognitions, emotions, attention, and behaviour) are clarified by examples provided by the facilitators, and are drawn on the whiteboard as a vicious circle.

The second topic of this first session is 'what is health anxiety'? This is a question that has to be answered before anyone can learn how to cope with this complaint. Participants are invited to discuss this question, and an inventory is made of their thoughts on the components of health anxiety. Some examples of answers to ‘what is health anxiety?’ have been: 'fear of having a disease', and,
'thinking that bodily sensations are a sign of a serious disease'. In the same fashion, an inventory is made of what health anxiety is not. A possible answer to this question is: 'suffering from health anxiety means you're crazy', 'you are just pretending to be ill while you are not', or 'you're only crying out for other people's attention'.

Next, as the first component of the model, the role of cognitions in health anxiety is addressed. Many of the participants hold the belief that bodily sensations are the direct cause of their anxiety. During this part of the session, the facilitators explain the intervening role of cognition in this connection. They illustrate this intervention by using the 'burglar example' (Beck, et al., 1979), which clarifies the mediating role of cognition. The burglar example incorporates the following: the facilitators ask participants to imagine themselves lying in bed at night. Suddenly, they hear a crashing noise. Then, the facilitators ask how the participants would feel if they thought 'there is as burglar in my house'. Many participants then indicate that they would feel anxious. Then, the facilitators ask them how they would feel if they thought 'maybe I left a window open, and the wind must have knocked over a vase'. Many participants answered that they would feel neutral, perhaps a bit annoyed that they had left a window open, and now a vase is broken. Once the role of cognitions is illustrated by the use of this example, and participants understand how certain thoughts can lead to certain emotions, facilitators ask the participants whether they have personal experiences with certain cognitions surrounding disease leading to anxiety.

Then, homework assignments for the week to come are introduced, which consist of reading the general information about the course, written in the participants' manual, writing down the physical sensations that start their own vicious cycle of health anxiety, and formulating the associated cognitions as explicitly as possible. For example, the cognition 'a stomach ache means that I may have cancer', provides more insight into one's fears than 'a stomach ache means that something is wrong'.

**Session 2: 'The role of your thoughts'.**

After showing the agenda of this session and supplying the motto, the facilitators and participants briefly discuss last week’s homework. Participants are usually able to write down which physical sensations trigger their anxiety. Sometimes help is needed in specifying certain cognitions, since many participants are not comfortable with using words like 'cancer', 'tumor' and 'heart attack'. When this is the case, a connection is made with the role of avoidance behaviour, which is discussed in session 4.

After this, the process of the reasoning bias is explained, by eliciting examples from the group and discussing them. Reasoning biases that usually play a part in hypochondriacal complaints in our experience are catastrophising ('this lump means I have cancer and will certainly die soon'), personalising ('bad things always happen to be, I am bound to get a terrible disease'), black-and-white thinking ('either you are very sick, or you are perfectly healthy'), and overgeneralisation ('if you are sick, then you die'). Examples the participants mention are usually centered on the misinterpretation of bodily sensations.
Therefore, during this session, some attention is given to the bodily sensations participants have, and which thoughts they experience in connection with these sensations. Furthermore, the focus is on the involuntary and automatic nature of the thoughts participants experience in relation with their complaints. The facilitators explain that these thoughts are habits that can be changed. This appears to be an eye-opener for many of the participants, who tend to think of these thoughts as ‘certainly true’ and unchangeable. The facilitators address the topics of distorted reasoning (e.g. black-and-white thinking and personification) and thinking habits, and then participants team up in pairs and practice examining their thoughts.

Later on in the session, the participants learn how to challenge thoughts that maintain their health anxiety. This challenging is done with the help of two CBT-techniques: the two-column technique and the pie chart technique. By means of the two-column technique, the participants are taught to think of evidence for and against certain thoughts, and write these down in two columns. An example of a thought that can be challenged by using this technique is ‘an abnormality on my skin means I have skin cancer’. Evidence for this thought might be ‘my dad died of skin cancer, and had certain skin abnormalities’, and evidence against the thought might be ‘a slight redness on my skin does not look like the marks my dad had on his skin’, and ‘I went to see my GP and he said that this redness was not an indication of me having skin cancer’. Writing evidence down in the two columns provides the participants with more information about whether their cognition is sound, and guides them into reviewing their cognition, so that a more realistic alternative cognition may be formulated, which is less anxiety provoking.

By means of the pie chart technique, participants learn how to award percentages to all the possible causes of a certain bodily sensation. They might award 100% to a brain tumor at first when they experience a headache, but when they are asked to write down other possible causes, such as stress, drinking too much coffee, and being tired from having worried all night, they learn how to award certain percentages to all of these possible causes of a headache. This technique also provides the participants with more information about their cognition, and when they have reviewed the possible causes of for example a headache, they are less likely to be convinced that a brain tumor is actually causing the headache. However, they are also taught that the brain tumor should still be one of the possible causes, because it cannot be ruled out entirely.

Then, the facilitators give a summary of all that has been discussed during the session. Next week’s homework assignments focus on learning how to change unwanted cognitions. The manual provides guidelines for the pie-chart and two-column techniques. At the end of this session participants should be able to recognise hypochondriacal thoughts and the associated reasoning errors. They have also been exposed to cognitive modification strategies.

Session 3: 'Attention and health anxiety'

This session focuses on the role of selective attention in the maintenance of health anxiety. Firstly, the two facilitators present the agenda, and last week’s
Psychoeducation for Hypochondriasis / 43

homework is discussed. In our experience, participants are usually excited about having learned how to change anxiety provoking thoughts and are very enthusiastic about the two challenging techniques.

The mini lecture focuses upon the 'attention' part of the vicious circle. Firstly, the facilitators explain that attention automatically turns to that which is attention-provoking, because there is only a limited amount of attention available, and it is considered reasonable and logical to pay attention to those things you fear. An example we have used often is that when you are crossing a street, and a car is approaching you, you will give that car your full attention because you are afraid you might be run over. However, paying too much attention to physical sensations because you are afraid of having or getting a disease might be less rational.

Furthermore, it is explained that selective attention makes sure that details are perceived. Therefore, participants may perceive bodily sensations as more prominent or even worse than they actually are, because a lot of attention is awarded to these symptoms.

Using the metaphor of a spotlight, the facilitators explain that attention can be focused in certain different ways: it can be focused weak or strong, broad or narrow, fixed or flexible, automatic or controlled and inward or outward. In the context of hypochondriasis, attention tends to be strong, fixed, narrow and automatically directed inward. As an exercise, the participants are asked to focus their attention on one hand and to report after a few minutes what they feel in that hand as compared to what they feel in the other hand, which they were not paying attention to. Participants usually report experiencing many sensations in the hand they were paying attention to, such as a tingling sensation, or a numb feeling, but usually report having felt nothing in the other hand. Another demonstration of how attention works is presented through the white bear experiment (purposefully suppressing certain images). Participants are asked firstly to imagine a white bear as vividly as they can. They are then asked to think about something completely different, and not to think about white bears at all. They are asked to record how many times they still did think about a white bear during the minute or so the experiment takes place. Usually, the image of the white bear cannot be suppressed and participants report many thoughts of a white bear even though they were explicitly asked not to think of one.

Subsequently, the facilitators explain to the participants that they can practice directing the attention outwards and try to focus their attention less fixedly on their body, but that suppression will result in the thoughts or images returning. A helpful exercise can be to have the participants think of different things to focus on when they notice their attention moving 'inward'.

Next, the main points are summarised, emphasising that the aim of this session is to become aware of the usefulness of flexible allocation of attention. For this purpose, the first homework assignment consists of switching the attention from something inward (e.g. a bodily sensation) to something outward (e.g. the smell of food) and notice how that change affects the perception of bodily sensations. The second homework exercise focuses on experiencing the limitation of attentional resources. By having to pay attention to two different
Psychoeducation for Hypochondriasis / 44

things at the same time, participants notice that this influences how well either of the subjects is perceived (for example, focusing on the design of a vase and the structure of the carpet at the same time).

Session 4: ‘Behaviour and health anxiety’

The focus of the fourth session lies on understanding behaviours that maintain hypochondriacal complaints. Previous week’s homework exercises are discussed briefly, and usually the participants have gained insight in their attentional process and have some idea how to change selective attention towards their body.

The facilitators explain that there are various types of safety behaviour that maintain health anxiety: avoidance behaviour, checking behaviour and reassurance seeking. The participants are invited to discuss their own behavioural patterns in connection with health anxiety, with a focus on short- and long term benefits and costs. Furthermore, several themes surrounding behaviour are addressed: a) how certain behaviour can worsen physical symptoms and sensations (e.g. rubbing a little lump underneath the skin will cause the skin to redden), b) how certain behaviour can indicate that one has an unbalanced way of dealing with information (e.g. searching for illness-related information on the internet, in the GP’s waiting room, and in magazines), and c) how behaviour can influence relationships with other people (e.g. providing the participants with insight in the mechanism of reassurance-seeking).

Furthermore, the relationship between health anxiety and medical service utilisation is discussed, and participants are given suggestions on how to deal with - and even profit from - medical consultations. After this introduction, participants form pairs and ask each other which types of behaviour they exhibit, and how this influences their hypochondriacal complaints. Both facilitators join the subgroups every now and again to support a constructive discussion.

Towards the end of the session, a summary is presented about the topics discussed. As homework assignment participants are encouraged to record which behaviours they exhibit during the week. Secondly, participants are encouraged to think of a plan to replace this behaviour (such as asking for reassurance) with more adaptive behaviour, to practice for a number of days, and to keep record of the results.

Session 5: ‘Stress and bodily sensations’

During session five, the focus lies on how stress and anxiety can influence bodily sensations. Firstly, last week’s homework is discussed, and participants usually have noticed a number of (automatic) behaviours that maintain their anxiety and they also usually have made a first attempt in altering these behaviours.

The mini-lecture in this session highlights the specific role of bodily sensations in the vicious circle. Firstly, the connection between physical sensations, stress, and anxiety is explained. Catastrophic thoughts about physical sensations lead to anxiety, and anxiety itself promotes and augments physical sensations, such as a racing pulse, palpitations, and sweating. Stress also plays a large role in this lecture, both in its acute and chronic form. Certain bodily
sensations are a result from either acute or chronic stress, and should be interpreted that way. The facilitators elicit and discuss the various manifestations and causes of stress. Later, the discussion moves towards bodily sensations: which bodily sensations do the participants experience themselves when they suffer from anxiety or stress?

As an exercise, progressive relaxation is undertaken in combination with abdominal breathing. During progressive relaxation, the participants are taught to relax 17 muscle groups throughout their body. The exercise is undertaken with the group as a whole, with one facilitator participating, and the other providing the instructions.

A second exercise during the session is have the participants figure out and discuss what they can do in daily life to relax. An inventory is made on the whiteboard of what people like to do to relax, and usually many different options are suggested. Three categories are suggested, i.e. (1) the use of specific relaxation exercises (e.g. progressive relaxation, yoga, meditation), (2) introducing relaxing moments during the week (e.g. listening to music, reading a book, taking a long bath, or taking a nap), (3) promoting a more relaxing lifestyle (e.g., don’t fill your agenda with appointments and obligations, resolve interpersonal problems, or behave less perfectionistic). A discussion in subgroups aims at making participants aware of the specific type of relaxation strategies they would find most beneficial.

After the conclusions of this week’s session have been formulated, the homework exercises entail two parts. Firstly, an exercise in muscle relaxation is provided, and participants are asked to practice relaxation at home, with the accompanying remark that it takes some time to master this technique. As a second exercise, the participants are asked to think about the link between stress and bodily sensations. Furthermore, they are asked to write down which activities they can do to help themselves relax, and what they can change in their daily schedules to achieve less stress.

Session 6: 'Your own vicious circle'

After having discussed last week’s homework, this session is dedicated to putting together each participant’s personal vicious circle on a form on which the general entries of the circle are given. After a brief interactive recapitulation, all work in pairs to construct their own vicious circles, with their own automatic thoughts, attention, behaviours and bodily sensations. The partners help each other by asking questions, and so do the facilitators who rotate between pairs. The second half of the session is devoted to a plenary discussion of the emerged vicious circles. This also provides with an opportunity to correct or modify certain aspects of specific issues. For example, if someone writes down the thought ‘I wish the pain would go away’, then the facilitators use that as a point for discussing the nature of hypochondriacal thoughts. It is our observation that during this session quite a few participants already speak in the past tense about their fears: ‘I used to think that having palpitations meant I was going to have a heart attack, but now I know that may not be true’.
Finally, time is also taken to answer questions about past sessions and participants are encouraged to carry on with the progress they have made thus far.

Session 7: ‘Booster session’.

The booster session takes place one month after the sixth session. The main point on the agenda is to discuss if and how the participants have been able to apply and integrate the course’s information into their daily lives. The facilitators present themselves as very curious about how life goes on with the newly acquired knowledge.

The content of this entire session largely depends upon issues raised and questions asked by the participants. Time is reserved for questions, and a recapitulation of the model and its components. Participants may also want to refreshen their knowledge about a certain part of the vicious circle. Usually, ways to challenge automatic thoughts are elaborated on further. Finally, the course is formally terminated.

Discussion

Over the years, the psychoeducational course 'Coping with health anxiety' has proven to be a feasible, efficacious and effective option for people suffering from hypochondriasis. Research has shown that acceptability of the course is high (over 85% attendance, and over 80% of the participants doing their homework). When asked about how they feel about the course, participants also state that the course teaches them a lot and that they benefit greatly from being able to discuss these matters with people who have similar complaints. Many participants state explicitly that there is a lot of recognition when they see the cognitive model of health anxiety for the first time and experience relief at the thought that ‘they are not the only one suffering from this’. The approach described in this paper shares many similarities with those from Barsky et al. (1988) and Avia et al. (1997). Rief, Bleichardt and Timmer (2002) developed an eight-session group approach for inpatients with somatisation disorder containing many of the same treatment components. In their study (n = 107) they found high acceptance and feasibility as well as gradual improvement. All are based upon a similar cognitive-behavioural conceptualisation and aim at presenting corrective information.

The psychoeducational approach described here has many potentially active ingredients that need further scrutiny. We will mention a number of candidates.

On a behavioural level, the facilitators explicitly and implicitly use selective reinforcement of healthy responses. For example, talking about health anxiety is welcomed rather than discouraged, which is probably different from what participants usually experience in daily life. Furthermore, rather than reinforcing complaining behaviour, the facilitators emphasise the emergence of adequate coping with fear and bodily sensations.

In addition, discussing serious diseases and doing various homework exercises provides exposure to issues most patients suffering from hypochondriasis try to avoid. For example writing down their feared disease after the first session may be very confronting to some participants. Some have
feared that writing the word ‘cancer’, would actually increase the risk of developing the disease. This fear is explicitly addressed and is taken as an example of one of the reasoning errors.

On a cognitive level, disclosure may be an important factor, according to the participants’ responses. Many of them had not been able (or willing) to share their worries with other people in the way they did during the course. In particular, the acknowledgement of the seriousness of health anxiety had been quite relieving to most of them.

During the sessions participants generally experienced a broadening of their cognitive style. Their initial restricted frame of reference prevented them from generating alternative interpretations in health related areas. Discussing this area in more detail with other people revealed that there are many ways to interpret bodily sensations, even if these interpretations would be equally anxiety provoking. This can be considered as change on a metacognitive level, i.e. the realisation that there are many ways to interpret the world in and around us. Metacognitive aspects in relationship with hypochondriasis and the course are described in chapter 5 of this thesis.

On a different level of abstraction, the psychoeducational approach seems to fit nicely within the transtheoretical model of change (Prochaska & DiClemente, 1982). The course provides information and issues for people in many stages of change: precontemplation (unawareness or denial of the problem), contemplation (considering change), preparation (taking initial steps), action (changing behaviour), and maintenance (sustaining new behaviour). The information provided is tuned to the needs of participants in each of these stages. For example, discussing the nature of health anxiety (session 1) may help them to move from the precontemplation to the contemplation stage. In addition, when in the second half of each session we provide suggestions on how to apply the information in every day life, this may help people to consolidate the ‘action stage’. For some participants the course is a sneak preview of what a cognitive-behavioural treatment could mean; their ‘action’ is to seek professional help.

Despite its many advantages psychoeducation could face a number of potential pitfalls (Roe & Yanos, 2006), such as facilitators being too much preoccupied with rigidly delivering the ‘right’ information and thereby ignoring the participant as an individual. The great opportunity lies in promoting empowerment and increased self-awareness, thus emphasising the importance of the role of facilitator.

Hypochondriasis is a costly psychological problem for which more and more solutions are emerging. We find that a psychoeducational approach like the one described in this paper is an excellent candidate as an initial step in a network of stepped care mental health facilities. A first step is a clear diagnosis and sometimes handing out a leaflet on how to deal with this problem. A second possible step is cognitive-behavioural bibliotherapy, the effect and acceptability of which is described in chapter 6 of this thesis. Next, a psychoeducational group format comes into play, since it is less intensive, less costly, and requires less expensive staff than individual psychotherapy, which is a further step in the model. Bower and Gilbody (2005) discuss a number of requirements related to the clinical and economic evaluation of stepped care models. Although much
needs to be investigated further in this area, at the same time it is encouraging to see that patients with hypochondriasis find a psychoeducational group an acceptable format.