










Cognitive behavioural therapy increases response in people with hypochondriasis

Greeven A, van Balkom AJLM, Visser S, *et al.* Cognitive behavior therapy and paroxetine in the treatment of hypochondriasis: a randomized controlled trial. *Am J Psychiatry* 2007;**164**:91–9.

Q Are cognitive behavioural therapy and paroxetine more effective than placebo for hypochondriasis?

METHOD

	Design: Randomised controlled trial.
	Allocation: Concealed.
	Blinding: Double blind (paroxetine and pill placebo groups only, blinding for cognitive behavioural therapy (CBT) group not described).
	Follow-up period: Sixteen weeks.
	Setting: Three psychiatric outpatient units in the Netherlands; January 1998 to July 2002.
	Patients: 112 adults (aged over 18 years) with hypochondriasis (DSM-IV). Main exclusions: severe comorbidity; substance abuse; diagnosis of anxiety or depression; use of antidepressants, antipsychotics or anticoagulants; already receiving psychotherapy; pregnancy or breastfeeding.
	Intervention: CBT (6–16 individual sessions as needed), paroxetine (up to 60 mg daily), or pill placebo for 16 weeks.
	Outcomes: Symptoms of hypochondriasis (4-point Likert scale version of the Whiteley Index); response (Jacobson and Truax criteria).
	Patient follow-up: 73% completed treatment (75% of CBT group; 70% of paroxetine group; 74% of placebo group); 97% included in last observation carried forward analyses.

MAIN RESULTS

Pooling results for CBT and paroxetine showed significantly improved symptoms compared with placebo (mean change from baseline in Whiteley Index score: -4.67 , 95% CI -7.20 to -2.14 ; $p < 0.001$). There was no significant difference in symptom change between CBT and paroxetine (mean change from baseline in Whiteley Index score: -1.92 , 95% CI -4.79 to -0.95 ; $p = 0.19$). In intention-to-treat analyses, CBT significantly increased response compared with placebo, but there was no significant difference between paroxetine and placebo or paroxetine and CBT (absolute risk of response: 45% with CBT vs 30% with paroxetine vs 14% with placebo; $p = 0.004$ for CBT vs placebo; $p = 0.12$ for paroxetine vs placebo; $p = 0.17$ for CBT vs paroxetine). In completer analyses both CBT and paroxetine significantly increased response compared with placebo (absolute risk of response: 54% with CBT vs 38% with paroxetine vs 12% with placebo; $p = 0.001$ for CBT vs placebo; $p = 0.03$ for paroxetine vs placebo; $p = 0.27$ for CBT vs paroxetine).

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CONCLUSIONS

Active treatment (CBT or paroxetine pooled) is more effective than placebo for hypochondriasis. CBT increases response compared with placebo. Paroxetine may increase response compared with placebo in people completing treatment.

NOTES

Results for CBT and paroxetine groups were pooled as the study lacked power to detect differences between individual treatments. The results of this pooled analysis are insufficient to determine whether one or both of the treatments are having an effect. The analysis comparing symptoms in the active treatment groups was also underpowered to detect significant differences between groups, and should be interpreted with caution. People who dropped out of the study had greater worry about their health, and more anxiety, depressive symptoms and psychoneurotic symptoms

Commentary

This paper examined the relative efficacy of cognitive behavioural therapy (CBT) and paroxetine for the treatment of hypochondriasis. Recent studies, most notably Barsky and Ahern,¹ suggest that CBT is a promising therapy for hypochondriasis. The present study is innovative because it is the first to compare CBT to paroxetine. There were few differences in outcomes between CBT and paroxetine, but both treatments performed significantly better than a placebo.

Until recently, clinical wisdom was pessimistic with regard to the treatment of hypochondriasis, which was assumed to be an intransigent condition. The present study (and other recent studies) raises the possibility that hypochondriasis can be treated by a relatively brief therapy. However, there are some concerns that should be addressed before these findings can have widespread impact on practice. Although both treatments performed significantly better than a placebo, most of the patients who were offered either active treatment did not respond to treatment (even with a generous definition of a treatment response as a score just one standard deviation below the pretreatment mean). In fact, fewer than one in three of the patients offered paroxetine and just 38% of the treatment completers in this condition were treatment responders. Although the outcomes were slightly better for CBT, only about half of these treatment completers were treatment responders. A second cause for concern is that roughly one third of the patients in the paroxetine condition reported side effects involving sexual problems. Although CBT does not have apparent side effects, questions remain about the generalisability of this treatment. What expertise and training is necessary for practitioners to be able to offer this treatment effectively? Finally, as the authors noted, the absence of follow-up data leaves open the question of whether these outcomes are maintained or dissipate over time. If treatment comparison studies of other mood and anxiety disorders^{2,3} can serve as a guide, it may be that CBT provides some longer-term benefits, but that patients treated with SSRIs are likely to relapse when the treatment is discontinued.

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Competing interests: None declared.

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- 2 Barlow DH, Gorman JM, Shear MK, *et al.* Cognitive-behavioral therapy, imipramine, or their combination for panic disorder: a randomized controlled trial. *JAMA* 2000;**283**:2529–36.
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