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CME Objectives

After completing this CME activity, the psychiatrist should be able to:

- Describe the explanatory therapy model.
- Use explanatory therapy in a patient with hypochondriasis.

Statement of Need and Purpose

A substantial number of patients present with somatic complaints that have no apparent physiologic cause. Physicians responding to surveys in *The Journal of Clinical Psychiatry* have requested information on the management of these patients. This CME enduring material reports on the effectiveness of explanatory therapy in the subgroup of these patients diagnosed with hypochondriasis. There are no prerequisites for this activity.

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Drs. Fava, Grandi, Rafanelli, Fabbri, and Cazzaro have no significant commercial relationships to disclose relative to the presentation.

Explanatory Therapy in Hypochondriasis

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Objective: The aim of the study was to evaluate the effectiveness of individual explanatory therapy in hypochondriasis.

Method: Twenty patients with DSM-IV hypochondriasis were randomly assigned to 2 groups. One received explanatory therapy and was assessed again after a 6-month follow-up. The other was first assigned to a waiting list and subsequently treated with explanatory therapy. All patients received usual medical care from their physicians. Assessments involved both observer and self-rated instruments.

Results: In both groups, explanatory therapy was significantly associated with a reduction of hypochondriacal fears and beliefs, improvement in affective disturbances and anxiety sensitivity, and a decrease in health care utilization. Therapeutic gains were maintained at follow-up. Substantial residual symptomatology, however, remained.

Conclusion: The results suggest that hypochondriasis is a treatable condition and that explanatory therapy is a viable therapeutic tool. Further research should disclose the actual components of the mechanism of change in hypochondriacal patients.

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Hypochondriasis is often a chronic and disabling condition, long regarded as refractory to treatment.[1] In the early 1980s, Kellner[2] challenged this pessimistic stance. In an uncontrolled investigation, he applied explanatory therapy to 36 patients with hypochondriacal fears and beliefs. Explanatory therapy is mostly derived from research findings of studies concerned with patients with functional somatic symptoms.[3] It consists in providing accurate information, teaching the principles of selective perception (attention to one part of the body makes the patient more aware of sensations in that part of the body than in other parts), reassurance, clarification, and repetition.[3] Kellner's approach never underwent controlled validation. Its components became, however, the basis for the cognitive-behavioral approach to patients with functional somatic symptoms and abnormal illness behavior.[4] Central to the model is the way a person thinks about bodily sensations, which leads to emotional distress. This latter in turn leads to further somatic symptoms and an increase in illness behavior. These processes may become linked in self-perpetuating vicious circles.[4]

Cognitive-behavioral therapy (CBT), by using a complex mixture of cognitive and behavioral techniques, attempts to modify dysfunctional assumptions about health. Explanatory therapy differs from the cognitive-behavioral approach in the following aspects: (1) it uses fewer therapeutic components; (2) it is much simpler and does not require specific psychotherapeutic skills; (3) it does not introduce specific behavioral techniques (e.g., response prevention for repeated bodily checking and reassurance seeking); and (4) it is not based on a specific theoretical framework (e.g., idiosyncratic dysfunctional automatic thoughts).

A few controlled studies using cognitive-behavioral strategies in hypochondriasis are available. Warwick et al.[5] compared CBT with a waiting list period in 32 patients with hypochondriasis. CBT was significantly more effective than waiting list. Only one therapist was used, however, and assessment measures mainly involved visual analog scales. A subsequent study[6] attempted to repli-

cate and extend the investigation by Warwick et al.[5] in 48 patients with hypochondriasis randomly assigned to either CBT, in the format of the previous study,[5] behavioral stress management (an equally credible alternative treatment which involved the same amount of therapist contact but was not aimed at directly challenging patients' hypochondriacal beliefs), or a waiting-list control group. Both active treatments were more effective than waiting list but were not substantially different at follow-up. Eight clinical psychologists were used as therapists. Like the Warwick et al.[5] study, assessments in this study[6] were also mainly based on visual analog scales. Avia et al.[7] compared group CBT and a waiting-list control in 14 patients with hypochondriasis. CBT resulted in significant therapeutic gains by means of several validated assessment instruments. Finally, after a preliminary study,[8] Bouman and Visser[9] compared a purely cognitive treatment with a purely behavioral one (exposure in vivo with response prevention) in 17 patients with hypochondriasis. Patients were used as their own controls by observing a 4-week period without interventions before and after treatment. Both treatments were effective to a comparable degree, as measured by means of several self-rating scales.

The aim of the present study was to provide a controlled evaluation of explanatory therapy in hypochondriasis, using a wide range of assessment instruments that might shed some light on the mechanisms of change.

METHOD

Twenty consecutive outpatients satisfying the criteria described below, who had been referred by primary care physicians to a psychosomatic outpatient clinic, were enrolled in the study. The patients' diagnoses were established by the consensus of a psychiatrist (G.A.F.) and a clinical psychologist (C.R.) independently using the Structured Clinical Interview for DSM-III-R in its Italian version,[10] supplemented by specific questions on the differential diagnosis of hypochondriacal fears and beliefs,[11] with special reference to nosophobia (disease phobia) and thanatophobia (fear of dying).[12] This interview covered the content addressed in DSM-IV criteria for hypochondriasis.[13]

Patients had to meet the following criteria: (1) a current diagnosis of hypochondriasis according to DSM-IV criteria[13]; (2) absence of psychiatric comorbidity on the first or second Axis of DSM-IV; (3) no active medical illness; (4) a minimum global severity score of 7 in a 1–9 scored global scale of illness severity,[14] which ranges from being well (score = 1) to incapacitating illness (score = 9), for the current episode of hypochondriasis. All patients gave written consent after the procedures were fully explained to them.

Patients were randomly assigned to either immediate explanatory therapy by a psychiatrist (S.G.) or waiting-list control. Patients in the waiting-list group received no treatment for 6 months, after which they received explanatory therapy by another psychiatrist (G.A.F.). All patients, however, received usual medical care from their physicians. Treatment consisted of 8 sessions over a 16-week period, following Kellner's guidelines.[1–3] Each session lasted half an hour.

Assessments were at pretreatment/pre–waiting list, posttreatment/post–waiting list, and 6-month follow-up/posttreatment after waiting list. They were performed by a clinical psychologist (C.R.) blind to treatment assignment. Assessment included the following measures:

1. The Clinical Interview for Depression (CID)[15] is an observer-rated scale found to be extremely sensitive in detecting change in treatment outcome studies.[15–19] A shortened version of the scale (Change Version), encompassing 20 items, each rated on a 1- to 7-point scale, was used. The CID-Change Version has a total score that ranges from 20 (minimum) to 140 (maximum). It includes depressive and anxiety symptoms. The hypochondriasis item from the full scale was also used (score 1–7). Additional 1–7 scored items assessing disease phobia, thanatophobia, and bodily preoccupations were used.
2. The Rating Scale of Somatic Symptoms (RSSS)[20] is a 9-item observer-rated scale on common somatic complaints. Each item is scored on a 1–9 scale, with anchor points. The total score may range from 9 to 81.
3. The number of visits to physicians and laboratory tests (including radiology) in a 3-month period.
4. The Illness Attitude Scales (IAS)[1] are self-rating scales that measure psychopathology associated with hypochondriasis and abnormal illness behavior. They consist of 7 scales: worry about illness, concern about pain, health habits, hypochondriasis, thanatophobia, nosophobia, and bodily preoccupations. Each scale consists of 3 questions with a self-rated response on a 5-point scale and a total score that ranges from 0 to 12. They have been extensively used in clinical research, including most of the controlled treatment trials of hypochondriasis.[7–9]

Table 1. Sociodemographic and Clinical Characteristics of Patients Assigned to Explanatory Therapy and 6-Month Follow-Up (group A)[a]

Characteristic						
Age at entry, mean (SD), y	29.5 (7.6)					
Sex (male/female)	2/8					
Marital status (married/unmarried)	3/7					
Social class (middle-upper/working)	6/4					
Duration of illness, mean (SD), mo	27.3 (14.4)					
	Pretreatment		Posttreatment		Follow-Up	
	Mean	SD	Mean	SD	Mean	SD
CID change**	49.4	9.0	35.3	8.3	31.4	6.2
CID hypochondriasis**	6.2	0.8	3.8	1.3	3.4	1.6
CID nosophobia*	5.1	1.7	3.6	1.4	2.4	1.2
CID thanatophobia*	4.6	1.3	2.7	1.6	2.6	1.6
CID bodily preoccupations	6.3	0.8	4.2	2.0	3.9	2.0
RSSS*	39.9	6.3	24.7	9.7	21.8	8.0
Number of visits to physicians**	9.9	6.0	4.6	4.7	4.4	5.3
Number of laboratory tests	3.1	3.3	2.4	3.2	2.1	3.2
IAS worry about illness*	10.2	1.7	8.3	2.5	7.9	2.8
IAS concern about pain*	9.4	2.0	7.8	3.0	6.6	3.8
IAS health habits	8.0	3.3	7.1	2.2	6.1	3.5
IAS hypochondriasis	6.4	3.7	5.8	4.1	5.2	3.9
IAS thanatophobia*	10.1	1.9	7.9	2.6	7.1	3.1
IAS nosophobia**	7.5	3.0	4.9	3.5	4.9	3.3
IAS bodily preoccupations*	9.0	2.2	7.5	2.8	6.1	2.9
ASI**	34.8	11.5	24.8	11.4	21.9	11.4

[a]Abbreviations: ANOVA = analysis of variance, ASI = Anxiety Sensitivity Index, CID = Clinical Interview for Depression, IAS = Illness Attitude Scales, RSSS = Rating Scale of Somatic Symptoms.
*p < .01 by 1-way ANOVA for repeated measurements.
**p < .001 by 1-way ANOVA for repeated measurements.

Table 2. Sociodemographic and Clinical Characteristics of Patients Assigned to Waiting List and, Subsequently, to Explanatory Therapy (group B)

Characteristic						
Age at entry, mean (SD), y	33.9 (7.9)					
Sex (male/female)	0/10					
Marital status (married/unmarried)	5/5					
Social class (middle-upper/working)	6/4					
Duration of illness, mean (SD), mo	34.8 (33.0)					
	Pre–Waiting List		Post–Waiting List		Posttreatment	
	Mean	SD	Mean	SD	Mean	SD
CID change*	39.9	4.0	40.9	3.1	33.8	4.8
CID hypochondriasis*	6.0	0.8	6.0	1.1	3.5	1.2
CID nosophobia*	3.8	1.6	4.2	1.6	2.7	1.3
CID thanatophobia*	4.5	1.0	4.7	1.5	2.8	1.2
CID bodily preoccupations*	6.7	0.9	6.8	0.4	3.8	1.8
RSSS*	29.3	7.2	26.9	4.1	21.0	5.0
Number of visits to physician*	11.9	5.9	10.6	7.9	3.0	2.7
Number of laboratory tests*	4.5	3.8	4.3	5.2	0.5	0.5
IAS worry about illness**	10.9	1.4	11.2	1.2	7.7	2.4
IAS concern about pain*	10.3	1.8	10.4	1.8	6.7	2.8
IAS health habits	7.1	4.1	7.6	4.0	7.1	3.7
IAS hypochondriasis*	6.4	3.9	7.1	3.5	3.4	2.9
IAS thanatophobia*	9.9	2.6	9.7	3.2	6.0	3.0
IAS nosophobia*	8.1	3.9	7.7	3.5	3.6	3.1
IAS bodily preoccupations*	9.6	2.1	9.6	2.1	7.0	2.1
ASI*	28.9	14.1	32.4	14.1	19.2	10.2

*p < .01 by 1-way ANOVA for repeated measurements.
**p < .001 by 1-way ANOVA for repeated measurements.

5. The Anxiety Sensitivity Index (ASI)[21] is a 16-item self-rating questionnaire developed to measure the fear of becoming anxious. For each item of the ASI, subjects rate the magnitude of concern on a 5-point scale.

Higher scores on the rating scales correspond to greater clinical severity. All the scales were administered in their independently validated Italian versions.[17–19,22–24]

A nonparametric method adapted by Pesarin,[25] the permutation test, was used to evaluate treatment effects. This test is an analog of the 2-tailed Student test and a parametric analysis of variance (ANOVA) and covariance without, however, being conditioned by normal distribution hypotheses. The method is based on a simulation or resampling procedure, conditional on the data, which provides a simulated estimate of the permutation distribution of any statistic. In fact, the data are repeatedly permuted—a test statistic is computed for each data division, and the proportion of the data permutations with as large a test statistic value as the value for the obtained experimental results determines the significance of the results. This straightforward method also directly provides the p value. This test is particularly suitable for multidimensional (multivariate and/or multiparametric) cases, since it allows a combination procedure whereby all or part of the comparisons performed are combined in the same analysis. This procedure provides a very effective control for multiple testing.[25] Endpoint (intent-to-treat) analysis was used for repeated measurements. Results are expressed as means with standard deviations. Statistical analysis was performed by M.C.

RESULTS

Randomization yielded 2 groups of 10 patients each: group A, which was immediately treated (Table 1), and

group B, which was assigned to a waiting list (Table 2). There were significant differences ($p < .05$) in CID change score and RSSS between the 2 groups at pretreatment (group A) and pre–waiting-list (group B) assessments, by permutation test. Eight patients in group A completed treatment; the same patients were available for the 6-month follow-up. Nine patients in group B were available for evaluation after the waiting-list period, and 8 of these patients completed treatment afterwards.

In group A, 1-way ANOVA for repeated measurements, by permutation test ($df = 29$), yielded significant changes in CID change ($p < .001$), CID hypochondriasis ($p < .001$), CID nosophobia ($p < .01$), CID thanatophobia ($p < .01$), RSSS ($p < .01$), number of visits to physicians ($p < .001$), IAS worry about illness ($p < .01$), IAS concern about pain ($p < .01$), IAS thanatophobia ($p < .01$), IAS nosophobia ($p <.001$), IAS bodily preoccupations ($p < .01$), and ASI ($p < .001$) (Table 1). When Pesarin's combination procedure encompassing all measurements was used, 1-way ANOVA for repeated measurements was highly significant ($p < .001$), as it was also in the 4 CID scales ($p < .001$) and 7 IAS ($p < .001$) components. Significant changes ($p < .05$) took place between baseline and posttreatment measurements for CID change, CID hypochondriasis, CID thanatophobia, RSSS, number of visits to physicians, IAS worry about illness, IAS nosophobia, and ASI, whereas significant changes occurred only for nosophobia ($p < .05$) between posttreatment and follow-up. The significant changes were thus induced by treatment—as shown also by the global combined difference ($p < .05$) with its CID ($p < .01$) and IAS ($p < .001$) components—and were maintained at follow-up. (The combined differences were not significant.)

In group B, 1-way ANOVA for repeated measurements, by permutation test, yielded significant changes in CID change ($p < .01$), CID hypochondriasis ($p < .01$), CID nosophobia ($p < .01$), CID thanatophobia ($p < .01$), and CID bodily preoccupations ($p < .01$), as well as RSSS ($p < .01$), number of visits to physician ($p < .01$), number of laboratory tests ($p < .01$), IAS worry about illness ($p < .001$), IAS concern about pain ($p < .01$), IAS hypochondriasis ($p < .01$), IAS thanatophobia ($p < .01$), IAS nosophobia ($p < .01$), IAS bodily preoccupations ($p < .01$), and ASI ($p < .01$). The combined difference encompassing all measurements was highly significant ($p < .001$) and remained so when it involved the 4 CID scales ($p < .001$) and the 7 IAS scales ($p < .001$). There were no significant changes—except for ASI ($p < .05$)—after waiting-list assignment, and this finding was also supported by the combined difference. There were significant changes between the second and third measurements (after treatment) on the following instruments: CID change ($p < .01$), CID hypochondriasis ($p < .01$), CID nosophobia ($p < .01$), CID thanatophobia ($p < .01$), CID bodily preoccupations ($p < .01$), RSSS ($p < .01$), number of visits to physicians ($p < .01$), number of laboratory tests ($p < .01$), IAS worry about illness ($p < .01$), IAS concern about pain ($p < .01$), IAS hypochondriasis ($p < .01$), IAS thanatophobia ($p < .01$), IAS nosophobia ($p < .05$), IAS bodily preoccupations ($p < .05$), and ASI ($p < .01$). The combined difference in this case was highly significant ($p < .01$), remaining so when it involved the 4 CID scales ($p < .01$) and the 7 IAS scales ($p < .01$).

When the 2 groups were compared at their second measurements (posttreatment for group A and post–waiting list for group B), using their initial measurements (pretreatment for group A and pre–waiting list for group B) as covariates, a significant effect of treatment in group A was detected in the following variables: CID change ($t = 4.54$, $df = 18$, $p < .001$), CID hypochondriasis ($t = 3.54$, $df = 18$, $p < .01$), CID thanatophobia ($t = 2.20$, $df = 18$, $p < .05$), CID bodily preoccupations ($t = 2.60$, $df = 18$, $p < .05$), RSSS ($t = 2.96$, $df = 18$, $p < .01$), IAS worry about illness ($t = 2.49$, $df = 18$, $p < .05$), IAS concern about pain ($t = 1.93$, $df = 18$, $p < .05$), IAS bodily preoccupations ($t = 2.09$, $df = 18$, $p < .05$), and ASI ($t = 1.92$, $df = 18$, $p < .05$). The combination of the 16 variables yielded a significant difference ($p < .01$), as well as the combination of the CID individual scales ($p < .01$) and IAS scales ($p < .05$).

Residual symptoms concerned with abnormal illness behavior were assessed in the 16 patients who completed treatment. Patients were classified according to the presence of a score of 3 or more in the CID,[15] as had been done in previous research.[18] After explanatory therapy, 9 of the 16 patients had a score of 3 or more in CID hypochondriasis, 6 in CID nosophobia, and 14 in CID thanatophobia, and 13 in CID bodily preoccupations.

DISCUSSION

The results of this controlled investigation indicate that explanatory therapy induces a significant improvement in illness behavior and affective disturbances and decreases health care utilization in patients with DSM-IV hypochondriasis, compared with assignment to a waiting list. Such improvement appears to persist at a 6-month follow-up. The results were supported by both observer-rated and self-rated methods and by the use of a statistical analysis that allowed control for a potential effect of multiple test-

ing (a nonparametric combination method for dependent permutation tests). Further, the sample in this study was devoid of psychiatric comorbidity and presented with a considerable degree of severity. Hypochondriasis, in fact, frequently coexists with other psychiatric disorders, particularly anxiety disturbances.[22,26,27] Since the presence of anxiety is conducive to hypochondriacal fears and beliefs,[22] it is difficult to ascertain whether improvement in illness behavior is secondary to a reduction in anxiety. These potentially spurious effects might have occurred in previous controlled trials,[5–9] and particularly in a recent one,[6] in which there were no substantial differences between specific (cognitive therapy) and nonspecific (behavioral stress management) treatment strategies. Finally, clinical variants of hypochondriasis (particularly disease phobia), which might entail differential therapeutic responses,[11] were also assessed. The results lend support to other controlled investigations[5–9] suggesting that hypochondriasis is a treatable condition.

Kellner's explanatory therapy is a relatively simple, short-term psychotherapeutic strategy. From the first session, patients are encouraged to keep a diary in which they report the most threatening hypochondriacal fears and beliefs that occurred from one session to another, in a 2-week period. As long as therapy progresses, patients are encouraged to write alternative interpretations of their somatic sensations.

Several types of feedback are provided by the therapist. The first is concerned with accurate information. Hypochondriacal patients mistakenly believe good health to be a symptom-free state[28] and believe common somatic sensations to be indicative of disease more than nonhypochondriacal patients.[28–30] It is emphasized to the patients that only a very small proportion of somatic symptoms is caused by organic pathology. There is evidence from research in psychophysiology that accurate information about the relationship of a threatening stimulus and its somatic consequences can influence several phenomena, including the severity of autonomic responses and subjective distress.[1] The attentional correlates of illness anxiety[31] are emphasized. For instance, a patient may realize that he does not experience hypochondriacal worries when he is busy at work. Indeed, explanatory therapy was associated with a significant improvement in dimensions such as worry about illness and concern about pain.

A second essential component involves explaining to patients that there is a strong tendency to pay attention to some parts of the body and to perceive threatening stimuli accordingly (selective perception). If one is anxious about the arrival of another person, one hears footsteps in the corridor, whereas if one does not have a motive, many of the footsteps are not perceived.[3] It takes a long period of time for patients who have become experts in the detection of bodily symptoms to unlearn these skills and the active pursuit of strategies such as distraction (unlearning).

An additional component involves clarification, both of previous faulty communications with physicians and of common psychophysiologic reactions. Patients are in fact often unable to attribute somatic symptoms to anxiety, but they can learn what type of symptoms may be induced by anxiety and how to pay attention to their concomitant affective state. Patients also learn that stress may not result immediately in somatic symptoms but that a delayed response may occur. As a result, certain symptoms secondary to anxiety and tension may occur and/or persist even when these latter have abated and may require a certain time to fade away. Indeed, a significant decrease in anxiety sensitivity, the fear of becoming anxious, occurred after explanatory therapy.

Finally, Kellner emphasized the difficulties that hypochondriacal individuals have in registering and retaining complex information.[1] As a result, repetition becomes an important aspect of treatment and may also take the form of written statements by the therapist in the diary.

Even though improvements that were highly statistically significant ensued after explanatory therapy as measured by both observer and self-rated instruments, most of the patients displayed substantial residual symptomatology. They still had symptoms concerned with hypochondriasis and other fears (such as bodily preoccupations). Therapy did not induce disappearance of hypochondriacal beliefs but led to a decrease in their intensity and facilitated a better control of the subject over them. This is in line with the presence of substantial residual symptomatology in mood and anxiety disorders.[32] The aim of therapy may thus be for the patient to regain control over hypochondriacal symptoms rather than to expect their complete disappearance.

Explanatory therapy requires a considerable degree of individual attention. It is not possible to know from this study whether patient improvement was due to these specific components or was a nonspecific attention-related effect. This question should be elucidated by further investigations comparing different treatment approaches.[6,9]

There is now evidence that different therapeutic approaches may lead to similar results.[33,34] The challenge of future research is to identify the most simplified treatments (in terms of components) and their relation with pretreatment individual variables. Our findings, however, confirm previous investigations on the stability of un-

treated hypochondriacal fears and beliefs,[35,36] and on persistence of therapeutic gains at follow-up,[5,6] which run counter to a temporary nonspecific effect.

Individual therapeutic sessions were used in this study. However, Barsky[37] has developed a group therapy approach for hypochondriasis. Group discussions and cognitive and behavioral exercises are used to teach patients to moderate 4 factors that amplify somatic distress and hypochondriacal fears and beliefs: the attention they pay to their symptoms, their thoughts about them, the context in which they experience their symptoms, and their affects.[37] Such strategy underwent controlled validation.[7] It is thus conceivable, even though yet to be tested, that explanatory therapy may also be suitable for a group format.

Hypochondriasis is a common and invalidating disorder in medical practice.[37,38] Even though treatment was administered by 2 psychiatrists in this study, the principles of explanatory therapy are relatively simple[1] and do not require highly specialized training. If the results of this investigation are confirmed by other studies, explanatory therapy may play a considerable role in the health care of hypochondriacal patients.

Disclosure of off-label usage: The authors have determined that, to the best of their knowledge, no investigational information about pharmaceutical agents has been presented in this article that is outside U.S. Food and Drug Administration–approved labeling.

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Instructions

Physicians may receive up to 1 hour of Category 1 credit toward the American Medical Association Physician's Recognition Award by reading the article starting on page 317 and correctly answering at least 70% of the questions in the posttest that follows.

1. Read each question carefully and circle the correct corresponding answer on the Registration form.
2. Type or print your full name and address and Social Security, phone, and fax numbers in the spaces provided.
3. Send the Registration form along with a check, money order, or credit card payment in the amount of $10 to: Physicians Postgraduate Press, Office of CME, P.O. Box 752870, Memphis, TN 38175-2870.
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1. Selective perception means that:
- a. The patient worries about a specific part of the body and disregards other parts.
- b. Attention to one part of the body makes the patient more aware of sensations in that part.
- c. The patient is concentrated only on a few sensations.
- d. The patient selects the type of medical information that is consistent with his/her worries.

2. The key aspect of cognitive-behavioral interpretation of hypochondriasis is that:
- a. Anxiety determines somatic symptoms.
- b. Hypochondriasis is a learned response.
- c. It is the way a person thinks about bodily sensations that causes hypochondriasis.
- d. The patient is unaware of the physiological correlates of anxiety.

3. All these are components of explanatory therapy, except:
- a. Explanation
- b. Accurate information
- c. Repetition
- d. Response prevention

4. All these aspects characterize hypochondriasis, except:
- a. Generalized worries
- b. Fear of dying
- c. Bodily preoccupations
- d. Fear of a specific disease

5. Hypochondriacal patients:
- a. Believe that health is a symptom-free status
- b. Are reassured only by laboratory tests
- c. Are reassured only by physical examinations
- d. Do not seek medical attention

6. Controlled treatment trials in hypochondriasis indicate that:
- a. All treatments are effective but benefits wane.
- b. Cognitive-behavioral approaches are superior to other treatments.
- c. Several treatments are effective and benefits persist.
- d. Explanatory therapy is superior to other treatments.

7. After treatment, hypochondriacal patients:
- a. No longer have hypochondriacal beliefs
- b. Still have hypochondriacal beliefs, but have achieved a better control over them
- c. No longer have hypochondriacal beliefs, but are still worried about illness
- d. Avoid medical treatment

8. Explanatory therapy could be suitable for different kind of settings such as:
- a. Individual and group setting
- b. Only individual therapeutic sessions
- c. Only group therapeutic sessions
- d. Family sessions

Answers to the October 1999 CME posttest

1. c 2. d 3. b 4. b 5. a 6. c 7. d

Circle the one correct answer for each question.

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3. Was the format of this activity appropriate for the content being presented? ❑ Yes ❑ No
4. Did the method of presentation hold your interest and make the material easy to understand? ❑ Yes ❑ No
5. Achievement of educational objectives:
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