**Commentary on:** Clinical and cost-effectiveness of cognitive behaviour therapy for health anxiety in medical patients (Tyrer et al THELANCET-D-13-04564R2)

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Unsurprisingly, anxiety and other emotional problems are common in general medical practice. Not infrequently anxiety focuses on the possibility of serious disease that is not in fact present; there are fashions in terminology and the current terms in vogue are health anxiety or hypochondriasis[1]. As with much of the DSM lexicon, the diagnostic threshold is low and prevalences in the order of 15-20% are reported across clinical settings[2]. In spite of the absence of underlying disease, affected patients may be badly troubled by symptoms and they use significant resources in terms of investigation and inappropriate treatment.

No surprise again that cognitive behavioural therapy (CBT) is the most widely recommended intervention[3], although the evidence is not strong. Access is typically limited, with a lack of accredited practitioners and long waiting lists in traditional mental health service settings[4]. There is therefore significant interest in modified shortened versions. For primary depression and anxiety approaches such as CBT self-help resources are now the recommended first step[5] but similar developments have not generalised to physical healthcare.

In this issue, Tyrer et al report their finding that low intensity, shorter and more easily delivered interventions may be effective for health anxiety seen in general medical clinics. Treatment was by non-CBT experts who were trained in just two workshops to deliver 5-10 sessions of a manualised CBT-based treatment. The intervention improved scores on a health anxiety symptom inventory and the costs were no different from usual care. This result is intriguing and the authors suggest that the approach could be implemented in medical clinics with benefit, albeit that staff and patient attitudes would have to change before it could be widely adopted.

Translation of these findings into services is problematic.

First, there is the issue of cost. Case finding for the intervention depends upon a two-stage screening. At 12 month follow up in the current trial 13.9% (n=30) CBT and 7.3% (N=16) controls no longer met case criteria for health anxiety, so screening of more than 28,000 patients attending hospital-based medical clinics led to the recovery of 14 people who wouldn't have got better with routine care. The cost of

screening wasn't included in the analysis: combined with the lack of effect on quality of life that raises a question about cost-effectiveness.

There are other unknowns - what happened to false positives or false negatives or to the more severe cases (beyond the capacity of the therapists in the trial) that would be identified in a screening programme in routine practice. The current study interestingly seemed to lack high users of the health service; average health costs were just over GBP 8000.

A challenge arises when we move from considering stand-alone therapies to thinking about service configuration, in that health anxiety is only one of the non-physical problems found in medical patients – depression, hazardous alcohol use, poor treatment adherence, and other forms of medically-unexplained presentation all press for recognition and intervention. It makes no sense to develop multiple parallel services especially as there is considerable overlap between the common emotional disorders - and CBT offers a generic treatment framework which is not fundamentally different across disorders. The intervention in the present study is unlikely to have been highly condition-specific, as indicated for example by the finding that general anxiety and depression levels also responded.

So, where do we go next in developing a comprehensive and effective response to the problem of psychological morbidity in physical healthcare settings? We need research to evaluate interventions that can be practically and affordably integrated into service provision[6]; economic evaluation should include all costs of service provision; we need to find ways to track longer-term outcomes in conditions that are notoriously prone to relapse. In the meantime in clinical practice it seems more efficient and achievable to focus on identifying and treating severe cases rather than screening for common but relatively mild problems where we lack strong evidence of cost-effectiveness. Such treatment should be available in general hospital settings, in multi-disciplinary liaison psychiatry or clinical health psychology clinics that can deal with the full range of problems that present.

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**Conflict of interest statement:** CW is author of a range of cognitive behaviour therapy-based book and online self-help resources addressing mental and physical health issues including issues such as medically unexplained symptoms; he is director and shareholder in Five Areas Limited, which licenses these resources.
AH declares that he has no conflicts of interest.