Managing Health Anxiety: Practitioner Guide

THE TALKING THERAPIES UK PRACTITIONER GUIDES



Managing Health Anxiety: Practitioner Guide

Delivering the programme as guided self-help

A practitioner guide · 8 contacts · to accompany the workbook

TALKING THERAPIES UK

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First edition, 2026.

This guide accompanies the Managing Health Anxiety programme on the Talking Therapies UK self-help platform and its workbook. It is drawn from the programme and is kept current with it: whenever the programme changes, the guide is set again.

Revised and expanded edition, November 2026: the approach and its evidence, written practitioner notes and a worked example for every contact, the module's own teaching set out for the practitioner, and the answers to every sorting task and quiz.

Revision 7. This printing was set on 8 November 2026 from the programme as it stood that day.

A note on clinical responsibility. This guide supports qualified practitioners delivering guided self-help within their competence, their supervision and their organisation's policies. It does not replace clinical judgement, and its thresholds are guidance: where your service's policy differs, follow your service's policy.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

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How to use this guide

This guide is for qualified practitioners who support clients through the Managing Health Anxiety programme as guided self-help: a short supported contact after each of its 8 modules, with the client working through the programme or its workbook in between.

Part 1 sets out the model the programme is built on, what the research shows, and who the programme is for. Part 2 covers what every contact needs: your part in guided self-help, how to structure a contact, how to review each kind of worksheet, what to do when the work is not being done, how to adapt the programme, the check-ins and when to step up, and risk. Read Parts 1 and 2 before you begin with a client.

Part 3 has a chapter for each contact, to read before that contact: what the client has read in the module, why the skill matters, the messages to reinforce, a plan, the questions to ask, a worked example with dialogue, how to review the week's worksheets with their answers, and what to do when the skill is hard, how to adapt it and its cautions. Part 4 covers ending the work, supervision, and the checklist.

The guide follows the programme as it stands on the platform, so its plans name the programme's own modules, teaching and worksheets, and it is set again whenever the programme changes.

What this guide covers

- The model the programme is built on, and what the research shows
- Who the programme suits, how to assess for it, and when it is not enough on its own
- Your part in guided self-help, and how to structure each contact
- For each of the 8 contacts: what the client has read, why it matters, a worked example with dialogue, a plan, and the worksheets with their answers
- What to do when a skill is hard to learn or use, how to adapt it, and its cautions
- Keeping the work going, adapting the programme, the check-ins and stepping up, and risk at every contact
- Ending well, supervision, and a checklist for delivering the programme as designed

PART 1

The approach and the evidence

The model the programme is built on, what the research shows, and who the programme is for.

In this part

- Chapter 1, The model behind the programme: health anxiety as a specific cognitive behavioural picture, the cognitive model and its maintenance cycles, and how the eight modules are built
- Chapter 2, What the research shows: the evidence for CBT in health anxiety, for its components, and for guided self-help, with its limits

CHAPTER 1

The model behind the programme

What health anxiety is

Health anxiety is persistent worry about having, or developing, a serious illness, out of proportion to the medical evidence and maintained by what the person does to manage it. It sits on a spectrum. At one end is sensible vigilance: noticing a change worth showing to a doctor, attending screening, asking about a new or persistent symptom. At the other is severe health anxiety, in which the person may see many doctors about the same symptom, demand investigations that have already been done, and find that each reassurance lasts a day or two before the worry returns about something else. The programme is written for the middle of that spectrum, and module 1 asks the client to locate themselves on it.

Clients often arrive expecting to be told that their worry is irrational, and many have been told so, kindly or otherwise, by doctors and family. The programme takes a different stance, which the practitioner should share: the worry makes sense given what the client believes about their body and their health, and the work is to find out whether those beliefs are accurate, not to argue them away.

The cognitive model

The programme is built on the cognitive behavioural account of health anxiety developed by Salkovskis and Warwick. Salkovskis and Warwick (1986) proposed that health anxiety arises when ordinary bodily sensations, minor ailments or pieces of health information are misinterpreted as signs of serious illness, and they described how reassurance, though it relieves anxiety in the short

term, can maintain it in the longer term. Warwick and Salkovskis (1990) set out the fuller model: beliefs about health and illness, often formed through earlier experience, are activated by a critical incident; thereafter, misinterpretations of sensations produce anxiety, and anxiety is maintained by increased attention to the body, by checking and reassurance-seeking, and by avoidance.

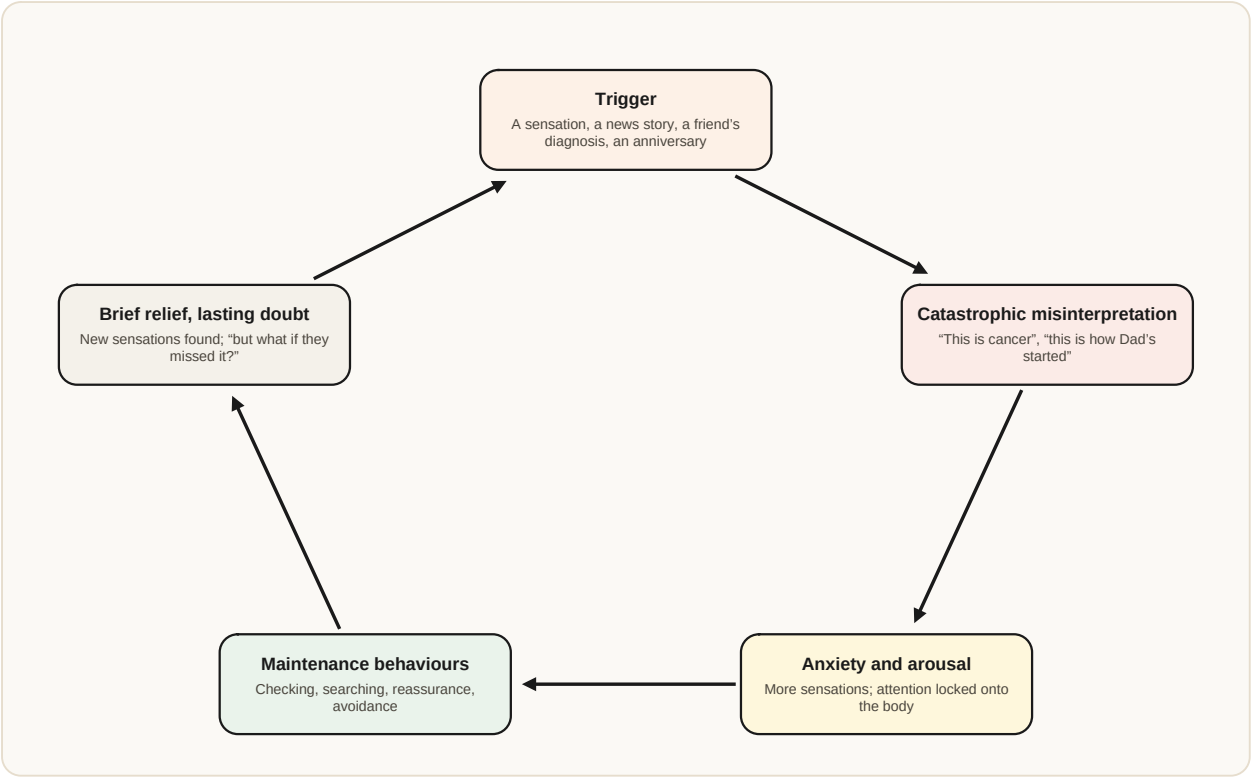


FIGURE 1.1 How health anxiety keeps itself going
The cognitive model of health anxiety. An ordinary sensation or a piece of health news is read as a sign of serious illness; anxiety brings more sensations and sharper attention to the body; and the checking, searching, reassurance-seeking and avoidance that follow relieve the fear for a while, produce more sensations and doubts, and leave the belief untested.

The model explains features that otherwise seem baffling. It explains why normal test results do not end the worry: the belief is not about the test but about what the test might have missed. It explains why checking makes things worse: pressing on a sore spot makes it sorer, and examining a mole daily makes every small change look significant. And it explains why attention matters: whatever part of the body is watched produces more noticeable sensations, which are taken as evidence. Module 2 teaches the model in these terms, and the rest of the programme intervenes at each point in the cycle.

How the programme breaks the cycle

Module 1 explains health anxiety and its costs and sets goals. Module 2 maps the client's own cycle and the experiences that made them vulnerable. Module 3 inventories the four maintaining behaviours: body checking, reassurance seeking, internet searching and avoidance. Module 4 works on the interpretations with a health-thought record. Modules 5 to 7 are the behavioural centre of the programme: experiments that drop safety behaviours or deliberately approach the worry, practices that change how the client attends to their body, and a policy for each part of the external surround, the internet, the medical system and the people closest to them. Module 8 consolidates the work and is explicit about when a symptom needs a doctor regardless of health

anxiety.

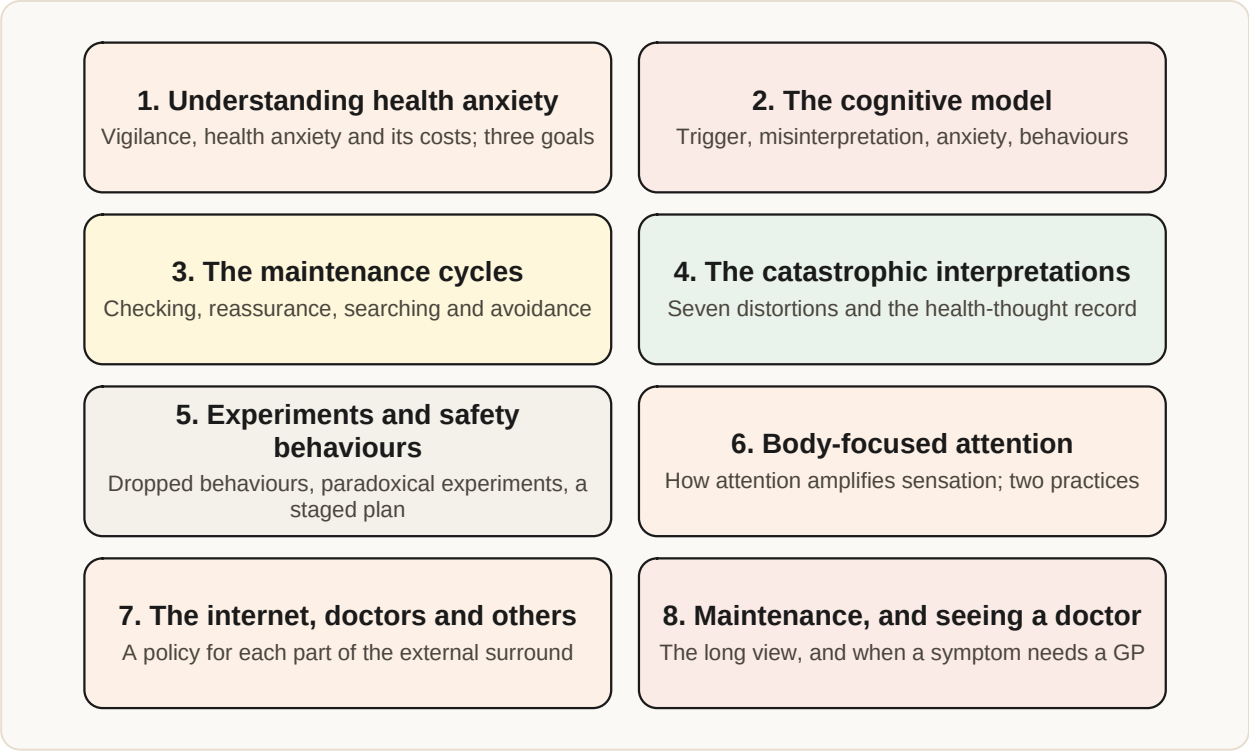


FIGURE 1.2 The eight modules and what each works on
Modules 1 and 2 explain health anxiety and map the client's own cycle. Module 3 inventories the behaviours that maintain it and module 4 examines the interpretations. Modules 5 to 7 are the behavioural centre: experiments, attention, and the internet, doctors and family. Module 8 keeps the gains and says plainly when a symptom needs a doctor.

How the modules are built

Each module has an introduction, two to four teaching sections, a sorting exercise, a practical worksheet, a closing summary with practice for the week ahead, and a reflection, "Taking this forward", which asks what the client most wants to keep, when it will be hardest to use, and what exactly they will do then. The check-ins come in modules 1, 4 and 8: the PHQ-9 and the Work and Social Adjustment Scale in module 1, and the PHQ-9, GAD-7 and WSAS in modules 4 and 8. Take the GAD-7 at assessment, and where your service uses it, the short form of the Health Anxiety Inventory (Salkovskis et al., 2002), which measures health worry, awareness of bodily sensations and feelings, and the feared consequences of illness, and is more sensitive than the GAD-7 to the change this programme aims for. The worked examples in this guide follow one composite client, Kwame, through all eight contacts.

What the practitioner adds

The programme carries the teaching. The practitioner's part has three particular demands in health anxiety. The first is to hold two things at once: that most of the client's symptoms are almost certainly benign, and that the practitioner is not medically qualified to say so, and must never tell a client that a symptom is "just anxiety". The second is not to become a source of reassurance. Clients with health anxiety are often skilled at drawing reassurance from anyone they speak to, and a practitioner who says "I'm sure it's nothing" has joined the cycle the programme is trying to break. The third is to keep the door to genuine medical care open. Some people with

health anxiety avoid doctors altogether, and anyone can develop a real illness; the programme's aim is appropriate use of medical care, not its absence. Chapter 5 shows how a thirty-minute contact can keep its attention on what the client does with a worry rather than on its content.

CHAPTER 2

What the research shows

CBT for health anxiety

Cognitive behavioural therapy is the best-supported psychological treatment for health anxiety. An early controlled trial found that patients with hypochondriasis treated with cognitive behavioural therapy improved significantly more than those on a waiting list, on measures including health anxiety, beliefs about illness and checking (Warwick et al., 1996). A systematic review and meta-analysis of fourteen randomised trials found a large effect of CBT compared with control conditions at the end of treatment, maintained at six and twelve months, against comparisons that included usual care, waiting list, medication and other psychological therapies (Cooper et al., 2017).

The largest trial was conducted in medical clinics in England. Tyrer and colleagues (2014) randomised 444 patients with health anxiety attending cardiology, endocrinology, gastroenterology, neurology and respiratory clinics to five to ten sessions of adapted CBT, delivered by hospital-based therapists, or to standard care. At twelve months health anxiety had improved significantly more with CBT, about twice as many patients had reached normal levels of health anxiety, the difference was sustained at two years, and total costs did not differ. The trial matters because it shows that the approach works in the people who most often present to medical services, and that therapists who are not specialist psychologists can deliver it.

The components

Two findings bear directly on the contacts. The first concerns reassurance. Rief and colleagues (2006) played people with medically unexplained symptoms, people with depression and healthy volunteers a recording of a doctor explaining the probability of various illnesses, and later asked them what the doctor had said. Those with unexplained symptoms remembered the doctor as having given illness a higher probability, a bias specific to medical information. It helps to explain why reassurance so often fails to last, and why the programme asks clients to change how they use medical care rather than to seek better reassurance. The second concerns attention. In a small case series, Papageorgiou and Wells (1998) found that training attention outwards reduced health anxiety and illness beliefs, which supports the attention practices of module 6.

Guided self-help

There is no NICE guideline specifically for health anxiety. In NHS Talking Therapies services it is treated with CBT, at low intensity for milder presentations and at high intensity where the difficulty is more severe or long-standing. Studies comparing guided self-help with face-to-face therapy for anxiety and depression have found similar effects (Cuijpers et al., 2010), and the structure of this programme, built around the same model and techniques as the trials above, makes it suitable for guided self-help in the mild to moderate range.

What the research does not show

No trial has tested this programme in its present form. The evidence above comes mainly from therapist-delivered CBT for health anxiety and from experimental studies of its processes. The programme applies that evidence with care, and the stepping-up guidance in Part 2 and in module 8 is the safeguard for clients for whom it is not enough: those whose health anxiety is severe or has led them to avoid medical care altogether, and those whose health anxiety is accompanied by depression, panic attacks, obsessive-compulsive features, the use of alcohol or drugs, or the effects of trauma.