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Illness Anxiety Disorder

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Continuing Education Activity

Illness anxiety disorder (previously called hypochondriasis) is a psychiatric disorder defined by excessive worry about having or developing a serious undiagnosed medical condition. People with illness anxiety disorder experience persistent anxiety or fear of developing or having a serious medical illness despite normal physical examination and laboratory testing results. This activity outlines the evaluation and management of illness anxiety disorder, particularly the role of the interprofessional team in evaluating patients with this condition.

Objectives:

- Describe the evaluation involved in evaluating illness anxiety disorder.
- Outline the DSM-5 diagnostic criteria for the diagnosis of illness anxiety disorder.
- Summarize the treatment of illness anxiety disorder.
- Outline the importance of improving care coordination among the interprofessional team to enhance care coordination for patients affected by illness anxiety disorder.

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Introduction

Illness anxiety disorder (previously called hypochondriasis, a term which has been revised in the DSM-5 due to its disparaging connotation) is a psychiatric disorder defined by excessive worry about having or developing a serious undiagnosed medical condition.[1] People with an illness anxiety disorder (IAD) experience persistent anxiety or fear of developing or having a serious medical illness that adversely affects their daily life.[2] This fear persists despite normal physical examination and laboratory testing results.[2] People suffering from IAD pay excessive attention to normal bodily sensations (such as functions of digestion or sweating) and misinterpret these sensations as indicators of severe disease. IAD is typically a chronic condition.[1]

Etiology

The exact etiology of illness anxiety disorder remains largely unknown. However, multiple risk factors have been implicated in the development of this disorder.

- People with IAD may be uncomfortable experiencing normal body sensations, and they may label the subtle bodily changes as pathological.[1]

- If a person is raised in a family where health anxieties are frequently discussed or if parents were disproportionately concerned about health-related issues, IAD may develop.[3]
- A person might be at increased risk of developing IAD if they experienced serious illness in their childhood or their parent(s) or siblings suffered from a serious medical condition.[2][3]
- People with underlying anxiety disorders (e.g., generalized anxiety disorder) are also at an increased risk of developing IAD.
- If a person spends an exorbitant amount of time reviewing health-related materials on the internet, he or she may be at an increased risk of developing IAD.[1]

Epidemiology

Illness anxiety disorder is a relatively new diagnosis, as it was first published in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) in 2013. Due to the novelty of this diagnosis, the prevalence of IAD is largely unknown.[1] The prevalence of IAD is estimated by the prevalence of the DSM-III and DSM-IV diagnosis of hypochondriasis.[2] Among patients who were previously diagnosed with hypochondriasis (which is now an obsolete diagnosis), about 25% of patients meet the criteria for IAD.[1] The prevalence of IAD varies according to the study location (e.g., medical clinical setting vs. community).[2][4] The estimated prevalence of IAD in the medical outpatient environment is about 0.75%, and in the general population, it is about 0.1%.[1][2] IAD is common in adolescents with no gender preponderance, and it typically worsens with age.[1][4] IAD is more common in unemployed and less educated persons.[1]

History and Physical

People with illness anxiety disorder often seek initial care from their primary care provider as opposed to a mental health care provider. A diagnosis of IAD is typically first speculated by primary care physicians when despite a normal physical examination, laboratory investigations, and repetitive assurances, the patients continue to have a severe disabling preoccupation and anxiety about an underlying serious medical condition. These patients often do not have somatic symptoms. If the somatic symptoms are present, they are only mild. If another medical condition is present, the preoccupation related to their health is clearly excessive and disproportionate to the severity of the condition.

The patients with IAD typically remain dissatisfied with negative evaluations and consult multiple physicians for the same medical problem. They have a belief that their previous doctors were either incompetent or were not paying attention to detail and have missed their serious medical condition, which will have terrible consequences.[1][5] The patients may also reveal that they frequently check their bodies for skin lesions, hair loss, or physical changes.[1] They may also overthink about death and disability. They are so preoccupied with their body-checking behaviors and health concerns that their social and occupational functioning may be significantly impaired.

Most of the patients with IAD belong to one of the two types:

1. A care-seeking type. These patients frequently utilize the health care system and keep changing their doctors. They may ask for multiple investigations and treatments.[1]
2. A care-avoidant type. These patients avoid medical care. They have severe anxiety with the belief that the primary doctor or laboratory testing will reveal a life-threatening illness (e.g., cancer).[1]

The presence of a general medical condition does not preclude a diagnosis of IAD. A general medical illness and IAD can be comorbid diagnoses. When a medical disorder is present, IAD is considered when health-related anxieties/preoccupations are out of proportion or excessive relative to the general medical disease.

Evaluation

Illness anxiety disorder is a diagnosis of exclusion. A comprehensive medical examination and appropriate testing according to the patient's symptoms should be conducted to exclude organic diseases before diagnosing a patient with IAD.[1] DSM-5 has also elaborated diagnostic criteria to help in the diagnosis of IAD.

The DSM-5 Diagnostic Criteria for Illness Anxiety Disorder [1] **:**

A. Excessive worry about having or developing a debilitating or life-threatening illness.

B. Somatic symptoms are absent. If somatic symptoms are present, they are only mildly distressing to the patient. If a medical condition is present or a high-risk for developing a medical condition is present (due to family history), the anxiety regarding the medical condition (or potential impending medical condition) is excessive.

C. Excessive concern and anxiety regarding health-related issues.

D. The individual exhibits disproportionate and redundant health-related behaviors, such as repeatedly checking his or her body for indications of disease.

E. Symptoms have been present for at least 6 months

F. The illness-related preoccupation is not better explained by another psychiatric condition

Specify if:

- Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is over-utilized. [1]
- Care-avoidant type: Medical care is rarely used or avoided.[1]

A structured, interviewer-administered assessment titled "The Health Preoccupation Diagnostic Interview" is available, which aids in the diagnosis of IAD. This tool allows the interviewer to clarify a patient's responses and assists in the diagnosis of IAD. It also differentiates IAD from somatic symptom disorder and healthy controls. The main limitations of this interview tool are that it is time-consuming and labor-intensive, and therefore is typically reserved for research purposes.[2]

As described above, a diagnosis of a general medical condition does not preclude a diagnosis of IAD. A general medical illness and IAD can be comorbid diagnoses. When a medical disorder is present, IAD is considered when health-related anxieties or preoccupations are out of proportion or excessive relative to the general medical disease.

Treatment / Management

The treatment of patients with illness anxiety disorder primarily is focused on helping patients cope with their health anxieties. Primary care providers should aim to establish a rapport and therapeutic alliance with their patients so that patients feel comfortable in discussing their health concerns.[1] The concerns and fears of patients should be acknowledged. Statements such as "it's all in your head" should be avoided. If required, the patient may be referred to other healthcare specialists if necessary. Once a serious medical condition has been ruled out, and a diagnosis of IAD has been established, the overutilization of the medical system, unnecessary imaging studies, specialist referrals, and laboratory investigations should be avoided. These patients should ideally be referred to a specialist health care professional or a psychiatrist. The primary care physician should make this referral in a tactful and non-judgemental way so that the patients do not feel invalidated or abandoned.[1] Patients should be scheduled for regular follow-ups with their primary care physician along with the psychiatrist. Frequent follow-ups will reduce visits to the emergency department or other physicians. It will also allow the physician to assess new complaints and associated triggers and stresses critically.[1]

Psychotherapy is the first-line treatment for IAD.[1] Cognitive-behavioral therapy (CBT) is a type of psychotherapy that focuses on treating the patient's dysfunctional maladaptive cognitive beliefs by behavioral modification strategies. It may address the patient's habits of excessive body checking for signs of illness. CBT also includes education about normal somatic sensations and their normal variations.[1] Mindfulness-based cognitive therapy, group therapies, and acceptance and commitment therapy may also be instituted.

Pharmacological drugs are the second-line treatment for IAD. Antidepressants such as selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) are proven to be effective in this condition.[2] Patients who respond to antidepressant therapy are recommended to receive maintenance treatment for at least 6 to 12 months. Most patients require a combination of psychotherapy and pharmacological agents.

Differential Diagnosis

Initial assessment should attempt to rule out any general medical disorders. Following the exclusion of organicity, diagnoses pertinent on the list of differentials include somatic symptom disorder, obsessive-compulsive disorder, generalized anxiety disorder, and body dysmorphic disorder.

Somatic symptom disorder (SSD) is a psychiatric condition characterized by multiple persistent somatic symptoms and excessive apprehension and anxiety regarding these symptoms.[6] However, patients with IAD typically experience minimal somatic symptoms and are more preoccupied with the belief that they are sick or diseased.

Obsessive-compulsive disorder (OCD) is a psychiatric disorder in which patients experience intrusive, unwanted thoughts that are only relieved by performing behaviors or compulsions.[7] Compulsive behaviors demonstrated in obsessive-compulsive disorder are typically ritualized, repetitive, and stereotyped, e.g., repetitively checking door locks. Furthermore, patients with OCD usually have obsessions and concerns pertaining to more than one concern.[7] Patients with IAD may experience intrusive thoughts about the illness and have associated compulsive behaviors, such as typically body checking or seeking reassurance. Still, these concerns are primarily preoccupied with health and disease only. They are not present in other areas of life.[7]

Patients with generalized anxiety disorder (GAD) have excessive worry and fear about almost all matters of daily living. They may seem tensed, keyed up, on edge, and excessively worried.[8] Patients with IAD may be initially mistakenly diagnosed with GAD. However, patients with IAD will have specific anxieties related to health, whereas patients with GAD may present preoccupied with issues pertaining to social, romantic, and occupational concerns.[8]

Body dysmorphic disorder (BDD) is a psychiatric condition characterized by a preoccupation with perceived defects in physical appearance that are not apparent or barely noticeable to others. Patients with BDD may demonstrate repetitive behaviors such as body checking and mirror checking. However, unlike IAD, patients with BDD are not concerned about being sick; they are preoccupied with being ugly or unattractive.[9]

- Anxiety disorders
- Body dysmorphic disorder
- Conversion disorders
- Delusional disorder
- Depression
- Generalized anxiety disorder
- Obsessive-compulsive disorder
- Personality disorders

- Schizophrenia
- Somatic symptom disorder

Prognosis

The prognosis for illness anxiety disorder is better for those patients who were referred early for psychiatric evaluation, as opposed to those who only received general medical care. Additionally, studies reveal that the patients who are cooperative, tolerant, and hopeful typically have better outcomes.[10] If a patient responds well to psychotherapy, medication, or both, the prognosis for IAD may be fair to good.[2] However, if the patient is experiencing severe symptoms of IAD, which are refractory to psychiatric medications and psychotherapy, the prognosis becomes poor.[10]

Complications

Illness anxiety disorder may significantly interfere with a patient's personal life and relationships. It prevents the patient from normal functioning in their daily life and may cause severe disability.[10] Additionally, due to frequent fears of being sick, patients may frequently take leave from work, causing problems within their occupational functioning. Further complications include financial distress from frequent healthcare visits and medical bills.[5] [10] These patients are also at a high risk for the development of another psychiatric illness such as major depressive disorder, other anxiety disorders, or a personality disorder.

Deterrence and Patient Education

Patient education is the single most fundamental part of the successful management of IAD. It is a delicate balance of validating the patients' concerns regarding their health fears, yet providing reassurance and education about normal bodily functions.[2] Physicians and health care providers should use empathetic statements to enhance the therapeutic alliance.

Enhancing Healthcare Team Outcomes

It is crucial for general practitioners, internists, and family medicine physicians to be well informed about illness anxiety disorder so that this psychiatric disorder may be recognized and treated appropriately. IAD can pose a tremendous burden on the healthcare system as providers may be ordering expensive and unnecessary investigations and imaging.[5] Once IAD is recognized, the primary care team needs to work closely with the mental health team so that collaborative care may be provided to the patient. Furthermore, both the primary care physician and psychiatrist should closely observe the patient for improvement or development of new symptoms and stressors.[1]

Review Questions

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