Illness Anxiety Disorder

Code: 300.7 (F45.21)

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Diagnostic Criteria 300.7 (F45.21)

A. Preoccupation with having or acquiring a serious illness.
B. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.
C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.
D. The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).
E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.
F. The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.
Specify whether:
Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is frequently used.
Care-avoidant type: Medical care is rarely used.

Diagnostic Features

Most individuals with hypochondriasis are now classified as having somatic symptom disorder; however, in a minority of cases, the diagnosis of illness anxiety disorder applies instead. Illness anxiety disorder entails a preoccupation with having or acquiring a serious, undiagnosed medical illness (Criterion A). Somatic symptoms are not present or, if present, are only mild in intensity (Criterion B). A thorough evaluation fails to identify a serious medical condition that accounts for the individual's concerns. While the concern may be derived from a nonpathological physical sign or sensation, the individual's distress emanates not primarily from the physical complaint itself but rather from his or her anxiety about the meaning, significance, or cause of the complaint (i.e., the suspected medical diagnosis). If a physical sign or symptom is present, it is often a normal physiological sensation (e.g., orthostatic dizziness), a benign and self-limited dysfunction (e.g., transient tinnitus), or a bodily discomfort not generally considered indicative of disease (e.g., belching). If a diagnosable medical condition is present, the individual's anxiety and preoccupation are clearly excessive and disproportionate to the severity of the condition (Criterion B). Empirical evidence and existing literature pertain to previously defined DSM hypochondriasis, and it is unclear to what extent and how precisely they apply to the description of this new diagnosis.
The preoccupation with the idea that one is sick is accompanied by substantial anxiety about health and disease (Criterion C). Individuals with illness anxiety disorder are easily
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alarmed about illness, such as by hearing about someone else falling ill or reading a health-related news story. Their concerns about undiagnosed disease do not respond to appropriate medical reassurance, negative diagnostic tests, or benign course. The physician's attempts at reassurance and symptom palliation generally do not alleviate the individual's concerns and may heighten them. Illness concerns assume a prominent place in the individual's life, affecting daily activities, and may even result in invalidism. Illness becomes a central feature of the individual's identity and self-image, a frequent topic of social discourse, and a characteristic response to stressful life events. Individuals with the disorder often examine themselves repeatedly (e.g., examining one's throat in the mirror) (Criterion D). They research their suspected disease excessively (e.g., on the Internet) and repeatedly seek reassurance from family, friends, or physicians. This incessant worrying often becomes frustrating for others and may result in considerable strain within the family. In some cases, the anxiety leads to maladaptive avoidance of situations (e.g., visiting sick family members) or activities (e.g., exercise) that these individuals fear might jeopardize their health.

Associated Features Supporting Diagnosis

Because they believe they are medically ill, individuals with illness anxiety disorder are encountered far more frequently in medical than in mental health settings. The majority of individuals with illness anxiety disorder have extensive yet unsatisfactory medical care, though some may be too anxious to seek medical attention. They generally have elevated rates of medical utilization but do not utilize mental health services more than the general population. They often consult multiple physicians for the same problem and obtain repeatedly negative diagnostic test results. At times, medical attention leads to a paradoxical exacerbation of anxiety or to iatrogenic complications from diagnostic tests and procedures. Individuals with the disorder are generally dissatisfied with their medical care and find it unhelpful, often feeling they are not being taken seriously by physicians. At times, these concerns may be justified, since physicians sometimes are dismissive or respond with frustration or hostility. This response can occasionally result in a failure to diagnose a medical condition that is present.

Prevalence

Prevalence estimates of illness anxiety disorder are based on estimates of the DSM-III and DSM-IV diagnosis hypochondriasis. The 1- to 2-year prevalence of health anxiety and/or disease conviction in community surveys and population-based samples ranges from 1.3% to 10%. In ambulatory medical populations, the 6-month/1-year prevalence rates are between 3% and 8%. The prevalence of the disorder is similar in males and females.

Development and Course

The development and course of illness anxiety disorder are unclear. Illness anxiety disorder is generally thought to be a chronic and relapsing condition with an age at onset in early and middle adulthood. In population-based samples, health-related anxiety increases with age, but the ages of individuals with high health anxiety in medical settings do not appear to differ from those of other patients in those settings. In older individuals, health-related anxiety often focuses on memory loss; the disorder is thought to be rare in children.

Risk and Prognostic Factors

Environmental. Illness anxiety disorder may sometimes be precipitated by a major life stress or a serious but ultimately benign threat to the individual's health. A history of child-
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hood abuse or of a serious childhood illness may predispose to development of the disorder in adulthood.
Course modifiers. Approximately one-third to one-half of individuals with illness anxiety disorder have a transient form, which is associated with less psychiatric comorbidity, more medical comorbidity, and less severe illness anxiety disorder.

Culture-Related Diagnostic Issues

The diagnosis should be made with caution in individuals whose ideas about disease are congruent with widely held, culturally sanctioned beliefs. Little is known about the phenomenology of the disorder across cultures, although the prevalence appears to be similar across different countries with diverse cultures.

Functional Consequences of Illness Anxiety Disorder

Illness anxiety disorder causes substantial role impairment and decrements in physical function and health-related quality of life. Health concerns often interfere with interpersonal relationships, disrupt family life, and damage occupational performance.

Differential Diagnosis

Other medical conditions. The first differential diagnostic consideration is an underlying medical condition, including neurological or endocrine conditions, occult malignancies, and other diseases that affect multiple body systems. The presence of a medical condition does not rule out the possibility of coexisting illness anxiety disorder. If a medical condition is present, the health-related anxiety and disease concerns are clearly disproportionate to its seriousness. Transient preoccupations related to a medical condition do not constitute illness anxiety disorder.
Adjustment disorders. Health-related anxiety is a normal response to serious illness and is not a mental disorder. Such nonpathological health anxiety is clearly related to the medical condition and is typically time-limited. If the health anxiety is severe enough, an adjustment disorder may be diagnosed. However, only when the health anxiety is of sufficient duration, severity, and distress can illness anxiety disorder be diagnosed. Thus, the diagnosis requires the continuous persistence of disproportionate health-related anxiety for at least 6 months.
Somatic symptom disorder. Somatic symptom disorder is diagnosed when significant somatic symptoms are present. In contrast, individuals with illness anxiety disorder have minimal somatic symptoms and are primarily concerned with the idea they are ill.
Anxiety disorders. In generalized anxiety disorder, individuals worry about multiple events, situations, or activities, only one of which may involve health. In panic disorder, the individual may be concerned that the panic attacks reflect the presence of a medical illness; however, although these individuals may have health anxiety, their anxiety is typically very acute and episodic. In illness anxiety disorder, the health anxiety and fears are more persistent and enduring. Individuals with illness anxiety disorder may experience panic attacks that are triggered by their illness concerns.
Obsessive-compulsive and related disorders. Individuals with illness anxiety disorder may have intrusive thoughts about having a disease and also may have associated compulsive behaviors (e.g., seeking reassurance). However, in illness anxiety disorder, the preoccupations are usually focused on having a disease, whereas in obsessive-compulsive disorder (OCD), the thoughts are intrusive and are usually focused on fears of getting a disease in the future. Most individuals with OCD have obsessions or compulsions involving other concerns in addition to fears about contracting disease. In body dysmorphic dis-
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order, concerns are limited to the individual's physical appearance, which is viewed as defective or flawed.
Major depressive disorder. Some individuals with a major depressive episode ruminate about their health and worry excessively about illness. A separate diagnosis of illness anxiety disorder is not made if these concerns occur only during major depressive episodes. However, if excessive illness worry persists after remission of an episode of major depressive disorder, the diagnosis of illness anxiety disorder should be considered.
Psychotic disorders. Individuals with illness anxiety disorder are not delusional and can acknowledge the possibility that the feared disease is not present. Their ideas do not attain the rigidity and intensity seen in the somatic delusions occurring in psychotic disorders (e.g., schizophrenia, delusional disorder, somatic type; major depressive disorder, with psychotic features). True somatic delusions are generally more bizarre (e.g., that an organ is rotting or dead) than the concerns seen in illness anxiety disorder. The concerns seen in illness anxiety disorder, though not founded in reality, are plausible.

Comorbidity

Because illness anxiety disorder is a new disorder, exact comorbidities are unknown. Hypochondriasis co-occurs with anxiety disorders (in particular, generalized anxiety disorder, panic disorder, and OCD) and depressive disorders. Approximately two-thirds of individuals with illness anxiety disorder are likely to have at least one other comorbid major mental disorder. Individuals with illness anxiety disorder may have an elevated risk for somatic symptom disorder and personality disorders.
Conversion Disorder
(Functional Neurological Symptom Disorder)

Diagnostic Criteria

A. One or more symptoms of altered voluntary motor or sensory function.
B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.
C. The symptom or deficit is not better explained by another medical or mental disorder.
D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.
Coding note: The ICD-9-CM code for conversion disorder is 300.11, which is assigned regardless of the symptom type. The ICD-10-CM code depends on the symptom type (see below).
Specify symptom type:
(F44.4) With weakness or paralysis
(F44.4) With abnormal movement (e.g., tremor, dystonic movement, myoclonus, gait disorder)
(F44.4) With swallowing symptoms
(F44.4) With speech symptom (e.g., dysphonia, slurred speech)
(F44.5) With attacks or seizures
(F44.6) With anesthesia or sensory loss
(F44.6) With special sensory symptom (e.g., visual, olfactory, or hearing disturbance)
(F44.7) With mixed symptoms
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Specify if:
Acute episode: Symptoms present for less than 6 months.
Persistent: Symptoms occurring for 6 months or more.
Specify if:
With psychological stressor (specify stressor)
Without psychological stressor

Diagnostic Features

Many clinicians use the alternative names of "functional" (referring to abnormal central nervous system functioning) or "psychogenic" (referring to an assumed etiology) to describe the symptoms of conversion disorder (functional neurological symptom disorder). In conversion disorder, there may be one or more symptoms of various types. Motor symptoms include weakness or paralysis; abnormal movements, such as tremor or dystonic movements; gait abnormalities; and abnormal limb posturing. Sensory symptoms include altered, reduced, or absent skin sensation, vision, or hearing. Episodes of abnormal generalized limb shaking with apparent impaired or loss of consciousness may resemble epileptic seizures (also called psychogenic or non-epileptic seizures). There may be episodes of unresponsiveness resembling syncope or coma. Other symptoms include reduced or absent speech volume (dysphonia/aphonia), altered articulation (dysarthria), a sensation of a lump in the throat (globus), and diplopia.
Although the diagnosis requires that the symptom is not explained by neurological disease, it should not be made simply because results from investigations are normal or because the symptom is "bizarre." There must be clinical findings that show clear evidence of incompatibility with neurological disease. Internal inconsistency at examination is one way to demonstrate incompatibility (i.e., demonstrating that physical signs elicited through one examination method are no longer positive when tested a different way). Examples of such examination findings include
• Hoover's sign, in which weakness of hip extension returns to normal strength with contralateral hip flexion against resistance.
• Marked weakness of ankle plantar-flexion when tested on the bed in an individual who is able to walk on tiptoes;
• Positive findings on the tremor entrainment test. On this test, a unilateral tremor may be identified as functional if the tremor changes when the individual is distracted away from it. This may be observed if the individual is asked to copy the examiner in making a rhythmical movement with their unaffected hand and this causes the functional tremor to change such that it copies or "entrains" to the rhythm of the unaffected hand or the functional tremor is suppressed, or no longer makes a simple rhythmical movement.
• In attacks resembling epilepsy or syncope ("psychogenic" non-epileptic attacks), the occurrence of closed eyes with resistance to opening or a normal simultaneous electroencephalogram (although this alone does not exclude all forms of epilepsy or syncope).
• For visual symptoms, a tubular visual field (i.e., tunnel vision).
It is important to note that the diagnosis of conversion disorder should be based on the overall clinical picture and not on a single clinical finding.

Associated Features Supporting Diagnosis

A number of associated features can support the diagnosis of conversion disorder. There may be a history of multiple similar somatic symptoms. Onset may be associated with stress or trauma, either psychological or physical in nature. The potential etiological rele-
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vance of this stress or trauma may be suggested by a close temporal relationship. However, while assessment for stress and trauma is important, the diagnosis should not be withheld if none is found.
Conversion disorder is often associated with dissociative symptoms, such as depersonalization, derealization, and dissociative amnesia, particularly at symptom onset or during attacks.
The diagnosis of conversion disorder does not require the judgment that the symptoms