Illness anxiety disorder: Epidemiology, clinical presentation, assessment, and diagnosis

AUTHOR: James L Levenson, MD
SECTION EDITOR: Joel Dimsdale, MD
DEPUTY EDITOR: David Solomon, MD

All topics are updated as new evidence becomes available and our peer review process is complete.

Literature review current through: **Oct 2023.**
This topic last updated: **Aug 29, 2022.**

INTRODUCTION

Illness anxiety disorder is characterized by excessive concern about having or developing a serious, undiagnosed general medical disease [1]. The patient's distress comes primarily from an unfounded fear of having a disease rather than physical symptoms, and persists despite appropriate physical examination and laboratory testing that are negative. Physical symptoms are not present, or they are minimal and often represent a misperception of normal bodily sensations. Illness anxiety disorder is usually chronic. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) diagnosis of illness anxiety disorder conceptually overlaps with the prior Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR), diagnosis of hypochondriasis [1,2].

This topic reviews the epidemiology, pathogenesis, clinical presentation, assessment, diagnosis, and differential diagnosis of illness anxiety disorder. Treatment and prognosis of illness anxiety disorder, and the clinical features, medical evaluation, and treatment of somatization are discussed elsewhere. (See "Illness anxiety disorder: Treatment and prognosis" and "Somatic symptom disorder: Epidemiology and clinical presentation" and "Somatic symptom disorder: Assessment and diagnosis" and "Somatic symptom disorder: Treatment".)

TERMINOLOGY AND DSM-5-TR

Illness anxiety disorder is a diagnosis (table 1) that was introduced with publication of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) in 2013 [3]. The diagnostic criteria remained the same with publication of the DSM-5-TR in 2022 [1]. The clinical features and diagnostic criteria are discussed elsewhere in this topic. (See 'Clinical presentation' below and 'Diagnosis' below.)

Illness anxiety disorder was derived in part from the diagnosis of hypochondriasis, which was eliminated from DSM-5/DSM-5-TR [1,3]. In DSM-5/DSM-5-TR, patients previously diagnosed with hypochondriasis are nearly always diagnosed with either somatic symptom disorder (if physical complaints are prominent) or illness anxiety disorder (if physical complaints are minimal or nonexistent). Although relatively few studies of illness anxiety disorder have been published, there is a larger literature on the symptom of health anxiety, defined as persistent unrealistic worry or conviction about having an illness. The spectrum of health anxiety ranges from none to severe, with the severe end representing a clinical endpoint (such as illness anxiety disorder or hypochondriasis) [4-6].

In the DSM-IV-TR, the term hypochondriasis (table 2) described patients who misinterpreted one or more bodily symptoms and believed that they had a serious disease or were preoccupied with fear of a disease, despite appropriate medical evaluation and reassurance [2]. Both the DSM-IV-TR diagnosis of hypochondriasis and the DSM-5/DSM-5-TR diagnosis of illness anxiety disorder include patients who believe that they have a serious disease or are preoccupied with fear of a disease, despite a normal physical examination, negative tests, and reassurance [1-3].

Among patients previously diagnosed with hypochondriasis, it is estimated that approximately 75 percent are subsumed under the DSM-5/DSM-5-TR diagnosis of somatic symptom disorder and 25 percent under the DSM-5/DSM-5-TR diagnosis of illness anxiety disorder [1,3]. Support for these estimates include a retrospective study of patients who initially received a DSM-IV diagnosis of hypochondriasis (n = 58); post-hoc application of DSM-5/DSM-5-TR criteria found that 76 percent met criteria for somatic symptom disorder and 24 percent met criteria for illness anxiety disorder [7]. Additional information about somatic symptom disorder, including its diagnostic criteria, is discussed separately. (See "Somatic symptom disorder: Epidemiology and clinical presentation" and "Somatic symptom disorder: Assessment and diagnosis".)

DSM-5/DSM-5-TR includes illness anxiety disorder in the category called somatic symptom and related disorders, which are diagnoses characterized by prominent somatic concerns, distress, and impaired functioning [1,3]. Patients with somatic symptom and related disorders typically present to primary care clinicians and general medical specialists rather than psychiatrists. Additional information about somatic symptom and related disorders is discussed separately.

(See "Somatic symptom disorder: Epidemiology and clinical presentation" and "Somatic symptom disorder: Assessment and diagnosis".)

Hypochondriasis remains a diagnosis in the World Health Organization's International Classification of Diseases, 11th Revision (ICD-11) [8]. The essential feature of the ICD-11 diagnosis is a persistent preoccupation with having at least one serious general medical illness. In addition, patients manifest either excessive health-related behaviors (eg, frequently checking oneself for signs of the illness), or avoidance behavior related to one's health, such as avoiding medical appointments. Clinically significant distress is present or functioning (eg, social or occupational) is impaired.

EPIDEMIOLOGY

The prevalence of illness anxiety disorder is largely unknown because it was introduced as a diagnosis in the DSM-5, which was published in 2013 [3]. The diagnostic criteria remained the same with publication of the DSM-5-TR in 2022 [1]. Illness anxiety disorder was derived in part from the diagnosis of hypochondriasis, which was eliminated from DSM-5/DSM-5-TR. It is estimated that among individuals who were diagnosed with hypochondriasis, approximately 33 percent would qualify for a diagnosis of illness anxiety disorder [9]. In addition, the prevalence of illness anxiety disorder can be estimated from studies of individuals with symptoms of health anxiety (persistent unrealistic worry or conviction about having an illness), which is a broad construct that exists along a continuum and presumably has a greater prevalence than illness anxiety disorder. (See 'Terminology and DSM-5-TR' above.)

The estimated prevalence of illness anxiety disorder depends upon the study sample and setting, and it is thought that illness anxiety disorder/health anxiety presents far more often in general medical clinics than other settings [1,3,10]:

- **General medical outpatients** – The prevalence of illness anxiety disorder in medical outpatients (eg, family practice and primary care) is approximately 0.75 percent, based upon a pooled analysis of 12 studies that found the prevalence of hypochondriasis was 3 percent [11]. Symptoms of health anxiety (unrealistic fears about illness) occur in approximately 5 to 30 percent of ambulatory medical patients.

- **Community dwelling adults** – A pooled analysis of seven community surveys found that the prevalence of hypochondriasis in the general population was 0.4 percent, suggesting that the prevalence of illness anxiety disorder is approximately 0.1 percent [11]. In a

different set of seven community surveys, symptoms of health anxiety occurred in 2 to 13 percent of community adults.

Age of onset for illness anxiety disorder is not known. Hypochondriasis is most common in early adulthood and rarely begins after the age of 50 years [2,12]. Health anxiety occurs across the lifespan but appears to be more common between ages 35 to 64 years [13]. Illness anxiety disorder is uncommon in children and it can be difficult to separate the child's anxiety from the parent's [14].

Hypochondriasis and health anxiety occur in males and females in approximately a one-to-one ratio and are not associated with marital status [8,13,15]. Health anxiety is more common in the unemployed than the working population [13]. Hypochondriasis and health anxiety are more common in less educated patients and often accompanied by disability [13,15].

PATHOGENESIS

The pathogenesis of illness anxiety disorder is not known. However, some inferences can be drawn from studies of hypochondriasis and the symptom of health anxiety (persistent unrealistic worry or conviction about having an illness). Psychosocial etiologies of hypochondriasis and health anxiety have been examined more than biological causes.

Illness anxiety disorder is a diagnosis (table 1) that was introduced with publication of the DSM-5 in 2013 [3]. The diagnostic criteria remained the same with publication of the DSM-5-TR in 2022 [1]. The disorder was derived in part from the diagnosis of hypochondriasis, which was eliminated from DSM-5/DSM-5-TR. It is estimated that among individuals who were diagnosed with hypochondriasis, approximately 25 percent would qualify for a diagnosis of illness anxiety disorder. In addition, the pathogenesis of illness anxiety disorder can be inferred from studies of individuals with symptoms of health anxiety (persistent unrealistic worry or conviction about having an illness). (See 'Terminology and DSM-5-TR' above.)

Psychosocial — Among the different psychosocial theories that describe how patients develop hypochondriasis, the cognitive-behavioral model has empirical support and leads to effective treatment [4,16]. In this model, the disorder is characterized by excessive and persistent anxiety about threats to one's health [16,17]. The anxiety is due to normal body sensations that are perceived as abnormally intense and misattributed to serious medical disease, leading the patient to seek assurance of good health. In addition, the way people interpret and react to naturally occurring, intrusive thoughts about illness appears to create vulnerability for developing illness anxiety disorder [18].

In the cognitive-behavioral model, risk factors for hypochondriasis, and likely for illness anxiety disorder, include dysfunctional assumptions about the prevalence and communicability of severe illnesses, the meaning of bodily symptoms, and the course and treatment of illnesses [19]. As an example, patients may believe that good health is a symptom-free state, or overestimate their vulnerability to developing disease [16,20,21]. The dysfunctional assumptions may stem from early family experiences and childhood illness. Abnormal illness behavior in parents (eg, their own high health anxiety or excessive worry about illness in their children), as well as a child's exposure to serious parental illness, appears to increase the risk of somatic symptom disorders in adulthood [22,23].

An event, such as reading about an illness or hearing about the illness of an acquaintance or celebrity, can activate dysfunctional assumptions and lead to excessive illness anxiety. Patients may increasingly monitor their bodily sensations for any sign of the illness, and amplify or exaggerate any evidence of illness. Normal somatic feelings are then prone to be misinterpreted as ominous. The misinterpretation triggers anxiety, which patients attempt to reduce by seeking assurance of good health from physicians and/or alternative care providers or remedies.

Despite medical reassurance, patients with illness anxiety disorder remain anxious about their health. One reason is that patients vigilantly monitor their bodies for symptoms and become sensitive to slight homeostatic fluctuations that occur normally [16].

In addition, it is thought that illness anxiety leads patients to confirm their fears through selective attention toward information that is consistent with having a disease and away from information that is consistent with good health. Support for this hypothesis includes a randomized trial that enrolled undergraduate students (n = 60, not selected for any psychopathology) and assigned them to spend one week frequently engaged in safety behaviors (such as checking one’s body or using the internet to research health information), or to spend one week monitoring their normal use of safety behaviors (controls) [24]. Health anxiety increased more in the group frequently engaging in safety behaviors compared with controls. Among individuals with illness anxiety, checking behaviors appear to reduce negative emotional states [25].

Avoidance behavior may also maintain illness anxiety symptoms. As an example, patients who erroneously believe that they have cardiac disease may avoid physical exertion because they think this will exacerbate their condition; patients thus lose the opportunity to verify their good health and correct the mistaken belief.

Genetics and biological correlates — The genetics of illness anxiety disorder and hypochondriasis are unknown, and there is little information about their neurobiology. A family study found that the prevalence of hypochondriasis was comparable in 72 first-degree relatives of patients with hypochondriasis and in 97 relatives of controls, but interpreting the results is difficult due to the small number of individuals involved and the relatively low incidence of the illness [26]. Studies of biologic correlates have found that compared with healthy controls, patients with hypochondriasis have decreased levels of plasma neurotrophin-3 and platelet serotonin [27], and smaller pituitary volumes [28]. Another observational study (n = 24) found that individuals with high levels of health anxiety focused more upon body symptom words (eg, dizziness, headache, and nausea) compared with individuals with low levels of health anxiety, and that this attentional bias toward body symptom words was associated with hypoactivity of the rostral anterior cingulate cortex [29]. However, due to the cross-sectional design of these neurobiologic studies, it is unclear whether the abnormalities represent etiologic causes, sequelae, neither, or both. In addition, the studies were small.

CLINICAL PRESENTATION

The clinical features of illness anxiety disorder discussed in this section are based in large part upon studies of hypochondriasis, as well as studies of individuals with symptoms of health anxiety (persistent unrealistic worry or conviction about having an illness). Illness anxiety disorder is a diagnosis (table 1) that was introduced with publication of the DSM-5 in 2013 [3]. The diagnostic criteria remained the same with publication of the DSM-5-TR in 2022 [1]. The disorder was derived in part from the diagnosis of hypochondriasis, which was eliminated from DSM-5/DSM-5-TR. It is estimated that among individuals who were diagnosed with hypochondriasis, approximately 33 percent would qualify for a diagnosis of illness anxiety disorder [9]. (See 'Terminology and DSM-5-TR' above.)

Symptoms — Symptoms of illness anxiety occur on a spectrum from normal to pathologic [5,6,30], and are considered a disorder when the preoccupation with health causes clinically significant distress or impairment [1]. Transient health anxiety preoccupations (eg, disease fears commonly experienced by second-year medical students) do not constitute illness anxiety disorder.

The core features of illness anxiety disorder are [1]:

- An excessive concern about acquiring or a preoccupation with having a serious medical illness, despite a normal physical examination, negative tests, and reassurance.

- Somatic symptoms are minimal or nonexistent.

Illness anxiety preoccupations are heterogeneous. Patients may be preoccupied with a particular diagnosis (eg, cancer or HIV infection), a bodily function (eg, bowel movements), normal variation in function (eg, in heart rate or blood pressure), or vague somatic sensation (eg, “tired heart”). The patient’s concern may involve one or more organ systems, and the focus of concern may shift over time from one organ or disease to another [31].

The degree of insight varies; some patients recognize that their disease fears are excessive, while others firmly maintain their convictions. However, the belief is not of delusional intensity, and patients can acknowledge the possibility that their disease fears are exaggerated or that there may be no disease at all.

The concern about the feared illness often becomes a central feature of the patient’s life, and psychosocial functioning may suffer (see 'Functioning' below) [1,30]. Many patients check their bodies to reassure themselves; examples of illness anxiety behavior include excessive breast self-examination or blood pressure and pulse monitoring. This behavior may increase during times of stress. In addition, health anxiety does not abate despite the benign course of the feared disease [31].

The preoccupation with illness typically leads to high health care utilization [1,9,13,31], with multiple normal examinations and laboratory tests that do not allay the patient’s concern [15,30]. Patients may press their physicians to order progressively more invasive diagnostic tests and higher-risk treatments, which can reinforce the disorder and increase the probability of iatrogenic complications. Seeking care from multiple clinicians ("doctor-shopping") is also common [16]. Despite extensive medical attention, patients with illness anxiety disorder often are disappointed and frustrated with their clinicians [30,32]. Clinicians in turn may become frustrated because their efforts at managing and reassuring the patient seem futile.

Some patients fear iatrogenic illness (eg, adverse medication effects or radiation exposure), avoid mainstream medical clinicians, and pursue a diagnosis and remedy through complementary and alternative practitioners. In addition, many patients use the internet to obtain information about prevention of feared diseases, and consume vitamins, over-the-counter remedies, and fad diets.

General medical illnesses may be present or may arise in patients with illness anxiety disorder [1,33]. Having feared serious illness, the patient with illness anxiety disorder may feel vindicated when diagnosed with a serious medical disease.

Little is known about cultural variation in illness anxiety disorder. The diagnosis should be made cautiously in individuals whose ideas about disease are consistent with widely held, culturally sanctioned beliefs [1]. Although cultural factors can influence how patients think about health and disease, a study found that the clinical features of hypochondriasis were similar across 14 countries [34].

Comorbid psychopathology — It is thought that patients with illness anxiety disorder have high rates of comorbid psychopathology, based upon high rates of comorbidity in hypochondriasis [15,35]. As an example, a study of patients with hypochondriasis (n = 42) who completed structured diagnostic interviews found that at least one comorbid disorder was present in 88 percent, including [36]:

- Generalized anxiety disorder – 71 percent of patients
- Dysthymia (persistent depressive disorder) – 45 percent
- Unipolar major depression – 43 percent
- Phobias – 43 percent
- Panic disorder – 17 percent
- Substance use disorder – 17 percent

The prevalence of anxiety and depressive disorders is higher in general medical clinic patients with hypochondriasis compared with patients without hypochondriasis [36,37].

Personality disorders also seem to occur more frequently in patients with hypochondriasis compared with controls [36]. A study of patients with hypochondriasis (n = 115) who completed self-administered assessments found that 77 percent had at least one personality disorder and 44 percent had at least four personality disorders, including [35]:

- Obsessive-compulsive personality disorder (56 percent of patients)
- Avoidant (41 percent)
- Paranoid (37 percent)
- Schizotypal (25 percent)
- Borderline (24 percent)
- Schizoid (22 percent)
- Narcissistic (22 percent)

In addition, individuals in the general population who have symptoms of health anxiety (persistent unrealistic worry or conviction about having an illness) are more likely to have other psychopathology than individuals who do not have health anxiety. Comorbidity that occurs more frequently with health anxiety includes major depression, dysthymia, bipolar disorder,

agoraphobia, panic disorder, social anxiety disorder, generalized anxiety disorder, posttraumatic stress disorder, and obsessive compulsive disorder [13].

Functioning — Illness anxiety disorder often interferes with psychosocial functioning, based upon studies of hypochondriasis [1,34]. In a systematic review of six community-based or primary care studies, hypochondriasis was associated with increased disability in each study [15].

In addition, symptoms of health anxiety (persistent unrealistic worry or conviction about having an illness) are associated with disability [38,39]. As an example, a community survey found that role functioning (eg, work) was impaired for more days during the prior month in the individuals with health anxiety, compared with the rest of the population (eight versus two days) [13]. In another general population study, which controlled for several potential confounding factors (eg, education, general medical illnesses and symptoms, and depression), health anxiety was associated with an increased risk of subsequent disability pension awards (odds ratio 2) [40].

Course of illness — Based upon studies of hypochondriasis and the symptom of health anxiety, it is thought that illness anxiety disorder is often chronic with fluctuating symptoms [1,39]. In seven prospective studies of patients with hypochondriasis (n >450), who were followed for 1 to 16 years, the disorder persisted in approximately 40 to 70 percent [41,42]. There were no consistent predictors of chronic hypochondriasis, and several studies found that comorbid anxiety and depressive disorders did not appear to influence course of illness in hypochondriasis.

It is not known whether remitted patients are at risk for recurrence of hypochondriasis.

ASSESSMENT

Assessment of patients presenting with possible illness anxiety disorder initially includes a medical history, physical examination, and focused laboratory tests, followed by a psychiatric history and mental status examination. Prior to diagnosing illness anxiety disorders, clinicians need to evaluate the patient for other medical conditions, particularly the early stages of endocrine, immunologic, neurologic, oncologic, and rheumatologic diseases [1,17]. A general medical illness may not be recognized because findings in the history, physical examination, or laboratory tests are overlooked; contemporary diagnostic techniques are not used; the medical illness is due to iatrogenic adverse effects; or a new disease has yet to be identified [43]. The medical evaluation and differential diagnosis for illness anxiety disorder are discussed

separately. (See "Somatic symptom disorder: Assessment and diagnosis", section on 'Assessment' and 'Differential diagnosis' below.)

The Health Preoccupation Diagnostic Interview is a structured, interviewer-administered instrument that is available for diagnosing illness anxiety disorder, but is seldom used in routine clinical care. The instrument enables the interviewer to clarify ambiguous or contradictory responses, and can help differentiate the diagnosis of illness anxiety disorder from somatic symptom disorder, and differentiate patients with illness anxiety disorder from normal controls. Reliability was demonstrated in a study of persons with clinically significant health anxiety (n = 52) and healthy controls (n = 52) [44]. However, structured instruments are labor intensive and generally reserved for specialized evaluation, treatment, or research settings.

When to suspect the disorder — In primary care or general medical settings, the presence of illness anxiety disorder is suggested by the following clues [1,45]:

- Patient receives extensive medical care, but is nevertheless dissatisfied
- Multiple clinicians are consulted for the same problem and diagnostic evaluations are consistently negative
- Medical attention exacerbates anxiety about health status rather than allaying the patient's worries
- Health related anxiety is impervious to repeated attempts at reassuring the patient

Interview — As part of the psychiatric evaluation [46,47], clinicians should address:

- Fears and beliefs about having a serious general medical illness
  - What bodily sensations trigger the patient's health anxiety?
  - How does the patient respond to the anxiety?
  - Degree of insight, ie, does the patient recognize the concern about health may be excessive?
  - The chronology of the current fears, and whether they are acute or chronic
- History of serious illnesses, particularly in childhood
- Current and past medical evaluations and treatments

- Complementary and alternative medical treatments
- Quality of relationship with current and past primary care clinicians
- Psychiatric comorbidity, such as anxiety, depressive, and other somatic symptom disorders
- Psychosocial functioning
- Family history of serious diseases

Screening — We typically do not use screening instruments as part of assessing patients for illness anxiety disorder.

Although there are no screening instruments specific for illness anxiety disorder, clinicians who want to screen for the disorder can use self-report instruments that were developed to screen for hypochondriasis. It is estimated that among patients who were diagnosed with hypochondriasis, approximately 25 percent meet criteria for the diagnosis of illness anxiety disorder [1]. In addition, self-report screening instruments for hypochondriasis have been used to screen for symptoms of health anxiety (persistent unrealistic worry or conviction about having an illness) [48], which is a broad construct that presumably has a greater prevalence than illness anxiety disorder. (See 'Terminology and DSM-5-TR' above.)

Among the available self-report measures that screen for hypochondriasis or health anxiety, the seven-item Whiteley Index (table 3) has been studied most often, has satisfactory psychometric properties, and includes validated subscales that assess illness worrying (items number two, four, and six) and illness conviction (items number three, five, and seven) [48,49]. Reasonable but longer alternatives include the 14- and 18-item versions of the Short Health Anxiety Inventory [50,51] and the 29-item Illness Attitude Scales [52,53].

DIAGNOSIS

According to the DSM-5-TR, the diagnosis of illness anxiety disorder requires each of the following criteria (table 1) [1]:

- Preoccupation with having or developing a serious illness.
- Somatic symptoms are mild or nonexistent. If a general medical illness is present or the risk for acquiring a medical illness is high (eg, strong family history), the preoccupation is clearly excessive.

- Substantial anxiety about health and a low threshold for becoming alarmed about one's health.
- Either of the following:
  - Excessive health related behaviors, such as repeatedly checking oneself for signs of illness.
  - Maladaptive avoidance of situations (eg, visiting sick family members, doctor appointments, or hospitals) or activities (eg, exercise) that are thought to represent health threats.
- Preoccupation with illness is present for at least six months.
- The illness preoccupation is not better explained by other mental disorders such as somatic symptom disorder, generalized anxiety disorder, or somatic type of delusional disorder.

The patient's distress in illness anxiety disorder comes primarily from unfounded fear of having a disease [1]. Symptoms are mild or nonexistent; if a symptom is present, it is often a normal sensation (eg, orthostatic dizziness) or is benign and self-limited (eg, transient tinnitus). It is not the symptom per se that causes distress, but rather the meaning and significance of the physical complaint.

Patients with illness anxiety disorder remain preoccupied with having or acquiring a serious medical disease despite appropriate, negative physical examination and laboratory testing. The illness preoccupation becomes a central focus of the patient's life that affects daily activities and functioning [1]. Patients often discuss their illness concerns with others, research their suspected disease, and seek reassurance from others.

DSM-5-TR recognizes two subtypes of illness anxiety disorder:

- Care-seeking type – Patients frequently utilize health care, including clinician visits, diagnostic tests, and procedures.
- Care-avoidant type – Patients avoid medical care and generally come to medical or psychiatric attention only when some other problem forces them to seek care.

The DSM-5 diagnosis of illness anxiety disorder is derived in part from the diagnosis of hypochondriasis. (See 'Terminology and DSM-5-TR' above.)

DIFFERENTIAL DIAGNOSIS

General medical disorders — Clinicians should rule out other medical disorders before diagnosing illness anxiety disorder [1]. Patients may worry about having an occult disease during its early stage, when signs on physical examination or laboratory test abnormalities are not readily apparent. This may be more frequent when there is a strong family history of a serious medical illness (eg, breast cancer, Alzheimer dementia, or coronary heart disease) or the serious disease has an insidious onset (eg, AIDS or ovarian or pancreatic cancer). Nevertheless, clinicians should avoid excessive tests and overdiagnosing patients. Specific diseases are discussed separately.

The presence of a general medical illness does not exclude the possibility of comorbid illness anxiety disorder [1,13]. If a medical disorder is present, illness anxiety disorder should be diagnosed when the health-related anxiety and disease concerns are clearly excessive or disproportionate to the coexisting medical disorder (eg, a patient in remission from cancer whose considerable fear of recurrence is disabling despite reassurance from the oncologist).

The medical evaluation for illness anxiety disorder is discussed separately within the context of somatization. (See "Somatic symptom disorder: Assessment and diagnosis", section on 'Assessment'.)

Psychiatric disorders — Symptoms of illness anxiety disorder (table 1) may overlap with symptoms of other psychiatric disorders [1]. In addition, some of the disorders that resemble illness anxiety disorder can also occur in conjunction with it [54]; if the patient meets full diagnostic criteria for both illness anxiety disorder and another psychiatric disorder (eg, unipolar major depression or generalized anxiety disorder), both conditions are diagnosed [31]. (See 'Comorbid psychopathology' above.)

The differential diagnosis for illness anxiety disorder includes [1,4]:

- **Normal reactions** – Among patients with or at significant risk for general medical conditions, health related anxiety may be either a normal response or a symptom of illness anxiety disorder. Health related anxiety in response to the threat or experience of serious medical illness is normal and is not a psychiatric disorder; this nonpathological health anxiety is clearly related to the medical disease, is proportionate to its seriousness, and typically abates over time (eg, within two to three months). By contrast, patients with illness anxiety disorder are preoccupied with or anxious about their medical condition to a degree that is clearly excessive and disproportionate, and the health related anxiety persists for at least six months.

- **Adjustment disorder** – Patients with or at significant risk for general medical conditions may develop illness anxiety disorder or an adjustment disorder with anxiety. Both illness anxiety disorder and adjustment disorder are characterized by disproportionate behavioral responses to the general medical illness, as well as impaired functioning. However, adjustment disorder is a residual diagnosis and is not diagnosed if the patient meets criteria for another specific disorder, such as illness anxiety disorder.

- **Somatic symptom disorder** – Both somatic symptom disorder and illness anxiety disorder are characterized by prominent somatic concerns that are accompanied by distress and impaired functioning. However, patients with somatic symptom disorder have significant somatic symptoms; typically there are multiple concurrent symptoms, but there may be only one severe symptom, such as pain. By contrast, somatic symptoms in illness anxiety disorder are at most minimal, and patients are more preoccupied with the idea that they are sick. (See "Somatic symptom disorder: Epidemiology and clinical presentation" and "Somatic symptom disorder: Assessment and diagnosis".)

- **Generalized anxiety disorder** – Patients with generalized anxiety disorder may worry excessively about illness but are also preoccupied with other issues, such as relationships, work, or finances. By contrast, the concern in illness anxiety disorder is restricted to having or developing an illness, and illness anxiety disorder is diagnosed only if the patient is solely preoccupied with or anxious about having an illness. (See "Generalized anxiety disorder in adults: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis".)

- **Obsessive-compulsive disorder** – Although illness anxiety disorder may include intrusive thoughts about having a disease (obsession) and associated compulsive behaviors (eg, seeking reassurance), the disorder does not include the stereotyped, repetitive, ritualized behaviors that characterize obsessive-compulsive disorder. Most patients with obsessive-compulsive disorder have obsessions or compulsions involving other concerns (eg, checking locks, counting, and/or keeping strict order) in addition to fears about contracting disease. Illness anxiety disorder is diagnosed when the predominant concerns are restricted to health and disease. (See "Obsessive-compulsive disorder in adults: Epidemiology, clinical features, and diagnosis", section on 'Clinical features'.)

- **Specific phobia** – Specific phobia and illness anxiety disorder both involve fear that is disproportionate to the perceived threat, can lead to maladaptive avoidance, and are present for at least six months. However, specific phobia involves a specific object or situation, such as animals, seeing blood, heights, receiving an injection, or flying. Patients with illness anxiety disorder are preoccupied with fears of having or acquiring a serious

disease. (See "Specific phobia in adults: Epidemiology, clinical manifestations, course, and diagnosis", section on 'Diagnosis'.)

- **Panic disorder** – Panic attacks can occur in both illness anxiety disorder and panic disorder, and both disorders are characterized by hypervigilance to benign somatic sensations. One distinction between the two disorders is that panic attacks in illness anxiety disorder are triggered by health fears, whereas the triggers in panic disorder are typically not limited to health concerns. In addition, health fears in illness anxiety disorder occur frequently, are persistent and enduring, and are not amenable to reassurance. Although patients with panic disorder may fear an imminent medical catastrophe (eg, myocardial infarction), these fears occur only during panic attacks, and patients usually are amenable to reassurance that their symptoms are panic attacks and not a myocardial infarction. (See "Panic disorder in adults: Epidemiology, clinical manifestations, and diagnosis", section on 'Diagnosis'.)

- **Body dysmorphic disorder** – Patients with illness anxiety disorder and body dysmorphic disorder are both preoccupied with perceived body abnormalities, excessively perform behaviors, such as checking their body, and may exhibit maladaptive avoidance. However, the preoccupation in illness anxiety disorder is with having or acquiring a serious illness, whereas the preoccupation in body dysmorphic disorder is with being ugly or deformed.

- **Psychotic disorders** – Psychotic patients may be convinced that they are ill as a result of somatic delusions (false, fixed beliefs about the body). By contrast, patients with illness anxiety disorder are not delusional and can consider the possibility that they are not seriously ill. Thus, the beliefs about health that occur in illness anxiety disorder do not rise to the rigid and intense level seen in somatic delusions. In addition, bizarre somatic beliefs that occur in conjunction with other signs of psychosis (eg, hallucinations or disorganized speech and behavior) indicate a psychotic disorder, such as schizophrenia, schizoaffective disorder, unipolar major depression with psychotic features, or bipolar disorder with psychotic features. However, it is more difficult to differentiate delusional disorder, somatic type (eg, delusional parasitosis), which is characterized by behavior and functioning that are not markedly strange or impaired, from illness anxiety disorder with poor insight. (See "Psychosis in adults: Epidemiology, clinical manifestations, and diagnostic evaluation", section on 'Determining the etiology'.)

- **Unipolar major depression or persistent depressive disorder (dysthymia)** – Depressed patients may ruminate over physical health and have difficulty accepting reassurance, but they also suffer other symptoms (eg, insomnia, anorexia, anergia, impaired memory and concentration, and suicidality) that are generally not seen in illness anxiety disorder. A

separate diagnosis of illness anxiety disorder is not made if health concerns arise only during depressive episodes. However, if excessive health anxiety persists after remission of a depressive episode and other criteria for illness anxiety disorder are met, the diagnosis of illness anxiety disorder should be made. (See "Unipolar depression in adults: Assessment and diagnosis".)

SUMMARY

- Illness anxiety disorder is a diagnosis that was introduced with publication of the American Psychiatric Association's Diagnostic and Statistical Manual, Fifth Edition (DSM-5). The diagnostic criteria remained the same with publication of the Diagnostic and Statistical Manual, Fifth Edition, Text Revision (DSM-5-TR) in 2022. The disorder was derived in part from the diagnosis of hypochondriasis, which was eliminated from DSM-5/DSM-5-TR. In DSM-5/DSM-5-TR, patients previously diagnosed with hypochondriasis are nearly always diagnosed with either somatic symptom disorder (if physical complaints are prominent) or illness anxiety disorder (if physical complaints are minimal or nonexistent). (See 'Terminology and DSM-5-TR' above.)

- The estimated 6- to 12-month prevalence of illness anxiety disorder among general medical outpatients is 0.2 to 1.5 percent. The disorder is thought to occur across the lifespan but is most prevalent in midlife and occurs in males and females in approximately a one-to-one ratio. (See 'Epidemiology' above.)

- The pathogenesis of illness anxiety disorder is not known. (See 'Pathogenesis' above.)

- The core feature of illness anxiety disorder is persistent preoccupation with having or developing a serious medical illness despite appropriate medical evaluation and reassurance. Illness anxiety preoccupations are heterogeneous and the degree of insight is variable. The concern about the feared illness often becomes a central feature of the patient's life and can lead to high health care utilization or marked avoidance of mainstream health care. (See 'Symptoms' above.)

- Patients with illness anxiety disorder often have comorbid psychopathology, especially anxiety and depressive disorders. Comorbid personality disorders appear common as well. (See 'Comorbid psychopathology' above.)

- Patients with possible illness anxiety disorder are evaluated for general medical conditions with a medical history, physical examination, and focused laboratory tests. (See "Somatic symptom disorder: Assessment and diagnosis", section on 'Assessment'.)

The psychiatric history and mental status examination should address the patient's fears and beliefs about having a serious general medical illness, history of serious illnesses, current and past medical treatments, the quality of the patient's relationship with current and past primary care clinicians, psychiatric comorbidity, psychosocial functioning, and family history of serious diseases. (See 'Interview' above.)

- The diagnostic criteria for illness anxiety disorder are summarized in the table (table 1). (See 'Diagnosis' above.)

- The differential diagnosis for illness anxiety disorder includes general medical disorders, as well as psychiatric disorders, such as adjustment disorders, somatic symptom disorder, generalized anxiety disorder, obsessive-compulsive disorder, specific phobia, panic disorder, body dysmorphic disorder, psychotic disorders, and depressive disorders. (See 'Differential diagnosis' above.)

Topic 14827 Version 13.0

→