Illness anxiety disorder: Treatment and prognosis

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INTRODUCTION

Medical and psychiatric care of illness anxiety disorder combines general strategies for patient management with specific therapeutic interventions. However, some patients do not respond and have a poor prognosis.

This topic reviews the treatment and prognosis of illness anxiety disorder. The epidemiology, clinical presentation, assessment, and diagnosis of illness anxiety disorder are discussed separately, as are the clinical features, medical evaluation, and treatment of somatization. (See "Illness anxiety disorder: Epidemiology, clinical presentation, assessment, and diagnosis" 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 American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) in 2013 [1]. The diagnostic criteria remained the same with publication of the Diagnostic and Statistical Manual, Fifth Edition, Text Revision (DSM-5-TR) in 2022 [2]. The clinical features and diagnostic criteria are discussed separately. (See "Illness anxiety disorder: Epidemiology, clinical presentation, assessment, and diagnosis".)

Illness anxiety 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). 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) [3-5].

In the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (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 [6]. 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 [1,2,6].

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 diagnosis of illness anxiety disorder [1,2]. Support for these estimates includes 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].

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 [1,2]. Patients with somatic symptom and related disorders typically present to primary care clinicians and general medical specialists rather than psychiatrists.

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.

TREATMENT

Treatment of illness anxiety disorder is largely based upon studies of patients who were diagnosed with hypochondriasis, as well as patients with excessive symptoms of health anxiety (persistent unrealistic worry or conviction about having an illness). Illness anxiety disorder was introduced as a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) [1]. (The diagnostic criteria remained the same with publication of the DSM-5-TR in 2022 [2].) 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 25 percent would qualify for a diagnosis of illness anxiety disorder. 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) [3-5]. (See 'Terminology and DSM-5-TR' above.)

Medical and psychiatric care of illness anxiety disorder combines general strategies for patient management with specific therapeutic interventions. The primary care clinician generally plays the central role in managing patients, and a mental health clinician may serve as a consultant and provide psychotherapy and/or pharmacotherapy.

General principles — The primary goal in managing illness anxiety disorder is to improve coping with health fears rather than eliminate them, and to prevent patients from adopting the sick role and becoming chronic invalids [9-11]. Clinicians should focus upon caring rather than curing, while assuring patients that their concerns about illness have been heard and will receive appropriate evaluation. Patients should feel that their concerns are understood and not dismissed with statements such as "it's all in your head."

We suggest that primary care clinicians or general medical specialists manage illness anxiety disorder according to the following general principles [12,13]:

- Schedule regular visits
- Attempt to establish a collaborative therapeutic alliance with the patient
- Acknowledge health fears
- Communicate and coordinate care with other clinicians
- Evaluate for and treat diagnosable general medical disease
- Limit diagnostic tests and referrals to specialists

- Reassure patients that serious medical diseases have been ruled out
- Assess for and treat comorbid psychiatric disorders (eg, anxiety disorders, depressive disorders, and substance use disorders)
- Educate patients about coping with health anxiety
- Explicitly make functional improvement the goal of treatment

A key part of management is to regularly schedule outpatient primary care visits that are not contingent upon active health concerns. As an example, visits may initially be scheduled every one to two months, and gradually tapered to once or twice a year as tolerated [12]. This allows patients to voice concerns about illness without feeling the need to make telephone calls or emergency visits. New health concerns and current stressors should be explored at these visits, without verbalizing that the illness anxiety is caused by the stressors.

Familiarity with the patient allows judicious evaluation of new worries. It is important to remember that patients with illness anxiety disorder, like all patients, remain at risk for developing new and potentially serious medical conditions [12]. After treatable general medical conditions are excluded, clinicians can express empathy for the patient's predicament, and try to gradually shift the focus away from the health concerns and toward the social situation in which new worries occur [11]. Unnecessary diagnostic tests, specialist referrals, and treatments should be avoided. The clinician should taper and discontinue unnecessary medications, especially those that are potentially addictive; however, this is best attempted after establishing a good clinician-patient relationship.

Reassurance during office visits is helpful to many patients, but must be carefully dosed and targeted [14,15]. Facile or excessive reassurance may exacerbate disease fears, or cause patients to feel their clinician has not listened or taken their concerns seriously.

It may be useful to address the quality of the clinician-patient relationship, which is often problematic [15]. A review found that patients with hypochondriasis often feel ignored by and speak disparagingly of their clinicians [16]. In addition, self-report measures completed by family medicine patients (n = 310) found that hypochondriacal symptoms were inversely correlated with the quality of the clinician-patient relationship [17]. Addressing the relationship includes focusing upon the process of the patient and clinician working together, rather than just the specifics of the patient's worries. As an example, patients can be asked to candidly describe their expectations about treatment and their feelings about the care they are receiving.

Not all patients with illness anxiety disorder are ready for treatment. Clinicians may find that some patients adamantly believe that they have a serious general medical illness and refuse to work with clinicians who do not confirm this belief. We suggest clinicians take a long-term perspective and let such patients know that the clinician is always available to work with the patient when the patient is ready.

Referral — Illness anxiety disorder is often long standing, and the relationship between the patient and doctor may be strained [13]. For patients who do not respond to management by primary care clinicians or general medical specialists, we suggest referral to a psychiatrist or other mental health clinician for a consultation, to reduce diagnostic uncertainty and potentially harmful procedures and interventions. Typically the consultation includes only the patient and psychiatrist; on occasion, it can be useful for the primary care clinician or specialist to attend part or all of the consultation. The consultation may occur as part of collaborative care, which is discussed separately in the context of depression. (See "Unipolar depression in adult primary care patients and general medical illness: Evidence for the efficacy of initial treatments", section on 'Collaborative care'.)

Indirect evidence supporting the value of a consult includes a systematic review of six randomized trials that compared a consultation letter (from a psychiatrist to the primary care clinician) with treatment as usual in 449 patients with physical symptoms (eg, fatigue, headache, or chest pain) with no identifiable general medical cause [18]. The consultation letter emphasized many of the points described above (see 'General principles' above). The review found that the consultation reduced the severity of physical symptoms, improved physical and social functioning, and reduced health care utilization.

Primary care clinicians may decide to refer patients with illness anxiety disorder to a mental health clinician for other reasons, such as help in establishing the diagnosis of a comorbid depressive and anxiety disorder. In addition, most primary care clinicians do not have the time or training to provide specific treatments such as cognitive-behavioral therapy. (See 'Choosing treatment' below.)

Many patients will resist or decline a mental health referral [12]. Clinicians should offer the referral in such a way that patients do not feel stigmatized or dismissed. Willingness to accept a mental health referral will likely depend in part upon the patient's conviction that the referring clinician will remain the primary caregiver and is not abandoning the patient. Primary care clinicians can frame the consult as a means of helping the clinician provide better care.

Choosing treatment — We suggest that acute treatment of illness anxiety disorder proceed according to the sequence described in the subsections below. Patients initially receive first line

therapy and progress through each step until they respond:

- First line – Cognitive-behavioral therapy (CBT)
- Second line – A different psychotherapy
- Third line – Antidepressant medication

Psychotherapy can be efficacious for illness anxiety disorder, based upon studies of hypochondriasis [9,19]. As an example, a meta-analysis of five randomized trials (n = 247 patients with hypochondriasis) compared psychotherapy with control conditions (eg, waiting list); the psychotherapies consisted of CBT, behavioral stress management, or psychoeducation. Improvement of hypochondriacal thoughts and behaviors, as well as anxiety and depression, was significantly greater with psychotherapy, and the clinical effects were large [20]. It is worth noting that psychotherapy studies are open label with regard to therapists and frequently with regard to patients, but outcome raters are blinded.

In addition, psychotherapy (especially CBT) has been more widely studied than pharmacotherapy for treating hypochondriasis, and limited evidence suggests that CBT is superior to pharmacotherapy. A 16-week randomized trial compared CBT (mean number of sessions was seven) with paroxetine (mean final dose was 40 mg per day) in 74 patients with hypochondriasis [21]. Response (a one-standard deviation decrease from the mean baseline hypochondriasis symptoms score) occurred in more patients who received CBT than paroxetine (45 versus 30 percent). Although this difference was not statistically significant, if real, it would be clinically meaningful.

Furthermore, some patients with hypochondriasis fear medications, especially adverse effects and dependency, and prefer psychotherapy [22].

Nevertheless, antidepressant medication is a reasonable alternative as first or second line treatment for illness anxiety disorder. Access to psychotherapy, especially CBT, is typically poor [23] and many patients decline psychotherapy. As an example, one study of CBT for hypochondriasis found that among patients (n >5700) who screened positive for the disorder, 68 percent refused to participate [24].

In addition, we use antidepressant drugs as first line treatment in patients with illness anxiety disorder plus comorbid anxiety disorders (eg, generalized anxiety disorder or panic disorder) and/or depressive disorders (eg, unipolar major depression or persistent depressive disorder [dysthymia]), as well as patients who are incapacitated by illness anxiety disorder. For patients receiving psychotherapy, the drug is used adjunctively; otherwise, the drug is used as monotherapy.

No head-to-head trials have compared psychotherapy plus pharmacotherapy with psychotherapy alone or pharmacotherapy alone. Nevertheless, many studies have administered psychotherapy in conjunction with usual care that often includes antidepressants. Patients receiving psychotherapy plus pharmacotherapy often have different clinicians administering each treatment. Collaboration between prescribing physicians and psychotherapists in mental health care is discussed separately. (See "Collaboration between prescribing physicians and psychotherapists in mental health care".)

Psychotherapy for illness anxiety disorder is typically time limited (eg, 5 to 10 sessions); thus, patients treated with CBT or a different psychotherapy generally receive a full course of therapy, regardless if nonresponse persists through the middle phases of treatment.

First line — For patients with illness anxiety disorder, we suggest CBT as first line treatment, based primarily upon randomized trials in hypochondriasis. Response may become apparent within one month of starting treatment [24], particularly for less severely ill patients. However, a reasonable alternative to CBT is antidepressant medication. (See 'Choosing treatment' above and 'Third line' below.)

CBT combines cognitive therapy with behavioral therapy [3]. The cognitive component of CBT employs techniques such as cognitive restructuring to address the maladaptive cognitive processes (eg, dysfunctional beliefs about health and selective attention to information) that maintain preoccupation with having a serious illness [25]. The behavioral component uses techniques such as exposure plus response prevention to address maladaptive behaviors (eg, excessively checking oneself for signs of illness or seeking reassurance from doctors). CBT teaches skills that patients are expected to practice between treatment sessions and adapt to their specific situation. In many instances, cognitive therapy and behavioral therapy each include elements of the other therapy. Cognitive therapy or behavioral therapy can each be used alone to treat illness anxiety disorder; however, clinicians typically use CBT, which has been studied more often.

Evidence regarding the efficacy of CBT includes a 12-week randomized trial that compared CBT for health anxiety with psychoeducation about anxiety in patients with illness anxiety disorder (n = 39), somatic symptom disorder (n = 39), or both (n = 8) [26]. CBT and psychoeducation were each administered online in six modules and included clinical support by email or telephone. Response occurred in more patients who received CBT than psychoeducation (84 versus 34 percent). In addition, CBT provided greater improvement of depression, generalized anxiety, functioning, body hypervigilance, and safety behaviors and avoidance.

Indirect evidence supporting CBT includes a 12-week randomized trial that evaluated a CBT program consisting of 12 text modules [27]. The trial included patients with either somatic symptom disorder (n = 114) or illness anxiety disorder (n = 18) who were randomly assigned to one of four treatments: internet CBT with therapist guidance (email-like communication), internet CBT with no therapist support, bibliotherapy (hardcopy of the CBT text modules), or a waiting list. Improvement of health anxiety was greater in each group that received CBT, compared with the wait list controls. In addition, the clinical benefit was large, and follow-up at six months showed that improvement was durable. Each form of CBT provided comparable improvement.

Additional indirect evidence supporting the use of CBT for illness anxiety disorder comes from multiple randomized trials of patients diagnosed with hypochondriasis [19]:

- A meta-analysis of 13 randomized trials compared CBT with control conditions (eg, usual treatment or waiting list) in patients (n >1000) with hypochondriasis or health anxiety symptoms [3]. The study found a significant and large clinical advantage for CBT at posttreatment, as well as a small to moderate advantage for CBT at follow-up (eg, one year). The effect of CBT was greater in patients with more severe illness, and more CBT sessions led to greater improvement of hypochondriasis. In addition, depressive symptoms improved more in patients who received CBT than controls.

- A subsequent randomized trial, lasting two years, compared standard care plus CBT with standard care alone in patients (n = 444) with hypochondriasis [24]. CBT was administered in general medical clinics by staff (eg, nurses) who had little previous experience with CBT and were trained in two workshops. CBT included 5 to 10 acute sessions and subsequent booster sessions; the mean number of administered sessions was 6. Improvement of hypochondriasis (health anxiety) and other anxiety symptoms was greater with adjunctive CBT than standard care alone.

The evidence supporting CBT for treatment of illness anxiety disorder includes head-to-head randomized trials that compared CBT with another active treatment (rather than waiting list controls or usual care) in patients with hypochondriasis:

- A 12-week randomized trial compared CBT with behavioral stress management (which included training in relaxation skills, problem solving, and activity scheduling) in patients with hypochondriasis (n = 158) [28]. Both treatments were administered via the internet. Although improvement of symptoms was large in both groups, improvement with CBT was greater.

- A four-month randomized trial compared CBT with behavioral stress management in patients with hypochondriasis (n = 32), and found that hypochondriacal thoughts and behaviors improved more with CBT [29]. However, there was little difference between the groups at the one-year follow-up.

Although randomized trials of CBT for hypochondriasis have mostly studied patients in their third or fourth decade of life [3], one trial found that CBT was efficacious in patients with a mean age of 69 years [30]. Other CBT trials have included patients with no maximum age restriction [10,28,31,32].

If patients have difficulty with either the cognitive or behavioral component of CBT, it is reasonable for clinicians to emphasize the other component. The evidence indicates that each component is efficacious for hypochondriasis, and by inference, for illness anxiety disorder. A 12-week study randomly assigned patients with hypochondriasis (n = 84) to one of three treatments: cognitive therapy, behavior therapy (exposure therapy), or a waiting list (control) [25]. Each active treatment was administered weekly for 50 minutes. Improvement of hypochondriacal cognitions and behaviors, as well as depression, was greater with each active treatment than the control condition, and the benefits of the two active treatments were comparable. In addition, the effects of cognitive therapy and behavioral therapy were maintained at the one-year follow-up. The investigators concluded that cognitive interventions are not necessary for changing dysfunctional cognitions.

CBT typically includes education about health anxiety [14]. As an example, the clinician can explain that some somatic sensations that worry the patient are normal aspects of bodily functions, such as autonomic arousal, muscle tension, ventilation, vascular changes, inactivity, and sleep disturbance [9]. Some authorities emphasize the educational nature of CBT, referring to it as a course on the perception of the body's functions, and likening the therapeutic relationship to that of teacher and student more than clinician and patient [33]. The purpose is to reduce the stigma of psychiatric treatment and patient resistance.

CBT is usually delivered according to a treatment manual that specifies the procedures to be used and content of each session. Most patients receive individual therapy (one patient and one clinician) over 6 to 16 weekly sessions, each lasting approximately 50 minutes [3]. However, CBT has also been successfully administered in group formats with approximately five to nine patients per group [34-36] and in an internet-based format [28,32].

Treatment delivery factors can affect outcomes in CBT. One such factor is the therapeutic alliance, which represents the strength of the relationship between the patient and therapist,

and their sense of collaboration and affective connection [37]. (See "Overview of the therapeutic relationship in psychiatric practice", section on 'Therapeutic alliance'.)

Second line — Patients with illness anxiety disorder may lack access to or not respond to CBT. For these patients, we suggest other psychotherapies as second line treatment. We typically use mindfulness based cognitive therapy or acceptance and commitment therapy, based upon randomized trials in patients with hypochondriasis. However, a reasonable alternative to these psychotherapies is antidepressant medication. (See 'Choosing treatment' above and 'Third line' below.)

Mindfulness based cognitive therapy is a skills-training group program that combines the clinical application of mindfulness meditation with elements of CBT. Mindfulness is purposeful, nonjudgmental attention to the present moment, which is developed through meditation and other practices. The theoretical foundation and administration of mindfulness based cognitive therapy is discussed separately in the context of treating depression. (See "Unipolar major depression: Treatment with mindfulness-based cognitive therapy".)

Indirect evidence supporting the use of mindfulness based cognitive therapy for treating illness anxiety disorder includes the following:

- An eight-week randomized trial compared usual care plus mindfulness based cognitive therapy with usual care alone in patients with hypochondriasis (n = 74) [38]. Mindfulness based cognitive therapy included eight weekly sessions, each lasting two hours, along with daily homework. Usual care included other psychotherapies, as well as pharmacotherapy. Fewer patients receiving the active intervention, compared with usual care alone, met criteria for hypochondriasis at the one-year follow-up (36 versus 76 percent). The benefit of active treatment appeared to be the result of changes in mindfulness, rather than effects upon symptoms of depression and anxiety.

- A six-month trial randomly assigned patients with hypochondriasis (n = 76) to one of three treatments: mindfulness based cognitive therapy, short term psychodynamic psychotherapy, or a waiting list control condition [34]. Each active treatment provided 16 therapy sessions. Improvement of hypochondriasis was greater with mindfulness based cognitive therapy than either psychodynamic psychotherapy or the control condition. The concepts and processes used in psychodynamic psychotherapy are discussed separately in the context of treating depression. (See "Unipolar depression in adults: Psychodynamic psychotherapy", section on 'Fundamental concepts and processes'.)

Acceptance and commitment therapy also utilizes mindfulness training, as well as acceptance of feared thoughts and feelings, clarification of values, and commitment to change behavior. A

four-month randomized trial compared usual care plus acceptance and commitment therapy with usual care alone in patients with severe health anxiety (n = 126; most patients met criteria for hypochondriasis) [39]. Acceptance and commitment therapy was administered in a group format that included 10 sessions, each lasting three hours. Marked improvement of illness worry at the six-month follow-up occurred in more patients who received acceptance and commitment therapy than the control condition (48 versus 16 percent). However, help seeking for illness worries was comparable for the two groups.

Third line — Patients with illness anxiety disorder may decline or not respond to either CBT or other psychotherapies. For these patients, we suggest antidepressant medications, such as selective serotonin reuptake inhibitors (SSRIs). However, serotonin-norepinephrine reuptake inhibitors are a reasonable alternative. Clinically meaningful improvement can be expected in approximately 30 to 50 percent of patients within 8 to 16 weeks of starting treatment.

Indirect evidence supporting the use of antidepressants for illness anxiety disorder includes randomized trials of SSRIs in patients with hypochondriasis [40]:

- A 24-week randomized trial compared fluoxetine with placebo in patients (n = 45) with hypochondriasis [41]. Fluoxetine was started at 20 mg per day and then increased by increments of 20 mg every two weeks as needed and tolerated; the maximum dose was 80 mg per day (median final dose was 50 mg per day). Response (a rating of much or very much improved) in the two groups was comparable at week 4; however, by week 8, response occurred in more patients who received fluoxetine than placebo (50 versus 19 percent). The advantage of fluoxetine persisted through continuation treatment; by week 24, there were more responders to fluoxetine than placebo (54 versus 24 percent of patients). In addition, discontinuation of treatment due to adverse effects was comparable for the two groups.

- A 16-week randomized trial compared paroxetine (20 to 60 mg per day, mean final dose was 40 mg per day) with placebo in patients with hypochondriasis (n = 72) [21]. Response (a one-standard deviation decrease from the mean baseline hypochondriasis symptoms score) occurred in more patients who received paroxetine than placebo (30 versus 14 percent). Although this difference was not statistically significant, if real, would be clinically meaningful. Fatigue and sexual dysfunction occurred in more patients who received paroxetine; heart palpitations occurred in more patients who received placebo. Attrition for the two groups was comparable. In addition, it appeared that the benefit of paroxetine was sustained for up to 18 months after treatment [42].

Additional indirect evidence for the benefit of SSRIs and other antidepressants in illness anxiety disorder comes from randomized trials in patients with other anxiety disorders (eg, generalized anxiety disorder, panic disorder, or social anxiety disorder). The symptoms of illness anxiety disorder and other anxiety disorders overlap with each other. (See "Illness anxiety disorder: Epidemiology, clinical presentation, assessment, and diagnosis", section on 'Psychiatric disorders'.)

For patients with illness anxiety disorder who are treated with antidepressant medications and show a partial response after two to four weeks, the dose is titrated up within the therapeutic dose range established for other psychiatric disorders, such as unipolar major depression (table 3). However, in some cases, the dose may exceed the maximum that is used for depression, provided that the drug is safely tolerated. As an example, some studies of paroxetine for hypochondriasis have used a maximum dose of 60 mg per day [21,43].

If meaningful improvement has not occurred within six to eight weeks, the drug is discontinued and a new drug is started. As an example, patients initially treated with an SSRI can be switched to a different SSRI or to a serotonin-norepinephrine reuptake inhibitor. Likewise, patients initially treated with a serotonin-norepinephrine reuptake inhibitor can be switched to a different serotonin-norepinephrine reuptake inhibitor or to an SSRI. The procedure for switching antidepressants is discussed separately. (See "Switching antidepressant medications in adults", section on 'Switching antidepressant medications'.)

Based upon clinical experience, patients who respond to an antidepressant typically receive continuation and maintenance treatment lasting at least 6 to 12 months; patients with a severe course of illness prior to response receive longer maintenance treatment lasting for years (eg, at least two to five years).

Other options — Based upon studies of hypochondriasis, the following psychotherapy options can be used for patients with illness anxiety disorder who lack access to or do not respond to CBT, mindfulness based cognitive therapy, and acceptance and commitment therapy:

- Problem solving therapy – In problem solving therapy, patients endeavor to identify and define their problems, and for each problem, consider the barriers to its resolution, set an achievable goal, list and evaluate the advantages and disadvantages for all available solutions (brainstorming), choose one option, develop an action plan and implement it, and evaluate the outcome. A six-week randomized trial compared problem solving therapy with CBT in 44 patients with hypochondriasis; a group format was used to administer weekly sessions lasting two hours [35]. Improvement was comparable for the two

treatments at the six-month follow-up. However, the absence of a group with no treatment makes it difficult to interpret the results.

- Relaxation training – Relaxation training includes progressive muscle relaxation, release only muscle relaxation, and diaphragmatic breathing. A randomized trial compared relaxation training with CBT in patients with hypochondriasis (n = 89) [44]. Relaxation training consisted of three sessions, each lasting 30 minutes. CBT consisted of three sessions, each lasting 60 minutes; patients who did not improve with CBT received an additional six sessions. At the one-year follow-up, improvement of hypochondriacal symptoms, other psychiatric symptoms, and functioning were comparable for the two groups.

- Behavioral stress management – Behavioral stress management combines elements of relaxation, problem solving, assertiveness training, and time management. A four-month randomized trial compared behavioral stress management (weekly sessions lasting one hour) with a waiting list control in patients with hypochondriasis (n = 31) [29]. Hypochondriacal thoughts and behaviors improved more in patients who received behavioral stress management than controls, and the benefits of active treatment persisted at the one-year follow-up.

These treatment options can be used in conjunction with antidepressants or as monotherapy.

Anxiety about illness may lead patients to misperceive the results of negative medical tests; thus, brief educational interventions may possibly help patients accept reassurance from clinicians and diagnostic test results that are negative [45]. As an example, a randomized trial found that for patients with chest pain (n = 92) who underwent a diagnostic test, education about the meaning of normal results increased the extent to which patients were reassured by negative findings [46].

PROGNOSIS

Based upon studies of hypochondriasis, the prognosis of illness anxiety disorder appears to vary from poor to good, depending upon the size of the trial and how outcome is defined. As an example, a relatively large randomized trial found that among patients who were treated with CBT (n >200), remission occurred in only 14 percent [24]. In smaller trials, each of which treated approximately 40 patients with CBT, response or clinically meaningful change (a lower level of improvement than remission) occurred in approximately 35 to 70 percent [21,30-32,35]. However, many patients refuse treatment.

Studies of hypochondriasis suggest that the prognosis for illness anxiety disorder may be better for patients who are referred early for psychiatric treatment, compared with patients who receive only general medical evaluations [11]. In addition, studies of hypochondriasis have found that prognosis was better for patients who scored less on ratings of harm avoidance (ie, fearfulness, timidity, and vulnerability) and dependent personality, and higher on ratings of cooperativeness (ie, helpfulness, tolerance, and forgiveness); however, these findings have not been replicated and it is thus not clear how much predictive power these factors have for any specific patient [47].

SUMMARY AND RECOMMENDATIONS

- Illness anxiety disorder is a diagnosis (table 1) 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 core clinical feature of illness anxiety disorder is persistent preoccupation with having a serious medical illness despite appropriate medical evaluation and reassurance.

  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 and "Illness anxiety disorder: Epidemiology, clinical presentation, assessment, and diagnosis", section on 'Clinical presentation'.)

- The primary goal in managing illness anxiety disorder is to improve coping with health fears rather than eliminate them (caring rather than curing). General principles for primary care clinicians to follow in initially managing illness anxiety disorder include scheduling regular visits, acknowledging health fears, evaluating for and treating diagnosable general medical disease, limiting diagnostic tests and referrals to specialists, providing reassurance that serious medical diseases have been ruled out, treating comorbid psychiatric disorders, and explicitly making functional improvement the goal of treatment. (See 'General principles' above.)

- Psychotherapy can be efficacious for illness anxiety disorder that does not respond to the general principles for initially managing the disorder. For these unresponsive patients, we suggest cognitive-behavioral therapy (CBT) as first line treatment rather than other

psychotherapies (**Grade 2C**). For patients with illness anxiety disorder who do not respond to or who lack access to CBT, we suggest mindfulness based cognitive therapy or acceptance and commitment therapy as second line treatment (**Grade 2C**). (See 'Choosing treatment' above and 'First line' above and 'Second line' above.)

However, psychotherapy for illness anxiety disorder is often ineffective, unavailable, or declined. For these patients, we prescribe antidepressant medications. We typically use selective serotonin reuptake inhibitors (eg, fluoxetine or paroxetine). However, serotonin-norepinephrine reuptake inhibitors are a reasonable alternative. (See 'Third line' above.)

In addition, we use antidepressants as first line treatment for patients with illness anxiety disorder plus comorbid anxiety disorders and/or depressive disorders, as well as patients who are incapacitated by illness anxiety disorder. The drug is prescribed adjunctively with psychotherapy, or as monotherapy if psychotherapy is unavailable or refused.

- Other psychotherapy options for treating illness anxiety disorder include problem solving therapy, relaxation training, and behavioral stress management. (See 'Other options' above.)

- The prognosis of illness anxiety disorder appears to vary from poor to good depending upon how outcome is defined; remission is uncommon, but many patients improve. (See 'Prognosis' above.)

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