SOMATIC SYMPTOM AND RELATED DISORDERS

Illness Anxiety Disorder

IAD

DSM-5-TR 300.7 | ICD-10-CM F45.21

Preoccupation with having or acquiring a serious illness for 6 months or longer, with somatic symptoms mild or entirely absent.

PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~1.3-10% by setting	Early to middle adulthood	Roughly equal	Chronic and relapsing

CLINICAL PICTURE

- Preoccupation centers on the meaning of bodily sensations rather than the sensations themselves, which are mild, normal, or entirely absent.
- The care-seeking type schedules repeated visits, scans, and second opinions, while the care-avoidant type avoids doctors entirely out of fear of bad news.
- Body checking is constant: palpating lymph nodes, taking pulses, inspecting moles, and searching symptoms online for hours at a time.
- Reassurance from a normal test result relieves anxiety for days at most before doubt about accuracy, timing, or the wrong test returns.
- A personal or family history of serious illness, or a recent death from cancer, commonly triggers or sharply intensifies the preoccupation.
- Relationships strain as family members are enlisted for reassurance and then blamed for dismissiveness when the reassurance fails to hold.

DIAGNOSTIC CRITERIA AT A GLANCE

- Preoccupation with having or acquiring a serious illness is the central feature that defines the disorder and organizes the clinical picture.
- Somatic symptoms are absent or mild, and when another medical condition exists the preoccupation is clearly excessive or disproportionate to it.
- A high level of health anxiety is present, with the person easily alarmed about personal health status by minor cues or news reports.
- Excessive health-related behaviors such as repeated body checking are present, or there is maladaptive avoidance of doctors and hospitals.
- Illness preoccupation persists at least 6 months, though the specific feared condition may change, and is not better explained by another disorder.

NEUROBIOLOGY & PHYSIOLOGY

- Interoceptive prediction error is central, as the brain overweights prior expectations of illness relative to the actual incoming bodily signal.
- Insula and anterior cingulate hyperactivity in response to health-threat cues parallels the pattern found across the anxiety disorders generally.
- Amygdala reactivity with weak prefrontal regulation supports the rapid, sticky threat appraisals that characterize this disorder clinically.
- Serotonergic modulation is implicated, consistent with SSRI response rates comparable to those seen in obsessive-compulsive and panic disorder.
- Genetic overlap with anxiety disorders and obsessive-compulsive disorder is substantial, despite classification among somatic symptom disorders.
- Chronic autonomic arousal generates real palpitations, gastrointestinal upset, and muscle tension that supply fresh evidence for the feared disease.

PSYCHOLOGICAL MECHANISMS

- Catastrophic misinterpretation of benign sensations, the core of the Warwick and Salkovskis cognitive model, is the central maintaining mechanism.
- Checking, reassurance-seeking, and internet searching function as safety behaviors that prevent disconfirmation and escalate steadily over time.
- Intolerance of uncertainty demands a guarantee of health that no test can deliver, which makes the pursuit of certainty inherently self-defeating.
- Selective attention toward the body lowers detection thresholds, so more sensations are noticed and each one then requires an explanation.
- Learning history matters: childhood illness, parental health anxiety, or a missed diagnosis in the family shapes the entire belief system.

DIFFERENTIAL & COMORBIDITY

- Somatic symptom disorder features prominent distressing somatic symptoms, whereas illness anxiety disorder places the fear itself at the center.
- Obsessive-compulsive disorder with contamination or illness obsessions spans multiple feared outcomes with ego-dystonic intrusions and rituals.
- Generalized anxiety worry ranges across many domains, and panic disorder fears immediate catastrophe in the moment rather than slow disease.
- Delusional disorder somatic type holds the belief with fixed conviction and no doubt, unlike the fluctuating conviction seen in illness anxiety.
- Major depression, generalized anxiety, and panic disorder are the most common comorbidities and should be identified and treated concurrently.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- SSRIs are first line, including **fluoxetine 20-60 mg/day**, **sertraline 50-200 mg/day**, or escitalopram 10-20 mg/day for at least 12 weeks.
- Start at half the usual dose, because these patients monitor bodily sensations closely and readily interpret side effects as evidence of new illness.
- Higher obsessive-compulsive-range doses and longer trials are frequently required before an SSRI is declared a genuine treatment failure.
- Combining an **SSRI** with **CBT** outperforms either treatment alone in trials of severe, long-standing, or highly impairing presentations.
- Avoid benzodiazepines, which reinforce avoidance and blunt the anxiety tolerance that effective exposure-based work actually requires.

PSYCHOTHERAPY

- **CBT** is the treatment of choice across 6-16 sessions, with large effect sizes maintained at 12-month follow-up in randomized controlled trials.
- **Exposure and response prevention** systematically eliminates body checking, reassurance-seeking, and internet searching while tolerating uncertainty.
- Behavioral experiments demonstrate how attention and checking themselves create sensations, replacing debate about whether disease is present.
- **Mindfulness-based cognitive therapy** reduces health anxiety by changing the relationship to intrusive illness thoughts rather than their content.
- **Acceptance and commitment therapy** redirects effort from certainty-seeking toward values-based living with uncertainty deliberately present.

ADJUNCT & SUPPORTIVE

- Agree with the primary care clinician on scheduled visits and a testing policy so that reassurance stops being contingent on new symptom reports.
- Ban internet symptom searching outright and negotiate a specific, shrinking reassurance-seeking budget with partners and family members.
- Track severity with the **Health Anxiety Inventory** or the **Whiteley Index** at intake and again every 4-6 weeks to document real change.
- Internet-delivered **CBT** with therapist support shows efficacy comparable to face-to-face treatment and substantially improves access to care.
- Address the care-avoidant subtype directly, since delayed presentation and skipped cancer screening create genuine and preventable medical risk.

CLINICAL PEARLS

- The fear of disease, not the presence of symptoms, is what separates this from SSD.
- Reassurance is the safety behavior, so giving more of it makes the disorder worse.
- Treat it like OCD: an SSRI at high dose plus exposure and response prevention.

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NOTE

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