



## Clinical Presentation and Management of Illness Anxiety Disorder

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### ABSTRACT

**Background.** Illness anxiety disorder is a somatoform disorder characterized by a persistent belief in a serious physical illness that is the cause of various symptoms, causing a person to often undergo repeated examinations even though the results are not proven to be correct. This condition can cause interference in daily activities such as social and work functions. This article aimed to present overview and management of illness anxiety disorder.

**Case Presentation.** A 56 years old-man came to the Hospital General Polyclinic with main complaint of having chronic kidney disease with advance stage. The patient worked as a civil servant. The patient was married. Patients complaint of sore waist, body discomfort, the stomach and chest area felt hot and uncomfortable. The doctors said that the patient's kidney function had indeed decreased slightly but was still within limits that were not dangerous for the patient's age. However, the patient did not believe it.

**Conclusion.** Illness anxiety disorder is a type of somatoform psychiatric disorder where the patient believes that he has a serious illness, even though the illness does not exist.

Keywords: Chronic Laryngitis, Smoking, GERD, Vocal Cord, Overuse

### 1. Introduction

Illness Anxiety Disorder (IAD) is a new diagnosis in the fifth edition of the Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (DSM V) that applies to people who have a preoccupation with being ill or with developing an illness of some type. This is a variant of somatic symptom disorder (hypochondriasis).<sup>1</sup> To differentiate the differential diagnosis between the two, according to DSM-5, somatic symptom disorder (SSD) is diagnosed when there are somatic symptoms, whereas in illness anxiety disorder, there are few or no somatic symptoms and the person is mainly concerned with the idea that they are sick. Compared with IAD, SSD is characterized as a disorder with higher severity in the form of more severe anxiety, somatic symptoms, depression and higher use of health services, comorbid depressive illness and panic disorder and agoraphobia. The signs and symptoms of IAD in DSM IV fall under the diagnosis of hypochondriasis, a term considered by some to have pejorative connotations. Over the past quarter century, the application of conceptual models and treatment techniques used for anxiety disorders has greatly improved the prognosis for what is now labeled IAD.<sup>1,2</sup> The prevalence of IAD is 4–6% of the general medical clinic population. According to the American Psychiatric Association, IAD is more common in older people.

Because they perceive themselves to be medically ill, individuals with IAD often visit general medical centers rather than mental health examinations. In fact, they demonstrate increased medical utilization by consulting multiple doctors with the same complaint and getting repeated negative diagnostic test results.<sup>1</sup> They do this by manipulating doctors to request diagnostic tests and imaging, such as CT Scans or MRIs. Patients with IAD will have a burden on the institutional budget and increase the risk of adverse health events (Adverse Health Events).<sup>3</sup>

Clinicians in general medical centers largely fail to recognize early and address such situations leading to overuse of diagnostic tests and imaging tests.<sup>1</sup> It is estimated that 10% to 20% of the US medical budget is spent on patients who have hypochondriasis or IAD. Because the patient did not respond to medical consultations from doctors or negative diagnostic tests, the doctor's efforts to reassure with consultations and providing symptomatic medication did not help. As a result, this could lead to "Doctor Shopping", going from one clinic to another in search of reassurance. Such behavior will not only harm government health institutions, doctors' time and energy, it will also increase the occurrence of Adverse Health Events. Most doctors who leave the patient will experience frustration and be confused about how to deal with the patient.<sup>3,4</sup> Therefore, one of the most important points in the management of patients with IAD is to avoid distrust between doctors and patients by building a good therapeutic relationship, regardless of modality. specific treatment to be used.<sup>5</sup>

Based on the Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (DSM V), illness anxiety disorder (IAD) is characterized as someone who is preoccupied with having a serious illness, this is a reconceptualization of the DSM IV version. IAD is categorized as a group of disorders with somatic symptoms and other related disorders, previously referred to as somatoform disorders in the Diagnostic and Statistical Manual for Mental

Disorders, Fourth Edition, Text Revision (DSM-IV-TR)<sup>1,2</sup> This new category of somatic symptom disorder includes (1) Somatic Symptom Disorder, (2) Illness Anxiety Disorder, (3) Conversion Disorder, (4) psychological factors that influence medical conditions other (Psychological Factors Affecting Other Medical Conditions), (5) factitious disorders (6) pain disorders (Pain Disorder), and (7) other specific and non-specific somatic symptom disorders.<sup>1</sup>

In the United States in 2014, the DSM estimated that the prevalence of IAD in the past 1-2 years in the community was 1.3-10%, while the prevalence in the past 6 months to 1 year in medical outpatients was 3-8%. In the world, the prevalence reaches 4-6% of the general medical clinic population. Some degree of preoccupation with illness appears to be common, as 10–20% of healthy people and 45% of people without major psychiatric disorders have unfounded concerns about illness. According to the American Psychiatric Association, IAD is more common in older people, but the most common age of onset is early adulthood. IAD can occur in men and women without any significant difference in number<sup>6</sup>

Patients with IAD have high rates of psychiatric comorbidity. In one general medical outpatient clinic, 88% of patients with IAD had one or more concurrent psychiatric disorders, generalized anxiety disorder was common (71%), dysthymic disorder (45.2%), major depression (42.9%), somatization disorder (21.4%), and panic disorder (16.7%).<sup>6</sup> These patients were 3 times more likely to have a personality disorder than the general population. Substance abuse or dependence is also a serious comorbid condition, especially the use of benzodiazepines, although epidemiological studies have not assessed the exact frequency of this problem.<sup>7</sup>

The neurochemical deficits associated with IAD appear similar to mood and anxiety disorders. For example, Hollander et al proposed an "obsessive-compulsive spectrum" to include hypochondriasis, obsessive-compulsive disorder (OCD), body dysmorphic disorder (BDD), anorexia nervosa, and Tourette's syndrome, all of which are believed to share similarities in responsiveness, i.e. exhibit "hyperactivity" in the frontal lobe area. A more recent article highlights the effectiveness of fluoxetine (a serotonin reuptake inhibitor and mainstay in the treatment of OCD), which is effective in the treatment of IAD.<sup>8,9</sup>

The findings of neurochemical deficits in patients with IAD are only preliminary, but such deficits may explain why symptoms overlap, why disorders are usually comorbid, and why treatments that are effective for obsessive compulsive (OC) spectrum disorders are also effective for IAD (e.g. selective serotonin reuptake inhibitors (SSRIs). In a biomarker study, subjects meeting DSM-IV-TR diagnostic criteria for hypochondriasis had reduced plasma neurotrophin (NT-3) levels and platelet serotonin (5-HT) levels, compared with healthy control subjects. NT-3 is a marker of neuronal function and platelet 5-HT is a surrogate marker of serotonergic activity.<sup>8,9</sup>

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## 2. Case Presentation

A 56 years old-man came to the Hospital General Polyclinic with main complaint of having chronic kidney disease with advance stage. The patient worked as a civil servant. The patient was married. Patients complaint of sore waist, body discomfort, the stomach and chest area felt hot and uncomfortable. Patients often went to four different internal medicine doctors. The patient had also been advised to have a laboratory examination, and the results were still in normal limit. The doctors said that the patient's kidney function had indeed decreased slightly but was still within limits that were not dangerous for the patient's age. However, the patient did not believe it and continued to believe that his kidney function was decreasing and that his current symptoms were related to kidney problems. The patient had read various popular health articles on Google and the patient's condition was matched with kidney failure disease. The patient felt that he had to seek treatment abroad to find out more about the disease he was experiencing. And now he felt his appetite had decreased and he was not enthusiastic about his daily activities. The patient had lost his wife due to sudden death about 3 years previously. The patient was currently remarried.

The patient had two children.

General physical examination was found to be normal. Neurological physical examination was normal. Psychiatric status, general impression of normal appearance, facial features that appear appropriate for age and appear worried, decreased concentration and attention, anxious/appropriate mood/affect, obsessional thought content and preoccupation in the form of worry about the complaints experienced. The patient's understanding of his illness had insight 6. The patient was then diagnosed multiaxially with Axis I: Hypochondric Disorder or Illness Anxiety Disorder (F45.2), Axis II: Anxious (Avoidant) Personality Characteristics, Axis III: No diagnosis yet, Axis IV: Problems with primary support group "family", Axis V: GAF 70-61. Then the patient was treated with psychotherapy and pharmacotherapy in the form of Fluoxetine 1 x 20 mg and Clobazam 1 x 10 mg.

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## 3. Discussion

A 56 years old-man came to the Hospital General Polyclinic with main complaint of having chronic kidney disease with advance stage. The patient worked as a civil servant. The patient was married. Patients complaint of sore waist, body discomfort, the stomach and chest area felt hot and uncomfortable. Patients often went to four different internal medicine doctors. The patient had also been advised to have a laboratory examination, and the results were still in normal limit. The doctors said that the patient's kidney function had indeed decreased slightly but was still within limits that were not dangerous for the patient's age. However, the patient did not believe it and continued to believe that his kidney function was decreasing and that his current symptoms were related to kidney problems. The patient had read various popular health articles on Google and the patient's condition was matched with kidney failure disease. The patient felt that he had to seek treatment abroad to find out more about the disease he was experiencing. And now he felt his appetite has decreased and he was not enthusiastic about his daily activities. The patient was diagnosed by the doctor with Hypochondric Disorder or Illness Anxiety Disorder (IAD).<sup>5,7</sup>

According to DSM V, an important characteristic of IAD is preoccupation with unfounded beliefs that a person has, or undiagnosed medical illness even though there are no somatic symptoms. Illness-related preoccupation is usually accompanied by excessive health-related anxiety as well as excessive or maladaptive avoidance behaviors aimed at reducing fear and protecting one's health. Common examples include seeking reassurance from a medical professional regarding good health (e.g., medical tests to ensure healthy blood pressure), checking a person for signs of illness (e.g., breast self-examination for cancer), reviewing published sources of information regarding a feared pain (for example searching on the internet), and trying various treatments such as herbal preparations. Avoiding situations and perceived stimuli related to the feared disease (e.g., avoiding airport security checkpoints for fear of radiation) and avoiding disease-related stimuli, such as doctor and hospital visits.<sup>4</sup>

The diagnostic criteria based on DSM V for IAD are<sup>4</sup>:

- A. Preoccupation with having or acquiring a serious illness.
- B. Somatic symptoms are absent or, if present, are only mild in intensity. If other medical conditions are present or there is a high risk of developing a medical condition (e.g., a strong family history is present), the preoccupation is clearly excessive or disproportionate.
- C. There is a high level of anxiety about health, and individuals easily worry about personal health status.
- D. Individuals engage in excessive health-related behaviors (e.g., repeatedly checking their body for signs of illness) or exhibit maladaptive avoidance (e.g., avoiding appointments and hospitals).
- E. The preoccupation with pain has been present for at least 6 months, but the specific disease of concern may change during that period.
- F. The preoccupation associated with this illness is not well explained by other mental disorders, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.

Patients with Illness Anxiety Disorder, just like those with Somatic Symptom Disorder, believe that they have a serious illness that has not been diagnosed and cannot be convinced otherwise. Patients maintain the belief that they have a particular disease, or over time, may shift their belief to another disease. This belief persists regardless of negative laboratory test results, the mild course of the stated disease over time, and with appropriate reassurance from the doctor. Patients' preoccupation with their disease interferes with their interactions with family, friends and co-workers. Patients with this disorder are generally addicted to searching on the internet for the disease they fear.<sup>8</sup>

- a. Somatic Symptom Disorder
  - b. Somatic symptom disorder is diagnosed when somatic symptoms are present, whereas in illness anxiety disorder, there are few or no somatic symptoms and the person is mainly concerned with the idea that they are sick. Somatic symptom disorder often occurs before the age of 30 years, while Illness Anxiety Disorder has a non-specific onset age.
- c. Conversion Disorders
  - d. Conversion disorder is more often acute, generally temporary, and more often involves symptoms than a specific disease
- e. Pain Disorders
  - f. Pain disorders are usually chronic, such as hypochondriasis, but the symptoms are limited to pain
- g. Other Mental Disorders
  - h. Fear of an illness usually occurs in patients with anxiety and depression disorders. Patients with panic disorder may initially present with the main complaint that they have an illness, but with a more thorough history, other symptoms of panic attacks can be found.

A good prognosis of IAD is associated with several conditions as follows:

- a. The patient's socioeconomic status is good.
- b. Sensitive to therapy for anxiety or depression.
- c. Sudden onset.
- d. Absence of personality disorders.
- e. No other non-psychiatric medical disorders were found.

The therapy carried out on this patient was psychotherapy and pharmacotherapy in the form of Fluoxetine 1 x 20 mg and Clobazam 1 x 10 mg. In principle, patients with psychiatric disorders can be treated with psychotherapy. Psychotherapy for IAD includes managing anxiety with social support and social interaction from close family members which aims to reduce anxiety. Pharmacotherapy is carried out if the symptoms experienced by the patient lead to anxiety or depression, so the principle of treatment is to use drugs aimed at reducing feelings of anxiety or depression. When treating IAD, anti-anxiety drugs such as Clobazam can be given. Clobazam is an anti-anxiety drug from the Benzodiazepine class that used to treat anxiety syndrome which includes (1) feelings of anxiety or unrealistic worry about two or more things that are perceived as threats that cause a person to be unable to rest in peace; (2)

presence of at least 6 of the symptoms including motor tension, autonomic hyperactivity, hypervigilance and reduced arrest; (3) impairment in daily life functions, which is characterized by a decrease in the ability to work, social relationships, and carry out routine activities.<sup>9</sup>

Benzodiazepine as anti-anxiety drugs work by reacting with Benzodiazepine receptors so that they can increase the inhibitory mechanism of GABA-ergic neurons which can then reduce hyperactivity of the limbic system of the central nervous system. Based on these considerations, the medication used by the patient in this case was an anti-anxiety medication, especially from the Benzodiazepine group. Apart from anti-anxiety drugs, this patient was also given an antidepressant drug in the form of Fluoxetine which aims to overcome the relative deficiency of one or several aminergic neurotransmitters in the synaptic gaps of neurons in the central nervous system, especially in the limbic system. This neurotransmitter deficiency can occur due to suppression of neurotransmitter activity by anti-anxiety drugs. Thus, administering these two types of drugs is expected to balance the activity of the patient's limbic system.<sup>5,9</sup>

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#### 4. Conclusion

Illness anxiety disorder is a type of somatoform psychiatric disorder where the patient believes that he has a serious illness, even though the illness does not exist. This belief causes patients to shop doctors, repeat laboratory tests, and look for related medical articles. If not treated immediately, IAD can develop into depression which can disrupt the patient's daily life.

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