OCD vs. IAD

Diagnostic Considerations & Treatment Interventions

Diagnoses:

- **Obsessive Compulsive Disorder (OCD)**: Defined by the presence of obsessions (intrusive, unwanted, recurrent thoughts/images/urges/ doubts) and/or compulsions (repetitive behaviors or mental acts performed to neutralize or reduce the distress caused by the obsessions). The obsessions/compulsions must be time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment.
- **Illness Anxiety Disorder (IAD)**: Formerly often referred to as "hypochondriasis" / "health anxiety". It is defined in DSM-5-TR by preoccupation with having or acquiring a serious illness, despite minimal or no somatic symptoms, or only mild ones. Key features include: preoccupation/high anxiety about health (persisting for at least 6 months); being easily alarmed about one's health status; and excessive health-related behaviors (e.g., repeatedly checking body for signs of illness). Could be care-seeking type or care-avoidant.
- **Also consider**: If a person has prominent somatic symptoms causing distress (chronic pain, dizziness, fatigue, etc.), often the diagnosis shifts to **somatic symptom disorder.**

Similarities:

- Both involve anxiety/fear and preoccupation.
- Can involve persistent, distressing thoughts about health/illness or threat.
- Can lead to time-consuming behaviors: such as repeated checking (body checking, medical reassurance seeking), avoidance (avoid health-related triggers like doctors, or reading/ hearing about illnesses), reassurance-seeking, internet research about diseases, etc.
- Both can significantly impair functioning, quality of life, and relationships.
- Cognitive factors: research shows that "illness anxiety symptoms" correlate particularly with certain aspects of OCD such as harm obsessions and checking rituals, as well as cognitive bias (e.g., overestimating threat and inflated responsibility for harm).

Key Differences

Feature/Domain	OCD	IAD
Core defining feature	Obsessions (intrusive thoughts, images, urges) **and/or** compulsions (behaviors or mental rituals).	Preoccupation with having/acquiring serious a illness; high health-related anxiety; excessive checking or avoidance behaviors; typically **no** or only **minimal** somatic symptoms.
Nature of preoccupation	Often about a wide range of themes: contamination, symmetry/order, harm, taboo thoughts, etc. Not limited to health.	Focused specifically on health/illness, real or feared. Fear of serious disease even when no objective evidence.
Somatic symptoms	Somatic symptoms may or may not be present depending on theme (e.g., contamination fears may or may not involve physical symptoms)	Minimal or no somatic symptoms (if there are prominent somatic symptoms + distress, then diagnosis might shift to Somatic Symptom Disorder rather than IAD.)
Primary mechanism/ process	Intrusive distressing thoughts → compulsive or ritualistic behaviors (or mental acts) to reduce distress or neutralize fears. Anxiety is often secondary to obsession.	Anxiety/worry about health → Paying excessive attention to normal bodily sensations and misinterpreting these as indicators of severe health conditions. Disproportionate and redundant health-related behaviors (checking, reassurance-seeking) or avoidance; but not necessarily structured compulsions in the OCD sense.
Diagnosis/ Classification	In "Obsessive-Compulsive and Related Disorders" category (DSM-5-TR)	In "Somatic Symptom and Related Disorders" chapter (DSM-5-TR).
Flexibility of feared content	May have multiple obsession/compulsion themes; can change over time but often multiple themes co-exist	The feared illness may change over time, but content remains health-related; not usually broad themes beyond health.
Insight	Often better (recognizes thoughts are unreasonable)	Often poor or fluctuating insight
Their focus	To prevent feared contamination/harm/ suffering.	Discovering illness, or to avoid medical confirmation.

The “Gold Standard” Treatment

- **Exposure and Response Prevention (ERP)**: A type of cognitive behavioral therapy, used in treating OCD and other anxiety disorders. It works by gradually exposing individuals to the situations, thoughts, or objects that trigger their obsessions and anxiety. Response prevention techniques help the individual resists the urge to perform a compulsion or ritual, such as washing their hands, checking, or seeking reassurance, to reduce their anxiety.
- **Habituation:** The initial distress gradually decreases with repeated exposure.
- **Inhibitory Learning:**The brain learns new, healthier associations with triggers, recognizing that the feared outcome doesn't happen or is manageable even without the compulsion.
- The goal is NOT reassurance; it’s learning discomfort tolerance and acceptance.
- Differentiate between compulsions (OCD) and safety behaviors (IAD).
- Normalize bodily sensations through interoceptive exposures.
- Lean heavily on scripting for catastrophic interpretations.
- Focus on: **“I can’t know for sure — and I can live fully anyway.”**
- **Ethical & Clinical Boundaries —> ERP for Health-Related Anxiety:**
    - ERP is *not* used when:
        - The client has a true, unresolved acute medical issue needing evaluation.
        - Medical red flags appear (weight loss, severe pain, neurological symptoms).
        - You’re unsure whether a behavior is risk-taking vs therapeutic.
    - ERP is used when:
        - Symptoms are chronic, medically evaluated, and not dangerous.
        - Checking behavior is driven by intrusive fear rather than actual illness.
        - Client’s fear persists despite medical reassurance.
    - Risk management includes:
        - Collaborating with PCP for reassurance *for the clinician*, not the client.
        - Setting boundaries: “I will never tell you you’re healthy, that’s not the goal.”
        - Ensuring exposures do not involve actual medical risk (e.g., no raw sewage, no ingesting contaminants).

Clinical Examples

Example 1 — Health-Concern OCD:

Jack fears he will contract HIV by touching a commonly used public surface (e.g., a door handle). He has intrusive thoughts: "What if I contracted HIV and I get really sick and spread it to others/my girlfriend," repeated for hours. In response, he repeatedly washes his hands, sterilizes everything multiple times, avoids touching certain objects, and mentally repeats prayers or rituals to "neutralize" the possibility. He recognizes the thoughts/behaviors are excessive or irrational but feels driven to complete the rituals. Functionally, the compulsions reduce anxiety only temporarily. This is a classic OCD pattern, just with a health-related theme.

Example 1 Treatment:

- Exposure Ideas (Graduated Hierarchy)
    - Touching a "feared" surface (doorknob, shopping cart, elevator button) and **not** washing hands afterward for a predetermined period.
    - Touching the surface and then touching one's face, clothing, or personal items.
    - Holding a mildly "dirty" object (e.g., a used but visibly clean cup) without washing.
    - Writing a statement like: "I might have interacted with the HIV virus today" and reading it aloud repeatedly.
    - Looking at photos of germs, viruses, or hospital environments.
    - Going to a public place (store, hospital lobby) and intentionally using the public restroom without excessive precautions.
- Response Prevention Targets
    - No handwashing, sanitizing, changing clothes, or wiping objects.
    - No mental compulsions (prayer, counting, neutralizing images).
    - No reassurance asking ("Do you think I'll get HIV?").
    - No Googling symptoms or disease transmission statistics.
- Clinical Notes
    - Emphasize *probability* vs *possibility*.
    - Target both overt and covert rituals — intrusive mental neutralizing is often missed.
    - Since his fear involves "harming others," exposures may include touching loved ones *after* touching a feared surface.

Example 2 — Classic Illness Anxiety Disorder:

Amy experiences mild bodily sensations (e.g., occasional fatigue, slight twinge of pain, heart palpitations) that most people would dismiss. She becomes preoccupied with the belief that these indicate a serious health issue (e.g., heart attack/heart disease). She frequently checks her body (apple watch heart rate, pulse oximeter), spend hours researching heart health online, and makes repeated medical appointments or lab tests. Reassurance from doctors ("you're fine, test results look healthy") doesn't relieve the worry for long. She avoids activities she fears are "risky" for her health such as eating certain foods she thinks could "clog her arteries"; canceling travel plans because she thinks she could get a blood clot on the plane; and avoiding caffeine/exercise despite loving it because she is afraid to raise her heart rate. The core driver is persistent health-related anxiety rather than a ritualistic compulsion, although the behaviors can become repetitive.

Example 2 Treatment:

- Exposure Ideas
    - Reading WebMD or Mayo Clinic articles about the feared illness, without reassurance checks.
    - Watching videos of people discussing the illness.
    - Saying aloud: "It's possible that I may have a heart attack." (Can expand on this and create a full worry script)
    - Looking at lists of symptoms of the feared condition.
    - Tracking normal bodily sensations *without* interpreting them.
    - Sitting with a mild bodily sensation without checking the body or researching.
    - Interoceptive exposures: experiencing bodily sensations like heart racing without interpretation. Examples: jumping jacks, burpees, dancing.
    - Read an article about diagnostic errors and tolerate uncertainty.
- Response Prevention Targets
    - No body checking.
    - No Googling symptoms.
    - No asking friends/family for reassurance.
    - Time-limiting medical portal checks (e.g., waiting 24 hours to open lab results).
    - Delaying scheduling follow-up appointments.

    - Resisting going to the ER.
- Clinical Notes
    - Emphasize uncertainty tolerance: “I cannot know right now with 100% certainty whether I’m healthy, and that’s okay.”
    - We are not exposing to **actual medical danger,** only to uncertain interpretations of benign sensations.

Brainstorming Treatment Strategies

What exposure plans and treatment ideas come to mind for these examples?

OCD Client Examples:

- Client fears getting the flu and missing school. Engages in elaborate bedtime rituals ("to prevent getting sick”) and frequent reassurance checks with parents (“Do I feel warm?”).
- Client believes if he touches doorknobs, he’ll pass deadly germs to his younger sibling. He is excessively handwashing, avoiding shared items, and sanitizing surfaces multiple times daily.
- Client notices a mild stomach sensation and becomes convinced it’s a sign of impending food poisoning. They engage in body scanning, googling “symptoms of food poisoning,” avoiding certain foods, and checking expiration dates on the same foods in the fridge over and over.
- Client is convinced that unless he repeats a counting ritual before bed, his mother will get cancer. He says mental prayers, repeating phrases until they “feel right.”

IAD Client Examples:

- Client interprets some normal light headedness as a sign of a brain tumor. She visits the doctor repeatedly, joins online forums about medical negligence, googles symptoms & seeks reassurance often.
- Client notices occasional muscle twitches after exercise and becomes convinced it’s ALS. He avoids physical activity to “monitor symptoms,” tests grip strength repeatedly, and excessively reads articles and research about ALS.
- Client believes bloating is a sign of colon cancer despite multiple medical reassurances. She avoids certain foods, tracks bowel movements obsessively, and requests repeat tests.
- Client interprets normal headaches or brief tingling as signs of an impending stroke. They google stroke symptoms, avoid driving long distances, repeatedly asks people if their face is “drooping.”