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Anxiety Disorders

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Anxiety Disorders Anxiety disorders include disorders that share features of excessive fear and anxiety and related behavioral disturbances. Fear is the emotional response to real or perceived imminent threat, whereas anxiety is anticipation of future threat. Obviously, these two states overlap, but they also differ, with fear more often associated with surges of autonomic arousal necessary for fight or flight, thoughts of immediate danger, and escape behaviors, and anxiety more often associated with muscle tension and vigilance in preparation for future danger and cautious or avoidant behaviors. Sometimes the level of fear or anxiety is reduced by pervasive avoidance behaviors. Panic attacks feature prominently within the anxiety disorders as a particular type of fear response. Panic attacks are not limited to anxiety disorders but rather can be seen in other mental disorders as well. The anxiety disorders differ from one another in the types of objects or situations that induce fear, anxiety, or avoidance behavior, and the associated cognition. Thus, while the anxiety disorders tend to be highly comorbid with each other, they can be differentiated by close examination of the types of situations that are feared or avoided and the content of the associated thoughts or beliefs. Anxiety disorders differ from developmentally normative fear or anxiety by being excessive or persisting beyond developmentally appropriate periods. They differ from transient fear or anxiety, often stress-induced, by being persistent (e.g., typically lasting 6 months or more), although the criterion for duration is intended as a general guide with allowance for some degree of flexibility and is sometimes of shorter duration in children (as in separation anxiety disorder and selective mutism). Since individuals with anxiety disorders typically overestimate the danger in situations they fear or avoid, the primary determination of whether the fear or anxiety is excessive or out of proportion is made by the clinician, taking cultural contextual factors into account. Many of the anxiety disorders develop in childhood and tend to persist if not treated. Most occur more frequently in girls than in boys (approximately 2:1 ratio). Each anxiety disorder is diagnosed only when the symptoms are not attributable to the physiological effects of a substance/medication or to another medical condition or are not better explained by another mental disorder. The chapter is arranged developmentally, with disorders sequenced according to the typical age at onset. The individual with separation anxiety disorder is fearful or anxious about separation from attachment figures to a degree that is developmentally inappropriate. There is persistent fear or anxiety about harm coming to attachment figures and events that could lead to loss of or separation from attachment figures and reluctance to go away from attachment figures, as well as nightmares and physical symptoms of distress. Although the symptoms often develop in childhood, they can be expressed throughout adulthood as well in the absence of a history of childhood separation anxiety disorder. Selective mutism is characterized by a consistent failure to

speak in social situations in which

there is an expectation to speak (e.g., school) even though the individual speaks in other situations. The failure to speak has significant consequences on achievement in academic or occupational settings or otherwise interferes with normal social communication. Individuals with specific phobia are fearful or anxious about or avoidant of circumscribed objects or situations. A specific cognition is not featured in this disorder, as it is in other anxiety disorders. The fear, anxiety, or avoidance is almost always immediately induced by the phobic situation, to a degree that is persistent and out of proportion to the actual risk posed. There are various types of specific phobias: animal; natural environment; blood-injection-injury; situational; and other situations. In social anxiety disorder, the individual is fearful or anxious about or avoidant of social interactions and situations that involve the possibility of being scrutinized. These include social interactions such as meeting unfamiliar people, situations in which the individual may be observed eating or drinking, and situations in which the individual performs in front of others. The cognition is of being negatively evaluated by others, by being embarrassed, humiliated, or rejected, or offending others. In panic disorder, the individual experiences recurrent unexpected panic attacks and is persistently concerned or worried about having more panic attacks or changes his or her behavior in maladaptive ways because of the panic attacks (e.g., avoidance of exercise or of unfamiliar locations). Panic attacks are abrupt surges of intense fear or intense discomfort that reach a peak within minutes, accompanied by physical and/or cognitive symptoms. Limited-symptom panic attacks include fewer than four symptoms. Panic attacks may be expected, such as in response to a typically feared object or situation, or unexpected, meaning that the panic attack occurs for no apparent reason. Panic attacks function as a marker and prognostic factor for severity of diagnosis, course, and comorbidity across an array of disorders, including, but not limited to, anxiety, substance use, depressive, and psychotic disorders. The specifier “with panic attacks” may therefore be used for panic attacks that occur in the context of any anxiety disorder, as well as other mental disorders (e.g., depressive disorders, posttraumatic stress disorder). Individuals with agoraphobia are fearful and anxious in many different situations, and the diagnostic criteria require symptoms in two or more of the following: using public transportation, being in open spaces, being in enclosed places, standing in line or being in a crowd, or being outside of the home alone in other situations. The individual fears these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms. These situations consistently induce fear or anxiety and are often avoided or require the presence of a companion. The key features of generalized anxiety disorder are persistent and excessive anxiety and worry about various domains, including work and school performance, that the individual finds difficult to control. In addition, the individual experiences physical symptoms, including restlessness or feeling keyed up or on edge; being easily fatigued; difficulty concentrating or mind going blank; irritability; muscle tension; and sleep disturbance. Substance/medication-induced anxiety disorder involves anxiety due to substance intoxication or withdrawal or to a medication treatment. In anxiety disorder due to another medical condition, anxiety symptoms are the physiological consequence of another medical

F93.0 condition. Disorder-specific scales are available to better characterize the severity of each anxiety disorder and to capture change in severity over time. For ease of use, particularly for individuals with more than one anxiety disorder, these scales have been developed to have the same format (but different focus) across the anxiety disorders, with ratings of behavioral

symptoms, cognitive symptoms, and physical symptoms relevant to each disorder. Individuals with anxiety may be more likely to have suicidal thoughts, attempt suicide, and die by suicide than those without anxiety. Panic disorder, generalized anxiety disorder, and specific phobia have been identified as the anxiety disorders most strongly associated with a transition from suicidal thoughts to suicide attempt. Separation Anxiety Disorder Diagnostic Criteria A. Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:

1. Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.
2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.
3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.
4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.
5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.
6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.
7. Repeated nightmares involving the theme of separation.
8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated. B. The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in adults. C. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.

D. The disturbance is not better explained by another mental disorder, such as refusing to leave home because of excessive resistance to change in autism spectrum disorder; delusions or hallucinations concerning separation in psychotic disorders; refusal to go outside without a trusted companion in agoraphobia; worries about ill health or other harm befalling significant others in generalized anxiety disorder; or concerns about having an illness in illness anxiety disorder. Diagnostic Features The essential feature of separation anxiety disorder is excessive fear or anxiety concerning separation from home or attachment figures. The anxiety exceeds what may be expected given the individual’s developmental level (Criterion A). Individuals with separation anxiety disorder have symptoms that meet at least three of the following criteria: They experience recurrent excessive distress when separation from home or major attachment figures is anticipated or occurs (Criterion A1). They worry about the well-being or death of attachment figures, particularly when separated from them, and they need to know the whereabouts of their attachment figures and want to stay in touch with them (Criterion A2). They also worry about untoward events to themselves, such as getting lost, being kidnapped, or having an accident, that would keep them from ever being reunited with their major attachment figure (Criterion A3). Individuals with separation anxiety disorder are reluctant or refuse to go out by themselves because of separation fears (Criterion A4). They have persistent and excessive fear or reluctance

about being alone or without major attachment figures at home or in other settings. Children with separation anxiety disorder may be unable to stay or go in a room by themselves and may display “clinging” behavior, staying close to or “shadowing” the parent around the house, or requiring someone to be with them when going to another room in the house (Criterion A5). They have persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home (Criterion A6). Children with this disorder often have difficulty at bedtime and may insist that someone stay with them until they fall asleep. During the night, they may make their way to their parents’ bed (or that of a significant other, such as a sibling). Children may be reluctant or refuse to attend camp, to sleep at friends’ homes, or to go on errands. Adults may be uncomfortable when traveling independently (e.g., sleeping in a hotel room away from home or attachment figures). There may be repeated nightmares in which the content expresses the individual’s separation anxiety (e.g., destruction of the family through fire, murder, or other catastrophe) (Criterion A7). Physical symptoms (e.g., headaches, abdominal complaints, nausea, vomiting) are common in children when separation from major attachment figures occurs or is anticipated (Criterion A8). Cardiovascular symptoms such as palpitations, dizziness, and feeling faint are rare in younger children but may occur in adolescents and adults. The disturbance must last for a period of at least 4 weeks in children and adolescents younger than 18 years and is typically 6 months or longer in adults (Criterion B). However, the duration criterion for adults should be used as a general guide, with allowance for some degree of

flexibility. The disturbance must cause clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning (Criterion C). Associated Features When separated from major attachment figures, children and adults with separation anxiety disorder may exhibit social withdrawal, apathy, sadness, or difficulty concentrating on work or play. Depending on their age, individuals may have fears of animals, monsters, the dark, muggers, burglars, kidnappers, car accidents, plane travel, and other situations that are perceived as presenting danger to the family or themselves. Some individuals become homesick and extremely uncomfortable when away from home. Separation anxiety disorder in children may lead to school refusal, which in turn may lead to academic difficulties and social isolation. When extremely upset at the prospect of separation, children may show anger or occasionally aggression toward someone who is forcing separation. When alone, especially in the evening or the dark, young children may report unusual perceptual experiences (e.g., seeing people peering into their room, frightening creatures reaching for them, feeling eyes staring at them). Children with this disorder may be described as demanding, intrusive, and in need of constant attention, and, as adults, may appear dependent and overprotective as parents. Adults with the disorder are likely to text or phone their major attachment figures throughout the day and repeatedly check on their whereabouts. The individual’s excessive demands often become a source of frustration for family members, leading to resentment and conflict within the family. Prevalence The 6- to 12-month prevalence of separation anxiety disorder in children is estimated to be approximately 4%. In a community sample of toddlers, separation anxiety disorder appears to be equally represented among girls and boys; however, school-age girls appear to have higher prevalence rates than school-age boys. In adolescents in the United States, the 12-month prevalence is 1.6%. Separation anxiety disorder decreases in prevalence from childhood through adolescence and adulthood. In clinical samples of children, the disorder is equally common in boys and girls in contrast to community samples, where the disorder is more frequent in girls. Reports from children tend to yield higher rates of separation anxiety disorder than parent reports of the child’s symptoms. For adults, the 12-month prevalence

of separation anxiety disorder in the United States ranges from 0.9% to 1.9%. Among adults with separation anxiety disorder, women tend to have higher prevalence rates of the disorder in both clinical and community studies. Across 18 countries, the mean 12-month prevalence in adults is 1.0%, with a range of < 0.1% to 2.7% (e.g., 0.3% in Romania, 2.7% in Colombia). A higher prevalence was observed in women compared with men in this total sample (1.3% compared with 0.8%). Development and Course Periods of heightened separation anxiety from attachment figures are part of normal early development and may indicate the development of secure attachment relationships (e.g., around

Environmental. Genetic and physiological. age 1 year, when infants may experience stranger anxiety). Onset of separation anxiety disorder may be as early as preschool age and may occur at any time during childhood and in adolescence. Across 18 countries, median age at onset reported by adults (age 18 years and older) with the disorder is in late adolescence in high- and upper-middle-income countries and in the mid-20’s in low- and lower-middle-income countries. Most adults report a fluctuating course of the disorder over their lifetime, and they may report some symptoms in childhood. Typically there are periods of exacerbation and remission. In some cases, both the anxiety about possible separation and the avoidance of situations involving separation from the home or nuclear family (e.g., going away to college, moving away from attachment figures) may persist through adulthood. However, the majority of children with separation anxiety disorder are free of impairing anxiety disorders over their lifetimes. The manifestations of separation anxiety disorder vary with age. Younger children are more reluctant to go to school or may avoid school altogether. Younger children may not express worries or specific fears of definite threats to parents, home, or themselves, and the anxiety is manifested only when separation is experienced. As children age, worries emerge; these are often worries about specific dangers (e.g., accidents, kidnapping, mugging, death) or vague concerns about not being reunited with attachment figures. In adults, separation anxiety disorder may limit their ability to cope with changes in circumstances (e.g., moving, getting married). Adults with the disorder are typically overconcerned about their offspring, spouses, parents, and pets and experience marked discomfort when separated from them. They may also experience significant disruption in work or social experiences because of needing to continuously check on the whereabouts of a significant other. Risk and Prognostic Factors Separation anxiety disorder often develops after life stress, especially a loss (e.g., the death of a relative or pet; an illness of the individual or a relative; a change of schools; parental divorce; a move to a new neighborhood; immigration; a disaster that involved periods of separation from attachment figures). Being bullied during childhood has been shown to be a risk factor for the development of separation anxiety disorder. In young adults, other examples of life stress include leaving the parental home, entering into a romantic relationship, and becoming a parent. A history of parental overprotection and intrusiveness may be associated with separation anxiety disorder in both childhood and adulthood. There is evidence that separation anxiety disorder may be heritable. Heritability was estimated at 73% in a community sample of 6-year-old twins, with higher rates found in girls. Children with separation anxiety disorder display particularly enhanced sensitivity to respiratory stimulation using CO_2-enriched air. Separation anxiety disorder also appears to aggregate in families. Culture-Related Diagnostic Issues There are cultural variations in the degree to which it is considered desirable to tolerate separation, so that demands and opportunities for separation between parents and children are avoided in some cultural contexts. For example, there is wide variation across countries and

Generalized anxiety disorder. Panic disorder. Agoraphobia. cultural contexts with respect to the age at which it is expected that offspring should leave the parental home. Youth vary in their self-reports of separation anxiety symptoms; for instance, Taiwanese youth endorse higher symptoms of separation anxiety compared with U.S. youth. It is important to differentiate separation anxiety disorder from the high value some cultural communities place on strong interdependence among family members. Association With Suicidal Thoughts or Behavior Separation anxiety disorder in children and adolescents may be associated with an increased risk for suicide, although this association is not specific to separation anxiety disorder and is found in other anxiety disorders where there is significant comorbidity. A large twin study showed that being bullied during childhood was a risk factor for suicidal thoughts during young adulthood. Functional Consequences of Separation Anxiety Disorder Individuals with separation anxiety disorder often limit independent activities away from home or attachment figures (e.g., in children, avoiding school, not going to camp, having difficulty sleeping alone; in adolescents, not going away to college; in adults, not leaving the parental home, not traveling long distances without their close attachments, not working outside the home). Symptoms in adults are often debilitating and affect multiple areas of their lives. For example, adults with separation anxiety disorder may deliberately reorganize their work schedules and other activities because of their anxieties about possible separations from close attachment figures; they may often express frustration with the limitations on their lives because of their need to maintain proximity to, or at least virtual contact with, their key attachment figures (e.g., by texting or phoning them repeatedly throughout the day). Separation anxiety disorder is associated with greater reported impairment in individuals from high- and uppermiddle-income countries compared with those from low- and lower-middle-income countries. Differential Diagnosis Separation anxiety disorder is distinguished from generalized anxiety disorder in that the anxiety in separation anxiety disorder predominantly concerns real or imagined separation from attachment figures. Furthermore, if other worries occur, they are not excessive. In separation anxiety disorder, threats of separation from close attachments may lead to extreme anxiety and panic attacks. In contrast to panic disorder, where panic attacks occur unexpectedly and are usually accompanied by fears of dying or going “crazy,” the panic attacks in separation anxiety disorder occur in anticipation of real or imagined separations from attachment figures or places of safety and security, or from worries that untoward events will befall the individual’s close attachments. Unlike individuals with agoraphobia, those with separation anxiety disorder are not anxious about being trapped or incapacitated in situations from which escape is perceived as difficult in the event of panic-like symptoms or other incapacitating symptoms. Instead, they fear being away from places of safety associated with their major attachment figures.

Conduct disorder. Social anxiety disorder. Posttraumatic stress disorder. Illness anxiety disorder. Prolonged grief disorder. Depressive and bipolar disorders. Oppositional defiant disorder. Psychotic disorders. Personality disorders. School avoidance (truancy) is common in conduct disorder, but anxiety about separation is not responsible for school absences, and the child or adolescent usually stays away from, rather than returns to, the home. School refusal may be attributable to social anxiety disorder. In such instances, the school avoidance is due to fear of being judged negatively by others rather than due to worries about being separated from attachment figures. Fear of separation from loved ones is common after a traumatic event such as a major disaster, particularly when periods of separation from loved ones are experienced during the traumatic event. In posttraumatic stress disorder (PTSD), the central symptoms concern intrusions about, and avoidance of, memories associated with the traumatic event itself, whereas in separation anxiety

disorder, the worries and avoidance concern the wellbeing of attachment figures and separation from them. Separation anxiety disorder concerns worries about the health and wellbeing of close attachments. In contrast, individuals with illness anxiety disorder worry about specific medical illnesses they themselves may have, not about them being separated from their close attachments. Intense yearning or longing for the deceased, intense sorrow and emotional pain, and preoccupation with the deceased or the circumstances of the death are expected responses occurring in prolonged grief disorder, whereas fear of possible separation from key attachment figures is central in separation anxiety disorder. These disorders may be associated with reluctance to leave home, but the main concern is not worry or fear of untoward events befalling attachment figures, but rather low motivation for engaging with the outside world. However, individuals with separation anxiety disorder may become depressed while being separated or in anticipation of separation. Children and adolescents with separation anxiety disorder may be oppositional in the context of being forced to separate from attachment figures. Oppositional defiant disorder should be considered only when there is persistent oppositional behavior unrelated to the anticipation or occurrence of separation from attachment figures. Unlike the hallucinations in psychotic disorders, the unusual perceptual experiences that may occur in separation anxiety disorder are usually based on a misperception of an actual stimulus, occur only in certain situations (e.g., nighttime), and are reversed by the presence of an attachment figure. Dependent personality disorder is characterized by an indiscriminate tendency to rely on others, whereas separation anxiety disorder involves concern about the proximity and safety of key attachment figures. Borderline personality disorder is characterized by fear of abandonment by loved ones, but problems in identity, self-direction, interpersonal functioning, and impulsivity are additionally central to that disorder, whereas they are not central to separation anxiety disorder. Comorbidity In children, separation anxiety disorder is highly comorbid with generalized anxiety disorder and

F94.0 specific phobia. In adults, common comorbidities include specific phobia, PTSD, panic disorder, generalized anxiety disorder, social anxiety disorder, agoraphobia, obsessive-compulsive disorder, prolonged grief disorder, and personality disorders. Among the personality disorders, dependent, avoidant, and obsessive-compulsive (Cluster C) personality disorders may be comorbid with separation anxiety disorder. Depressive and bipolar disorders are also comorbid with separation anxiety disorder in adults. Selective Mutism Diagnostic Criteria A. Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations. B. The disturbance interferes with educational or occupational achievement or with social communication. C. The duration of the disturbance is at least 1 month (not limited to the first month of school). D. The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation. E. The disturbance is not better explained by a communication disorder (e.g., childhood-onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder. Diagnostic Features When encountering other individuals in social interactions, children with selective mutism do not initiate speech or reciprocally respond when spoken to by others. Lack of speech occurs in social interactions with children or adults. Children with selective mutism will speak in their home in the presence of immediate family members but often not even in front of close friends or seconddegree relatives, such as grandparents or cousins. The disturbance is most often marked by high social anxiety. Children with selective mutism often refuse to speak at school, leading to academic or educational impairment, as teachers often find it difficult to assess skills such as reading. The lack of speech

may interfere with social communication, although children with this disorder sometimes use nonspoken or nonverbal means (e.g., grunting, pointing, writing) to communicate and may be willing or eager to perform or engage in social encounters when speech is not required (e.g., nonverbal parts in school plays). Associated Features Associated features of selective mutism may include excessive shyness, fear of social

Temperamental. Environmental. Genetic and physiological. embarrassment, social isolation and withdrawal, clinging, compulsive traits, negativism, temper tantrums, or mild oppositional behavior. Although children with this disorder generally have normal language skills, there may occasionally be an associated communication disorder, although no particular association with a specific communication disorder has been identified. Even when these disorders are present, anxiety is present as well. In clinical settings, children with selective mutism are almost always given an additional diagnosis of another anxiety disorder—most commonly, social anxiety disorder. Prevalence Selective mutism is a relatively rare disorder and has not been included as a diagnostic category in epidemiological studies of prevalence of childhood disorders. Point prevalence using various clinic or school samples in the United States, Europe, and Israel ranges between 0.03% and 1.9% depending on the setting and ages of the sample. Studies in community-based and treatmentseeking samples suggest an equal gender distribution for selective mutism, although there is also evidence that selective mutism is more common among girls than boys. Prevalence does not seem to vary by race/ethnicity, but individuals who need to speak in a non-native language (e.g., children of immigrant families) run greater risk for developing the disorder. The disorder is more likely to manifest in young children than in adolescents and adults. Development and Course The onset of selective mutism is usually before age 5 years, but the disturbance may not come to clinical attention until entry into school, where there is an increase in social interaction and performance tasks, such as reading aloud. The persistence of the disorder is variable. Although clinical reports suggest that many individuals “outgrow” selective mutism, the longitudinal course of the disorder is largely unknown. In most cases, selective mutism may fade, but symptoms of social anxiety disorder often remain. Risk and Prognostic Factors Temperamental risk factors for selective mutism are not well identified. Negative affectivity (neuroticism) or behavioral inhibition may play a role, as may parental history of shyness, social isolation, and social anxiety. Children with selective mutism may have subtle receptive language difficulties compared with their peers, although receptive language is still within the normal range. Social inhibition on the part of parents may serve as a model for social reticence and selective mutism in children. Furthermore, parents of children with selective mutism have been described as overprotective or more controlling than parents of children with other anxiety disorders or no disorder. Because of the significant overlap between selective mutism and social anxiety disorder, there may be shared genetic factors between these conditions. There is also evidence for increased abnormalities in the auditory efferent neural activity during vocalization in individuals with selective mutism, which could lead to peculiarities in the perception of their

Silent period in immigrant children learning a second language. Communication disorders. Neurodevelopmental disorders and schizophrenia and other psychotic disorders. Social anxiety disorder. own voice and hence a reticence to speak. Culture-Related Diagnostic Issues Children in families who have migrated to a country where a different language is spoken may appear to have selective mutism because they may refuse to speak the new language because of lack of knowledge of the language. Such children would not qualify for the diagnosis because such cases

are explicitly excluded from the diagnosis. Functional Consequences of Selective Mutism Selective mutism may result in social impairment, as children may be too anxious to engage in reciprocal social interaction with other children. As children with selective mutism mature, they may face increasing social isolation. In school settings, these children may suffer academic impairment, because often they do not communicate with teachers regarding their academic or personal needs (e.g., not understanding a class assignment, not asking to use the restroom). Severe impairment in school and social functioning, including that resulting from teasing by peers, is common. In certain instances, selective mutism may serve as a compensatory strategy to decrease anxious arousal in social encounters. Differential Diagnosis Selective mutism must be distinguished from the typical “silent period” associated with the acquisition of a new language in young children. If comprehension of the new language is adequate but refusal to speak persists in both languages, in several unfamiliar settings, and for a prolonged period, a diagnosis of selective mutism may be warranted. Selective mutism should be distinguished from speech disturbances that are better explained by a communication disorder, such as language disorder, speech sound disorder (previously phonological disorder), childhood-onset fluency disorder (stuttering), or social (pragmatic) communication disorder. Unlike selective mutism, the speech disturbance in these conditions is not restricted to a specific social situation. Individuals with an autism spectrum disorder, schizophrenia or another psychotic disorder, or severe intellectual developmental disorder (intellectual disability) may have problems in social communication and be unable to speak appropriately in social situations. In contrast, selective mutism should be diagnosed only when a child has an established capacity to speak in some social situations (e.g., typically at home). The social anxiety and social avoidance in social anxiety disorder may be associated with selective mutism. In such cases, both diagnoses may be given. Comorbidity The most common comorbid conditions are other anxiety disorders, most often social anxiety

disorder, followed by separation anxiety disorder and specific phobia. In clinical settings, selective mutism and autism spectrum disorder have also been noted as frequently co-occurring conditions. Oppositional behaviors can be observed in a substantial minority of children with selective mutism, although this oppositional behavior may be limited to situations requiring speech. Communication delays or disorders also may appear in some children with selective mutism. Specific Phobia Diagnostic Criteria A. Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood). Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging. B. The phobic object or situation almost always provokes immediate fear or anxiety. C. The phobic object or situation is actively avoided or endured with intense fear or anxiety. D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context. E. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more. F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. G. The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in agoraphobia); objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in posttraumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder). Specify if: Code based on the phobic stimulus: F40.218 Animal (e.g., spiders, insects, dogs). F40.228 Natural environment (e.g., heights, storms, water). F40.23x Blood-injection-injury (e.g., needles, invasive medical procedures).

Coding note: Select specific ICD-10-CM code as follows: F40.230 fear of blood; F40.231 fear of injections and transfusions; F40.232 fear of other

medical care; or F40.233 fear of injury. F40.248 Situational (e.g., airplanes, elevators, enclosed places). F40.298 Other (e.g., situations that may lead to choking or vomiting; in children, e.g., loud sounds or costumed characters). Coding note: When more than one phobic stimulus is present, code all ICD-10-CM codes that apply (e.g., for fear of snakes and flying, F40.218 specific phobia, animal, and F40.248 specific phobia, situational). Specifiers It is common for individuals to have multiple specific phobias. The average individual with specific phobia fears three objects or situations, and approximately 75% of individuals with specific phobia fear more than one situation or object. In such cases, multiple specific phobia diagnoses, each with its own diagnostic code reflecting the phobic stimulus, would need to be given. For example, if an individual fears thunderstorms and flying, then two diagnoses would be given: specific phobia, natural environment, and specific phobia, situational. Diagnostic Features A key feature of this disorder is that the fear or anxiety is circumscribed to the presence of a particular situation or object (Criterion A), which may be termed the phobic stimulus. The categories of feared situations or objects are provided as specifiers. Many individuals fear objects or situations from more than one category, or phobic stimulus. For the diagnosis of specific phobia, the response must differ from normal, transient fears that commonly occur in the population. To meet the criteria for a diagnosis, the fear or anxiety must be intense or severe (i.e., "marked") (Criterion A). The amount of fear experienced may vary with proximity to the feared object or situation and may occur in anticipation of or in the actual presence of the object or situation. Also, the fear or anxiety may take the form of a full or limited symptom panic attack (i.e., expected panic attack). Another characteristic of specific phobias is that fear or anxiety is evoked nearly every time the individual comes into contact with the phobic stimulus (Criterion B). Thus, an individual who becomes anxious only occasionally upon being confronted with the situation or object (e.g., becomes anxious when flying only on one out of every five airplane flights) would not be diagnosed with specific phobia. However, the degree of fear or anxiety expressed may vary (from anticipatory anxiety to a full panic attack) across different occasions of encountering the phobic object or situation because of various contextual factors such as the presence of others, duration of exposure, and other threatening elements such as turbulence on a flight for individuals who fear flying. Fear and anxiety are often expressed differently between children and adults. Also, the fear or anxiety occurs as soon as the phobic object or situation is encountered (i.e., immediately rather than being delayed). The individual actively avoids the situation, or if he or she either is unable or decides not to avoid it, the situation or object evokes intense fear or anxiety (Criterion C). Active avoidance means the individual intentionally behaves in ways that are designed to prevent or minimize contact with phobic objects or situations (e.g., takes tunnels instead of bridges on daily commute to work for fear of heights; avoids entering a dark room for fear of spiders; avoids accepting a job in a locale where a phobic stimulus is more common). Avoidance behaviors are often

obvious (e.g., an individual who fears blood refusing to go to the doctor) but are sometimes less obvious (e.g., an individual who fears snakes refusing to look at pictures that resemble the form or shape of snakes). Many individuals with specific phobias have suffered over many years and have changed their living circumstances in ways designed to avoid the phobic object or situation as much as possible (e.g., an individual diagnosed with specific phobia, animal, who moves to reside in an area devoid of the particular feared animal). Therefore, they no longer experience fear or

anxiety in their daily life. In such instances, avoidance behaviors or ongoing refusal to engage in activities that would involve exposure to the phobic object or situation (e.g., repeated refusal to accept offers for work-related travel because of fear of flying) may be helpful in confirming the diagnosis in the absence of overt anxiety or panic. The fear or anxiety is out of proportion to the actual danger that the object or situation poses, or more intense than is deemed necessary (Criterion D). Although individuals with specific phobia often recognize their reactions as disproportionate, they tend to overestimate the danger in their feared situations, and thus the judgment of being out of proportion is made by the clinician. The individual's sociocultural context should also be considered. For example, fears of the dark may be reasonable in a context of ongoing violence, and the degree of fear of insects considered to be disproportionate would be higher in settings where insects are consumed in the diet. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more (Criterion E), which helps distinguish the disorder from transient fears that are common in the population, particularly among children. The specific phobia must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning in order for the disorder to be diagnosed (Criterion F). Associated Features Individuals with specific phobia typically experience an increase in physiological arousal in anticipation of or during exposure to a phobic object or situation. However, the physiological response to the feared situation or object varies. Whereas individuals with situational, natural environment, and animal specific phobias are likely to show sympathetic nervous system arousal, individuals with blood-injection-injury specific phobia often demonstrate a vasovagal fainting or near-fainting response that is marked by initial brief acceleration of heart rate and elevation of blood pressure followed by a deceleration of heart rate and a drop in blood pressure. Additionally, specific phobia is most consistently associated with abnormal activity in the amygdala, anterior cingulate cortex, thalamus, and insula in response to the phobic object/situation. Prevalence In the United States, the 12-month community prevalence estimate for specific phobia is approximately 8%–12%. Prevalence rates in European countries are largely similar to those in the United States (e.g., about 6%), but rates are generally lower in Asian, African, and Latin American countries (2%–4%). Prevalence estimates in children average approximately 5%

across various countries, with a range of 3%–9%, and are approximately 16% in adolescents ages 13–17 years in the United States. Prevalence estimates are lower in older individuals (about 3%–5%), possibly reflecting diminishing severity to subclinical levels. Women are more frequently affected than men across subtypes, at a rate of approximately 2:1. Development and Course Specific phobia sometimes develops following a traumatic event (e.g., being attacked by an animal or stuck in an elevator), observation of others going through a traumatic event (e.g., watching someone drown), an unexpected panic attack in the to be feared situation (e.g., an unexpected panic attack while on the subway), or informational transmission (e.g., extensive media coverage of a plane crash). However, many individuals with specific phobia are unable to recall the specific reason for the onset of their phobias. Specific phobia usually develops in early childhood, with the majority of cases developing prior to age 10 years. Median age at onset is between 7 and 11 years, with the mean at about 10 years. Situational specific phobias tend to have a later age at onset than natural environment, animal, or blood-injection-injury specific phobias. Specific phobias that develop in childhood and adolescence are likely to wax and wane during that period. However, phobias that do persist into adulthood are unlikely to remit for the majority of individuals. When specific phobia is being diagnosed in children, two issues should be considered. First, young children may express their fear and anxiety by crying, tantrums, freezing, or clinging. Second,

young children typically are not able to understand the concept of avoidance. Therefore, the clinician should assemble additional information from parents, teachers, or others who know the child well. Excessive fears are quite common in young children but are usually transitory and only mildly impairing and thus considered developmentally appropriate. In such cases a diagnosis of specific phobia would not be made. When the diagnosis of specific phobia is being considered in a child, it is important to assess the degree of impairment and the duration of the fear, anxiety, or avoidance, and whether it is typical for the child's particular developmental stage. Although the prevalence of specific phobia is lower in older populations, it remains one of the more commonly experienced disorders in late life. Several issues should be considered when diagnosing specific phobia in older populations. First, older individuals may be more likely to endorse natural environment specific phobias, as well as phobias of falling. Second, specific phobia (like all anxiety disorders) tends to co-occur with medical concerns in older individuals, including coronary heart disease, chronic obstructive pulmonary disease, and Parkinson's disease. Third, older individuals may be more likely to attribute the symptoms of anxiety to medical conditions. Fourth, older individuals may be more likely to manifest anxiety in an atypical manner (e.g., involving symptoms of both anxiety and depression) and thus be more likely to warrant a diagnosis of unspecified anxiety disorder. Additionally, the presence of specific phobia in older adults is associated with decreased quality of life and may serve as a risk factor for major neurocognitive disorder. Although most specific phobias develop in childhood and adolescence, it is possible for a

Temperamental. Environmental. Genetic and physiological. specific phobia to develop at any age, often as the result of experiences that are traumatic. For example, phobias of choking almost always follow a near-choking event at any age. Risk and Prognostic Factors Temperamental risk factors for specific phobia, such as negative affectivity (neuroticism) or behavioral inhibition, are risk factors for other anxiety disorders as well. Environmental risk factors for specific phobias, such as parental overprotectiveness, parental loss and separation, and physical and sexual abuse, tend to predict other anxiety disorders as well. As noted earlier, negative or traumatic encounters with the feared object or situation sometimes (but not always) precede the development of specific phobia. There may be a genetic susceptibility to a certain category of specific phobia (e.g., an individual with a first-degree relative with a specific phobia of animals is significantly more likely to have the same type of specific phobia than any other category of phobia). Twin studies have examined the heritability of individual subtypes of fears and phobias, suggesting that animal phobia has approximately 32% heritability, blood-injury-injection phobia has 33%, and situational phobia has 25%. Culture-Related Diagnostic Issues In the United States, individuals of Asian and Latinx descent report lower prevalence of specific phobia than non-Latinx Whites and African Americans. The prevalence of specific phobia subtypes varies cross-nationally. Sex- and Gender-Related Diagnostic Issues Animal, natural environment, and situational specific phobias are predominantly experienced by women, whereas blood-injection-injury phobia is experienced nearly equally among women and men. The average age at onset of specific phobia during childhood does not differ between girls/women and boys/men. Association With Suicidal Thoughts or Behavior Specific phobia is associated with both suicidal thoughts and suicide attempts based on national U.S. survey data. Specific phobia is also associated with a transition from ideation to attempt. For individuals in the community ages 14–24 years, a large prospective study over a 10-year period in Germany found that 30% of first suicide attempts could be attributable to specific phobia. Functional Consequences of Specific Phobia Individuals with specific phobia show similar patterns of impairment in psychosocial functioning and decreased quality of life as individuals with other

anxiety disorders and alcohol and substance use disorders, including impairments in occupational and interpersonal functioning. In older adults, impairment may be seen in caregiving duties and volunteer activities. Also, fear of

Agoraphobia. Social anxiety disorder. Separation anxiety disorder. Panic disorder. Obsessive-compulsive disorder. falling in older adults can lead to reduced mobility and reduced physical and social functioning, and may lead to receiving formal or informal home support. The distress and impairment caused by specific phobias tend to increase with the number of feared objects and situations. Thus, an individual who fears four objects or situations is likely to have more impairment in his or her occupational and social roles and a lower quality of life than an individual who fears only one object or situation. Individuals with blood-injection-injury specific phobia are often reluctant to obtain medical care even when a medical concern is present. Additionally, fear of vomiting and choking may substantially reduce dietary intake. Differential Diagnosis Situational specific phobia may resemble agoraphobia in its clinical presentation, given the overlap in feared situations (e.g., flying, enclosed places, elevators). If an individual fears only one of the agoraphobic situations, then specific phobia, situational, may be diagnosed. If two or more agoraphobic situations are feared, a diagnosis of agoraphobia is likely warranted. For example, an individual who fears airplanes and elevators (which overlap with the “public transportation” agoraphobic situation) but does not fear other agoraphobic situations would be diagnosed with specific phobia, situational, whereas an individual who fears airplanes, elevators, and crowds (which overlap with two agoraphobic situations, “using public transportation” and “standing in line or being in a crowd”) would be diagnosed with agoraphobia. Criterion B of agoraphobia (the situations are feared or avoided “because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms”) can also be useful in differentiating agoraphobia from specific phobia. If the situations are feared for reasons other than not being able to escape or get help, such as fear of being harmed directly by the object or situation (e.g., fear of the plane crashing, fear of the animal biting), a specific phobia diagnosis may be more appropriate. If the situations are feared because of negative evaluation, social anxiety disorder should be diagnosed instead of specific phobia. If the situations are feared because of separation from a primary caregiver or attachment figure, separation anxiety disorder should be diagnosed instead of specific phobia. Individuals with specific phobia may experience panic attacks when confronted with their feared situation or object. A diagnosis of specific phobia would be given if the panic attacks only occurred in response to the specific object or situation, whereas a diagnosis of panic disorder would be given if the individual also experienced panic attacks that were unexpected (i.e., not in response to the specific phobia object or situation). If an individual’s primary fear or anxiety is of an object or situation as a result of obsessions (e.g., fear of blood due to obsessive thoughts about contamination from blood-borne pathogens [i.e., HIV]; fear of driving due to obsessive images of harming others), and if other diagnostic criteria for obsessive-compulsive disorder are met, then obsessive-compulsive disorder should be diagnosed.

Trauma- and stressor-related disorders. Eating disorders. Schizophrenia spectrum and other psychotic disorders. F40.10 If the phobia develops following a traumatic event, posttraumatic stress disorder (PTSD) should be considered as a diagnosis. However, traumatic events can precede the onset of PTSD and specific phobia. In this case, a diagnosis of specific phobia would be assigned only if all of the criteria for PTSD are not met. A diagnosis of specific phobia is not given if

the avoidance behavior is exclusively limited to avoidance of food and food-related cues, in which case a diagnosis of anorexia nervosa or bulimia nervosa should be considered. When the fear and avoidance are attributable to delusional thinking (as in schizophrenia or other schizophrenia spectrum and other psychotic disorders), a diagnosis of specific phobia is not warranted. Comorbidity Specific phobia is rarely seen in medical-clinical settings in the absence of other psychopathology and is more frequently seen in nonmedical mental health settings. Specific phobia is frequently associated with a range of other disorders. Because of early onset, specific phobia is typically the temporally primary disorder. Individuals with specific phobia are at increased risk for the development of other disorders, including other anxiety disorders, depressive and bipolar disorders, substance-related disorders, somatic symptom and related disorders, and personality disorders (particularly dependent personality disorder). Social Anxiety Disorder Diagnostic Criteria A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech). Note: In children, the anxiety must occur in peer settings and not just during interactions with adults. B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others). C. The social situations almost always provoke fear or anxiety. Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations. D. The social situations are avoided or endured with intense fear or anxiety. E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more. G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition. I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder. J. If another medical condition (e.g., Parkinson’s disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive. Specify if: Performance only: If the fear is restricted to speaking or performing in public. Specifiers Individuals with the performance only type of social anxiety disorder have performance fears that are typically most impairing in their professional lives (e.g., musicians, dancers, performers, athletes) or in roles that require regular public speaking. Performance fears may also manifest in work, school, or academic settings in which regular public presentations are required. Individuals with performance only social anxiety disorder do not fear or avoid nonperformance social situations. Diagnostic Features The essential feature of social anxiety disorder is a marked, or intense, fear or anxiety of social situations in which the individual may be scrutinized by others. In children the fear or anxiety must occur in peer settings and not just during interactions with adults (Criterion A). When exposed to such social situations, the individual fears that he or she will be negatively evaluated. The individual is concerned that he or she will be judged as anxious, weak, crazy, stupid, boring, intimidating, dirty, or unlikable. The individual fears that he or she will act or appear in a certain way or show anxiety symptoms, such as blushing, trembling, sweating, stumbling over one’s words, or staring, that will be negatively evaluated by others (Criterion B). Some individuals fear offending others or being rejected as a result. Fear of offending others—for example, by a gaze or

by showing anxiety symptoms—may be the predominant fear in individuals from cultures with strong collectivistic orientations. An individual with fear of trembling of the hands may avoid drinking, eating, writing, or pointing in public; an individual with fear of sweating may avoid shaking hands or eating spicy foods; and an individual with fear of blushing may avoid public performance, bright lights, or discussion about intimate topics. Some individuals fear and avoid urinating in public restrooms when other individuals are present (i.e., paruresis, or "shy bladder syndrome"). The social situations almost always provoke fear or anxiety (Criterion C). Thus, an individual who becomes anxious only occasionally in the social situation(s) would not be diagnosed with

social anxiety disorder. However, the degree and type of fear and anxiety may vary (e.g., anticipatory anxiety, a panic attack) across different occasions. The anticipatory anxiety may occur sometimes far in advance of upcoming situations (e.g., worrying every day for weeks before attending a social event, repeating a speech for days in advance). In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, or shrinking in social situations. The individual will often avoid the feared social situations. Alternatively, the situations are endured with intense fear or anxiety (Criterion D). Avoidance can be extensive (e.g., not going to parties, refusing school) or subtle (e.g., overpreparing the text of a speech, diverting attention to others, limiting eye contact). The fear or anxiety is judged to be out of proportion to the actual risk of being negatively evaluated or to the consequences of such negative evaluation (Criterion E). Sometimes, the anxiety may not be judged to be excessive, because it is related to an actual danger (e.g., being bullied or tormented by others). However, individuals with social anxiety disorder often overestimate the negative consequences of social situations, and thus the judgment of being out of proportion is made by the clinician. The individual's sociocultural context needs to be taken into account when this judgment is being made. For example, in certain cultures, behavior that might otherwise appear socially anxious may be considered appropriate in social situations (e.g., might be seen as a sign of respect). The duration of the disturbance is typically at least 6 months (Criterion F). This duration threshold helps distinguish the disorder from transient social fears that are common, particularly among children and in the community. The fear, anxiety, and avoidance must interfere significantly with the individual's normal routine, occupational or academic functioning, or social activities or relationships, or must cause clinically significant distress (Criterion G). For example, an individual who is afraid to speak in public would not receive a diagnosis of social anxiety disorder if this activity is not routinely encountered on the job or in classroom work, and if the individual is not significantly distressed about it. However, if the individual avoids, or is passed over for, the job or education he or she really wants because of social anxiety symptoms, Criterion G is met. Associated Features Individuals with social anxiety disorder may be inadequately assertive or excessively submissive or, less commonly, highly controlling of the conversation. They may show overly rigid body posture or inadequate eye contact, or speak with an overly soft voice. These individuals may be shy or withdrawn, and they may be less open in conversations and disclose little about themselves. They may seek employment in jobs that do not require social contact, although this is not the case for individuals with social anxiety disorder, performance only. They may live at home longer. Men may be delayed in marrying and having a family, whereas women who would want to work outside the home may live a life without ever doing so. Self-medication with substances is common (e.g., drinking before going to a party). Social anxiety among older adults may also include exacerbation of symptoms of medical illnesses, such as increased tremor or tachycardia. Blushing is a hallmark physical

response of social anxiety disorder.

Prevalence The 12-month prevalence estimate of social anxiety disorder for the United States is approximately 7%. Lower 12-month prevalence estimates are seen in much of the world using the same diagnostic instrument, clustering around 0.5%–2.0%; median prevalence in Europe is 2.3%. Prevalence appears to be increasing in the United States and East Asian countries. Twelvemonth prevalence rates in young adolescents (ages 13–17 years) are roughly half those in adults. Twelve-month prevalence rates decrease after age 65. The 12-month prevalence for older adults in North America, Europe, and Australia ranges from 2% to 5%. In general, higher rates of social anxiety disorder are found in women than in men in the general population (with odds ratios ranging from 1.5 to 2.2), and the gender difference in prevalence is more pronounced in adolescents and young adults. Gender rates are equivalent or slightly higher for men in clinical samples, and it is assumed that gender roles and social expectations play a significant role in explaining the heightened help-seeking behavior in men. Prevalence in the United States has been found to be lower in individuals of Asian, Latinx, African American, and Caribbean Black descent compared with non-Hispanic Whites. Development and Course Median age at onset of social anxiety disorder in the United States is 13 years, and 75% of individuals have an age at onset between 8 and 15 years. The disorder sometimes emerges out of a childhood history of social inhibition or shyness in U.S. and European studies. Onset can also occur in early childhood. Onset of social anxiety disorder may follow a stressful or humiliating experience (e.g., being bullied, vomiting during a public speech), or it may be insidious, developing slowly. First onset in adulthood is relatively rare and is more likely to occur after a stressful or humiliating event or after life changes that require new social roles (e.g., marrying someone from a different social class, receiving a job promotion). Social anxiety disorder may diminish after an individual with fear of dating marries and may reemerge after divorce. Among individuals presenting to clinical care, the disorder tends to be particularly persistent. Adolescents endorse a broader pattern of fear and avoidance, including of dating, compared with younger children. Older adults express social anxiety at lower levels but across a broader range of situations, whereas younger adults express higher levels of social anxiety for specific situations. In older adults, social anxiety may concern disability due to declining sensory functioning (hearing, vision) or embarrassment about one’s appearance (e.g., tremor as a symptom of Parkinson’s disease) or functioning due to medical conditions, incontinence, or cognitive impairment (e.g., forgetting people’s names). Detection of social anxiety disorder in older adults may be challenging because of several factors, including a focus on somatic symptoms, comorbid medical illness, limited insight, changes to social environment or roles that may obscure impairment in social functioning, or reticence about describing psychological distress. There is large variation in rates of remission for social anxiety disorder, suggestive of different trajectories (short, fluctuating, and chronic).

Temperamental. Environmental. Genetic and physiological. Risk and Prognostic Factors Underlying traits that predispose individuals to social anxiety disorder include behavioral inhibition and fear of negative evaluation, as well as harm avoidance. Personality traits consistently associated with social anxiety disorder are high negative affectivity (neuroticism) and low extraversion. There is evidence that negative social experiences, particularly peer victimization, are associated with the development of social anxiety disorder, although causal pathways remain unknown. Childhood maltreatment and adversity are risk factors for social anxiety disorder. Among African Americans and Caribbean Blacks in the United States, everyday forms of ethnic discrimination and racism are

associated with social anxiety disorder. Traits predisposing individuals to social anxiety disorder, such as behavioral inhibition, are strongly genetically influenced. The genetic influence is subject to gene-environment interaction; that is, children with high behavioral inhibition are more susceptible to environmental influences, such as socially anxious modeling by parents. Also, social anxiety disorder is heritable. First-degree relatives have a two to six times greater chance of having social anxiety disorder, and liability to the disorder involves the interplay of disorderspecific (e.g., fear of negative evaluation) and nonspecific (e.g., negative affectivity [neuroticism]) genetic factors. Genetic contribution to social anxiety disorder has been found to be higher for social anxiety disorder in children than social anxiety disorder in adults and higher for social anxiety symptoms than a clinical diagnosis of social anxiety disorder. Culture-Related Diagnostic Issues The nature and types of social situations that precipitate symptoms of social anxiety disorder are similar across U.S. ethnoracial groups, including fear of performance/public speaking, social interaction, and being observed. U.S. non-Latinx Whites report an earlier age at onset of social anxiety disorder than U.S. Latinx, yet the latter describe greater impairment across home, work, and relationship domains associated with the disorder. Immigrant status is associated with lower rates of social anxiety disorder in both Latinx and nonLatinx White groups. The syndrome of taijin kyofusho (e.g., in Japan and Korea) is often characterized by social-evaluative concerns, fulfilling criteria for social anxiety disorder, which are associated with the fear that the individual makes other people uncomfortable (e.g., “My gaze upsets people so they look away and avoid me”), a fear that is at times experienced with delusional intensity. Other presentations of taijin kyofusho may fulfill criteria for body dysmorphic disorder or delusional disorder. Sex- and Gender-Related Diagnostic Issues Age at onset of social anxiety disorder does not differ by gender. Women with social anxiety disorder report a greater number of social fears and comorbid major depressive disorder and other anxiety disorders, whereas men are more likely to fear dating; have oppositional defiant disorder, conduct disorder, or antisocial personality disorder; and use alcohol and illicit drugs to

Normative shyness. Agoraphobia. Panic disorder. Generalized anxiety disorder. relieve symptoms of the disorder. Paruresis is more common in men. Association With Suicidal Thoughts or Behavior Among U.S. adolescents, social anxiety disorder has been reported to increase the risk for active suicidal thoughts and suicide attempts in Latinx but not in non-Latinx Whites, independently of the effect of major depression and family income. Functional Consequences of Social Anxiety Disorder Social anxiety disorder is associated with elevated rates of school dropout and with decreased well-being, employment, workplace productivity, socioeconomic status, and quality of life. Social anxiety disorder is also associated with being single, unmarried, or divorced and with not having children, particularly among men, whereas women are more likely to be unemployed. Social anxiety disorder is also negatively associated with friendship quality, such that individuals with social anxiety disorder report having friendships that are less close and less supportive than persons without the disorder. In older adults, there may be impairment in caregiving duties and volunteer activities. Social anxiety disorder also impedes leisure activities. Despite the extent of distress and social impairment associated with social anxiety disorder, only about half of individuals with the disorder in high-income societies ever seek treatment, and they tend to do so only after 15–20 years of experiencing symptoms. Not being employed is a strong predictor for the persistence of social anxiety disorder. Differential Diagnosis Shyness (i.e., social reticence) is a common personality trait and is not by itself pathological. In some societies, shyness is even evaluated positively. However, when there is a significant adverse impact on social, occupational, and other important areas of functioning, a diagnosis of social anxiety disorder should be

considered, and when full diagnostic criteria for social anxiety disorder are met, the disorder should be diagnosed. Only a minority (12%) of selfidentified shy individuals in the United States have symptoms that meet diagnostic criteria for social anxiety disorder. Individuals with agoraphobia may fear and avoid social situations (e.g., going to a movie) because escape might be difficult or help might not be available in the event of incapacitation or panic-like symptoms, whereas individuals with social anxiety disorder are most fearful of scrutiny by others. Moreover, individuals with social anxiety disorder are likely to be calm when left entirely alone, which is often not the case in agoraphobia. Individuals with social anxiety disorder may have panic attacks, but the panic attacks are always cued by social situations and do not occur “out of the blue.” Additionally, individuals with social anxiety disorder are more likely to be distressed by fear of negative evaluation stemming from a panic attack than by the panic attacks themselves. Social worries are common in generalized anxiety disorder, but the focus is more on the nature of ongoing relationships rather than on fear of negative evaluation.

Separation anxiety disorder. Specific phobias. Selective mutism. Major depressive disorder. Body dysmorphic disorder. Delusional disorder. Autism spectrum disorder. Personality disorders. Individuals with generalized anxiety disorder, particularly children, may have excessive worries about the quality of their social performance, but these worries also pertain to nonsocial performance and when the individual is not being evaluated by others. In social anxiety disorder, the worries focus on social performance and others’ evaluation. Individuals with separation anxiety disorder may avoid social settings (including school refusal) because of concerns about being separated from attachment figures or, in children, about requiring the presence of a parent when it is not developmentally appropriate. Individuals with separation anxiety disorder are usually comfortable in social settings when their attachment figure is present or when they are at home, whereas those with social anxiety disorder may be uncomfortable when social situations occur at home or in the presence of attachment figures. Individuals with specific phobias may fear embarrassment or humiliation (e.g., embarrassment about fainting when they have their blood drawn), but they do not generally fear negative evaluation in other social situations. Individuals with selective mutism may fail to speak because of fear of negative evaluation, but they do not fear negative evaluation in social situations where no speaking is required (e.g., nonverbal play). Individuals with major depressive disorder may be concerned about being negatively evaluated by others because they feel they are bad or not worthy of being liked. In contrast, individuals with social anxiety disorder are worried about being negatively evaluated because of certain social behaviors or physical symptoms. Individuals with body dysmorphic disorder are preoccupied with one or more perceived defects or flaws in their physical appearance that are not observable or appear slight to others; this preoccupation often causes social anxiety and avoidance. If their social fears and avoidance are caused only by their beliefs about their appearance, a separate diagnosis of social anxiety disorder is not warranted. Individuals with delusional disorder may have nonbizarre delusions and/or hallucinations related to the delusional theme that focus on being rejected by or offending others. Although extent of insight into beliefs about social situations may vary, many individuals with social anxiety disorder have good insight that their beliefs are out of proportion to the actual threat posed by the social situation. Social anxiety and social communication deficits are hallmarks of autism spectrum disorder. Individuals with social anxiety disorder typically have adequate ageappropriate social relationships and social communication capacity, although they may appear to have impairment in these areas when first interacting with unfamiliar peers or adults. Given its frequent onset in childhood and its persistence into and

through adulthood, social anxiety disorder may resemble a personality disorder. The most apparent overlap is with avoidant personality disorder. Individuals with avoidant personality disorder have a broader avoidance pattern and higher rates of impairment than those individuals with social anxiety disorder. Moreover, individuals with avoidant personality disorder have a strong and pervasively negative self-concept, a view of rejection as equating to a global evaluation of the self as being of little worth, and a sense of not fitting in

Other mental disorders. Other medical conditions. Oppositional defiant disorder. F41.0 socially that dates from early childhood. Nonetheless, social anxiety disorder is typically more comorbid with avoidant personality disorder than with any other personality disorder, and avoidant personality disorder is more comorbid with social anxiety disorder than with any other anxiety disorder. Social fears and discomfort can occur as part of schizophrenia, but other evidence for psychotic symptoms is usually present. In individuals with an eating disorder, it is important to determine that fear of negative evaluation about eating disorder symptoms or behaviors (e.g., purging and vomiting) is not the sole source of social anxiety before applying a diagnosis of social anxiety disorder. Similarly, obsessive-compulsive disorder may be associated with social anxiety, but the additional diagnosis of social anxiety disorder is used only when social fears and avoidance are independent of the foci of the obsessions and compulsions. Medical conditions may produce symptoms that may be embarrassing (e.g., trembling in Parkinson’s disease). When the fear of negative evaluation due to other medical conditions is judged to be excessive, a diagnosis of social anxiety disorder should be considered. Refusal to speak because of opposition to authority figures should be differentiated from failure to speak because of fear of negative evaluation. Comorbidity Social anxiety disorder is often comorbid with other anxiety disorders, major depressive disorder, and substance use disorders, and the onset of social anxiety disorder generally precedes that of the other disorders, except for specific phobia and separation anxiety disorder. Chronic social isolation in the course of social anxiety disorder may result in major depressive disorder. Comorbidity with depression is high also in older adults. Substances may be used as selfmedication for social fears, but the symptoms of substance intoxication or withdrawal, such as trembling, may also be a source of (further) social fear. Social anxiety disorder is frequently comorbid with body dysmorphic disorder, and generalized social anxiety disorder is often comorbid with avoidant personality disorder. In children, comorbidities with high-functioning autism spectrum disorder and selective mutism are common. Panic Disorder Diagnostic Criteria A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur: Note: The abrupt surge can occur from a calm state or an anxious state.

1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort.
7. Nausea or abdominal distress.
8. Feeling dizzy, unsteady, light-headed, or faint.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).

11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or “going crazy.”
13. Fear of dying. Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms. B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:
14. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, “going crazy”).
15. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations). C. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders). D. The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in obsessive-compulsive disorder; in response to reminders of traumatic events, as in posttraumatic stress disorder; or in response to separation from attachment figures, as in separation anxiety disorder). Diagnostic Features Panic disorder is characterized by recurrent unexpected panic attacks (Criterion A). (For a detailed description of symptoms and course characterizing a panic attack, see Panic Attack

Specifier, “Features” section, following this text on panic disorder.) A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time 4 or more of a list of 13 physical and cognitive symptoms occur. The term recurrent means more than one unexpected panic attack. The term unexpected refers to a panic attack for which there is no obvious cue or trigger at the time of occurrence—that is, the attack appears to occur from out of the blue, such as when the individual is relaxing or emerging from sleep (nocturnal panic attack). In contrast, expected panic attacks are those for which there is an obvious cue or trigger, such as a situation in which panic attacks have typically occurred. The determination of whether panic attacks are expected or unexpected is made by the clinician, who makes this judgment based on a combination of careful questioning as to the sequence of events preceding or leading up to the attack and the individual’s own judgment of whether the attack seemed to occur for no apparent reason. Cultural interpretations may influence the assignment of panic attacks as expected or unexpected (see section “Culture-Related Diagnostic Issues” for this disorder). In the United States and Europe, approximately one-half of individuals with panic disorder have expected panic attacks as well as unexpected panic attacks. Thus, the presence of expected panic attacks does not rule out the diagnosis of panic disorder. The frequency and severity of panic attacks vary widely. In terms of frequency, there may be moderately frequent attacks (e.g., one per week) for months at a time, or short bursts of more frequent attacks (e.g., daily) separated by weeks or months without any attacks or with less frequent attacks (e.g., two per month) over many years. Individuals who have infrequent panic attacks resemble those with more frequent panic attacks in terms of panic attack symptoms, demographic characteristics, comorbidity with other disorders, family history, and biological data. In terms of severity, individuals with panic disorder may have both full-symptom (four or more symptoms) and limited-symptom (fewer than four symptoms) attacks, and the number and type of panic attack symptoms frequently differ from one panic attack

to the next. However, more than one unexpected full-symptom panic attack is required for the diagnosis of panic disorder. A nocturnal panic attack (i.e., waking from sleep in a state of panic) differs from panicking after fully waking from sleep. In the United States, nocturnal panic attack has been estimated to occur at least one time in roughly one-quarter to one-third of individuals with panic disorder, of whom the majority also have daytime panic attacks. Individuals with both daytime and nocturnal panic attacks tend to have more severe panic disorder overall. The worries about panic attacks or their consequences usually pertain to physical concerns, such as worry that panic attacks reflect the presence of life-threatening illnesses (e.g., cardiac disease, seizure disorder); social concerns, such as embarrassment or fear of being judged negatively by others because of visible panic symptoms; and concerns about mental functioning, such as "going crazy" or losing control (Criterion B). Individuals who report fears of dying in their panic attacks tend to have more severe presentations of panic disorder (e.g., panic attacks involving more symptoms). The maladaptive changes in behavior represent attempts to minimize or avoid panic attacks or their consequences. Examples include avoiding physical exertion, reorganizing daily life to ensure that help is available in the event of a panic attack, restricting usual daily activities, and avoiding agoraphobia-type situations, such as leaving home, using

public transportation, or shopping. If agoraphobia is present, a separate diagnosis of agoraphobia is given. Associated Features In addition to worry about panic attacks and their consequences, many individuals with panic disorder report constant or intermittent feelings of anxiety that are more broadly related to health and mental health concerns. For example, individuals with panic disorder often anticipate a catastrophic outcome from a mild physical symptom or medication side effect (e.g., thinking that they may have heart disease or that a headache means presence of a brain tumor). Such individuals often are relatively intolerant of medication side effects. In addition, there may be pervasive concerns about abilities to complete daily tasks or withstand daily stressors, excessive use of drugs (e.g., alcohol, prescribed medications or illicit drugs) to control panic attacks, or extreme behaviors aimed at controlling panic attacks (e.g., severe restrictions on food intake or avoidance of specific foods or medications because of concerns about physical symptoms that provoke panic attacks). Prevalence In the general population, the 12-month prevalence estimate for panic disorder across the United States and several European countries is about 2%–3% in adults and adolescents. The global lifetime prevalence is estimated at 1.7%, with a 2.7% projected lifetime risk in the World Mental Health Surveys. In the United States, significantly lower prevalence estimates of panic disorder are reported among Latinx, African Americans, Caribbean Blacks, and Asian Americans, compared with non-Latinx Whites. Prevalence estimates of panic disorder in American Indians range from 2.6% to 4.1%. Lower estimates have been reported for Asian, African, and Latin American countries, ranging from 0.1% to 0.8%. Women are more frequently affected than men, at a rate of approximately 2:1. The gender differentiation occurs in adolescence and is already observable before age 14 years. Although panic attacks occur in children, the overall prevalence of panic disorder is low before age 14 years (<0.4%). The rates of panic disorder show a gradual increase during adolescence and possibly following the onset of puberty, and peak during adulthood. The prevalence declines in older individuals (i.e., 1.2% in adults older than age 55, 0.7% in adults older than age 64), possibly reflecting diminishing severity to subclinical levels. Development and Course The median age at onset for panic disorder in the United States is 20–24 years, and crossnationally is 32 years. The mean age at onset is 34.7 years. A small number of cases begin in childhood, and onset after age 55 years is unusual but can occur. The usual course, if the disorder is untreated, is chronic but waxing and waning. Some individuals

may have episodic outbreaks with years of remission in between, and others may have continuous severe symptomatology. According to a longitudinal study in the Netherlands, about one-quarter of the individuals with panic disorder experienced recurrence of symptoms within the initial 2-year follow-up period. Only a minority of individuals have full remission without subsequent relapse within a few years. The course of panic disorder typically is complicated by a range of other disorders, in

Temperamental. Environmental. particular other anxiety disorders, depressive disorders, and substance use disorders (see section “Comorbidity” for this disorder). African American adults have been reported to have a more chronic course of panic disorder compared with non-Latinx White adults, possibly because of the enduring impact of racism and discrimination, stigma due to mental illness, and limited access to adequate care. Although panic disorder is very rare in childhood, first occurrence of “fearful spells” is often dated retrospectively back to childhood. As in adults, panic disorder in adolescents tends to have a chronic course and is frequently comorbid with other anxiety, depressive, and bipolar disorders. To date, no differences in the clinical presentation between adolescents and adults have been found. However, adolescents may be less worried about additional panic attacks than are young adults. Lower prevalence of panic disorder in older adults appears to be attributable to age-related “dampening” of the autonomic nervous system response. Many older individuals with “panicky feelings” are observed to have a “hybrid” of limited-symptom panic attacks and generalized anxiety. Also, older adults tend to attribute their panic attacks to certain stressful situations, such as a medical procedure or social setting. Older individuals may retrospectively endorse explanations for the panic attack (which would preclude the diagnosis of panic disorder), even if an attack might actually have been unexpected in the moment (and thus qualify as the basis for a panic disorder diagnosis). This may result in under-endorsement of unexpected panic attacks in older individuals. Thus, careful questioning of older adults is required to assess whether panic attacks were expected before entering the situation, so that unexpected panic attacks and the diagnosis of panic disorder are not overlooked. While the low rate of panic disorder in children could relate to difficulties in symptom reporting, this seems unlikely given that children are capable of reporting intense fear or panic in relation to separation and to phobic objects or phobic situations. Adolescents might be less willing than adults to openly discuss panic attacks. Therefore, clinicians should be aware that unexpected panic attacks do occur in adolescents, much as they do in adults, and be attuned to this possibility when encountering adolescents presenting with episodes of intense fear or distress. Risk and Prognostic Factors Negative affectivity (neuroticism) (i.e., proneness to experiencing negative emotions), anxiety sensitivity (i.e., the disposition to believe that symptoms of anxiety are harmful), behavioral inhibition, and harm avoidance are risk factors for the onset of panic attacks and panic disorder. History of “fearful spells” (i.e., limited-symptom attacks that do not meet full criteria for a panic attack) may be a risk factor for later panic attacks and panic disorder, particularly when the first panic experience is appraised as negative. Although separation anxiety in childhood, especially when severe, may precede the later development of panic disorder, it is not a consistent risk factor. Most individuals report identifiable stressors in the months before their first panic attack (e.g., interpersonal stressors and stressors related to physical well-being, such as negative experiences with illicit or prescription drugs, disease, or death in the family).

Genetic and physiological. Furthermore, more chronic life stress is associated with greater panic disorder severity. Between 10% and 60% of individuals with panic disorder endorse a history of

trauma, and stressful life experiences and childhood adversities are associated with more severe panic pathology. Parental overprotection and low emotional warmth are also risk factors for panic disorder. Individuals with few economic resources are more likely to have symptoms that meet criteria for panic disorder. Smoking is a risk factor for panic attacks and panic disorder. Multiple genes likely confer vulnerability to panic disorder; however, the exact genes, gene products, or functions related to the genetic regions implicated remain unknown. There is an increased risk for panic disorder among offspring of parents with anxiety, depressive, and bipolar disorders. Individuals with panic disorder display particularly enhanced sensitivity to respiratory stimulation using CO2-enriched air. Respiratory disturbance, such as asthma, may be associated with panic disorder, in terms of past history, comorbidity, and family history. Culture-Related Diagnostic Issues The rate of fears about mental and somatic symptoms of anxiety appears to vary across cultural contexts and may influence the rate of panic attacks and panic disorder. Also, cultural expectations may influence the classification of panic attacks as expected or unexpected. For example, a Vietnamese individual who has a panic attack after walking out into a windy environment (trúng gió; “hit by the wind”) may attribute the panic attack to exposure to wind as a result of the cultural syndrome that links these two experiences, resulting in classification of the panic attack as expected. Various other cultural concepts of distress are associated with panic disorder, including ataque de nervios (“attack of nerves”) among Latin Americans and khyâl attacks and “soul loss” among Cambodians. Ataque de nervios may involve trembling, uncontrollable screaming or crying, aggressive or suicidal behavior, and depersonalization or derealization, which may be experienced longer than the few minutes typical of panic attacks. Some clinical presentations of ataque de nervios fulfill criteria for conditions other than panic attack (e.g., functional neurological symptom disorder). These concepts of distress have an impact on the symptoms and frequency of panic disorder, including the individual’s attribution of unexpectedness, as cultural concepts of distress may create fear of certain situations, ranging from interpersonal arguments (associated with ataque de nervios), to types of exertion (associated with khyâl attacks), to atmospheric wind (associated with trúng gió attacks). Clarification of the details of cultural attributions may aid in distinguishing expected and unexpected panic attacks. For more information regarding cultural concepts of distress, refer to the “Culture and Psychiatric Diagnosis” chapter in Section III. The specific worries about panic attacks or their consequences are likely to vary across ethnoracial groups and cultural contexts (and across different age groups and gender). Among Asian Americans, Hispanic Americans, and African Americans in the United States, panic disorder is associated with reports of ethnic discrimination and racism, after the effect of demographic factors is taken into account. For panic disorder, U.S. community samples of nonLatinx Whites have significantly less functional impairment than African Americans. There are also higher rates of objectively defined severity in non-Latinx Caribbean Blacks with panic disorder, and lower reported rates of panic disorder overall in both African Americans and Caribbean Blacks, suggesting that among U.S. community samples of African descent, panic

disorder criteria may be endorsed only when there is substantial severity and impairment. The rate of mental health service use for panic disorder varies across ethnoracial groups. Sex- and Gender-Related Diagnostic Issues The rate of panic disorder is nearly twofold higher in women compared with men. Relapse from panic disorder also occurs more frequently in adult women compared with men, suggesting that women have a more unstable illness course. Gender differences in clinical course are also found among adolescents. Panic disorder has a larger impact on health-related quality of life in women than in men, which may be attributable to greater anxiety sensitivity

among some women or greater comorbidity with agoraphobia and depression. There is some evidence for sexual dimorphism, with high expression of MAOA-uVNTR alleles potentially acting as a female-specific risk factor for panic disorder. Diagnostic Markers Individuals with panic disorder exhibit an attentional bias to threatening stimuli. Panic attacks may be provoked by agents with disparate mechanisms of action, such as sodium lactate, caffeine, isoproterenol, yohimbine, CO_2, and cholecystokinin, to a much greater extent in individuals with panic disorder than in those without it. There is considerable interest in the relationship between panic disorder and sensitivity to these panic-provoking agents. While none of the data suggest diagnostic utility, data for sensitivity to respiratory stimulation reflect some level of specificity for panic disorder and related conditions, such as separation anxiety disorder. Chronically higher baseline hyperventilation and rate of sighing may occur among individuals with panic disorder. However, none of these laboratory findings are considered diagnostic of panic disorder. Association With Suicidal Thoughts or Behavior Panic attacks and a diagnosis of panic disorder in the past 12 months are related to a higher rate of suicidal behavior and suicidal thoughts in the past 12 months even when comorbidity and a history of childhood abuse and other suicide risk factors are taken into account. Approximately 25% of primary care patients with panic disorder report suicidal thoughts. Panic disorder may increase risk for future suicidal behaviors but not deaths. Epidemiological survey data of panic attack symptoms show that the cognitive symptoms of panic (e.g., derealization) may be associated with suicidal thoughts, whereas physical symptoms (e.g., dizziness, nausea) may be associated with suicidal behaviors. Functional Consequences of Panic Disorder Panic disorder is associated with high levels of social, occupational, and physical disability; considerable economic costs; and the highest number of medical visits among the anxiety disorders, although the effects are strongest with the presence of agoraphobia. Individuals with panic disorder may be frequently absent from work or school for doctor and emergency room

Only limited-symptom panic attacks. Anxiety disorder due to another medical condition. Substance/medication-induced anxiety disorder. Other mental disorders with panic attacks as an associated feature (e.g., other anxiety disorders and psychotic disorders). visits, which can lead to unemployment or dropping out of school. In older adults, impairment may be seen in caregiving duties or volunteer activities, and panic disorder is related to lower health-related quality of life and greater receipt of emergency department services. Full-symptom panic attacks typically are associated with greater morbidity (e.g., greater health care utilization, more disability, poorer quality of life) than limited-symptom attacks. Differential Diagnosis Panic disorder should not be diagnosed if full-symptom (unexpected) panic attacks have never been experienced. In the case of only limited-symptom unexpected panic attacks, an other specified anxiety disorder or unspecified anxiety disorder diagnosis should be considered. Panic disorder is not diagnosed if the panic attacks are judged to be a direct physiological consequence of another medical condition. Examples of medical conditions that can cause panic attacks include hyperthyroidism, hyperparathyroidism, pheochromocytoma, vestibular dysfunctions, seizure disorders, and cardiopulmonary conditions (e.g., arrhythmias, supraventricular tachycardia, asthma, chronic obstructive pulmonary disease [COPD]). Appropriate laboratory tests (e.g., serum calcium levels for hyperparathyroidism; Holter monitor for arrhythmias) or physical examinations (e.g., for cardiac conditions) may be helpful in determining the etiological role of another medical condition. Features such as onset after age 45 years or the presence of atypical symptoms during a panic attack (e.g., vertigo, loss of consciousness, loss of bladder or bowel control, slurred speech, amnesia) suggest the possibility that another medical condition or a substance may be causing the

panic attack symptoms. Panic disorder is not diagnosed if the panic attacks are judged to be a direct physiological consequence of a substance. Intoxication with central nervous system stimulants (e.g., cocaine, amphetamine-type substances, caffeine) or cannabis and withdrawal from central nervous system depressants (e.g., alcohol, barbiturates) can precipitate a panic attack. However, if panic attacks continue to occur outside of the context of substance use (e.g., long after the effects of intoxication or withdrawal have ended), a diagnosis of panic disorder should be considered. In addition, because panic disorder may precede substance use in some individuals and may be associated with increased substance use, especially for purposes of selfmedication, a detailed history should be taken to determine if the individual had panic attacks prior to excessive substance use. If this is the case, a diagnosis of panic disorder should be considered in addition to a diagnosis of substance use disorder. Features such as onset after age 45 years or the presence of atypical symptoms during a panic attack (e.g., vertigo, loss of consciousness, loss of bladder or bowel control, slurred speech, amnesia) suggest the possibility that another medical condition or a substance may be causing the panic attack symptoms. Panic attacks that occur as a symptom of other anxiety disorders are expected (e.g., triggered by

social situations in social anxiety disorder, by phobic objects or situations in specific phobia or agoraphobia, by worry in generalized anxiety disorder, by separation from home or attachment figures in separation anxiety disorder) and thus would not meet criteria for panic disorder. (Note: Sometimes an unexpected panic attack is associated with the onset of another anxiety disorder, but then the attacks become expected, whereas panic disorder is characterized by recurrent unexpected panic attacks.) If the panic attacks occur only in response to specific triggers, then only the relevant anxiety disorder is assigned. However, if the individual experiences unexpected panic attacks as well and shows persistent concern and worry or behavioral change because of the attacks, then an additional diagnosis of panic disorder should be considered. Comorbidity Panic disorder infrequently occurs in clinical settings in the absence of other psychopathology. In the general population, 80% of individuals with panic disorder had a lifetime comorbid mental diagnosis. The prevalence of panic disorder is elevated in individuals with other disorders, particularly other anxiety disorders (and especially agoraphobia), major depressive disorder, bipolar I and bipolar II disorder, and possibly mild alcohol use disorder. While panic disorder occasionally has an earlier age at onset than the comorbid disorder(s), onset often occurs after the comorbid disorder and may be seen as a severity marker of the comorbid illness. Reported lifetime rates of comorbidity between major depressive disorder and panic disorder vary widely, ranging from 10% to 65% in individuals with panic disorder. In approximately onethird of individuals with both disorders, the depression precedes the onset of panic disorder. In the remaining two-thirds, depression occurs coincident with or following the onset of panic disorder. A subset of individuals with panic disorder develop a substance-related disorder, which for some represents an attempt to treat their anxiety with alcohol or medications. Comorbidity with other anxiety disorders and illness anxiety disorder is also common. Panic disorder is significantly comorbid with numerous general medical symptoms and conditions, including, but not limited to, dizziness, cardiac arrhythmias, hyperthyroidism, asthma, COPD, and irritable bowel syndrome. However, the nature of the association (e.g., cause and effect) between panic disorder and these conditions remains unclear. Although mitral valve prolapse and thyroid disease are more common among individuals with panic disorder than in the general population, the increases in prevalence are not consistent. Panic Attack Specifier Note: Symptoms are presented for the purpose of identifying a panic attack; however, panic attack is not a mental disorder and cannot be coded. Panic attacks can occur in the

context of any anxiety disorder as well as other mental disorders (e.g., depressive disorders, posttraumatic stress disorder, substance use disorders) and some medical conditions (e.g., cardiac, respiratory, vestibular, gastrointestinal). When the presence of a panic attack is identified, it should be noted as a specifier

(e.g., “posttraumatic stress disorder with panic attacks”). For panic disorder, the presence of panic attack is contained within the criteria for the disorder and panic attack is not used as a specifier. An abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur: Note: The abrupt surge can occur from a calm state or an anxious state. 1.

1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort.
7. Nausea or abdominal distress.
8. Feeling dizzy, unsteady, light-headed, or faint.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or “going crazy.”
13. Fear of dying. Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms. Features The essential feature of a panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes and during which time 4 or more of 13 physical and cognitive symptoms occur. Eleven of these 13 symptoms are physical (e.g., palpitations, sweating), while 2 are cognitive (i.e., fear of losing control or going crazy, fear of dying). “Fear of going crazy” is a colloquialism often used by individuals with panic attacks and is not intended as a pejorative or diagnostic term. The term within minutes means that the time to peak intensity is literally only a few minutes. A panic attack can arise from either a calm state or an anxious state, and time to peak intensity should be assessed independently of any preceding anxiety. That is, the start of the panic attack is the point at which there is an abrupt increase in discomfort rather than the point at which anxiety first developed. Likewise, a panic attack can return to either an anxious state or a calm state and possibly peak again. A panic attack is distinguished from ongoing anxiety by its time to peak intensity, which occurs within minutes; its discrete nature; and its typically greater severity. Attacks that meet all other criteria but have fewer than four physical and/or cognitive symptoms are referred to as limited-symptom attacks.

There are two characteristic types of panic attacks: expected and unexpected. Expected panic attacks are attacks for which there is an obvious cue or trigger, such as situations in which panic attacks have typically occurred. Unexpected panic attacks are those for which there is no obvious cue or trigger at the time of occurrence (e.g., when relaxing or out of sleep [nocturnal panic

attack]). The determination of whether panic attacks are expected or unexpected is made by the clinician, who makes this judgment based on a combination of careful questioning as to the sequence of events preceding or leading up to the attack and the individual's own judgment of whether the attack seemed to occur for no apparent reason. Panic attacks can occur in the context of any mental disorder (e.g., anxiety disorders, depressive disorders, bipolar disorders, eating disorders, obsessive-compulsive and related disorders, personality disorders, psychotic disorders, substance use disorders) and some medical conditions (e.g., cardiac, respiratory, vestibular, gastrointestinal), with the majority of presentations never meeting criteria for panic disorder. Recurrent unexpected panic attacks are required for a diagnosis of panic disorder. Associated Features One type of unexpected panic attack is a nocturnal panic attack (i.e., waking from sleep in a state of panic), which differs from panicking after fully waking from sleep. Prevalence In the general population, 12-month prevalence estimates for panic attacks in Spain and in the United States range from 9.5% to 11.2% in adults. Twelve-month prevalence estimates do not appear to differ significantly among African Americans, Asian Americans, and Latinx. Approximately 8.5% of American Indians report a lifetime history of panic attacks. Lifetime prevalence rates of panic attacks cross-nationally are 13.2%. Women are more frequently affected than men, although this gender difference is more pronounced for panic disorder. Panic attacks can occur in children but are relatively rare until the age of puberty, when the prevalence rates increase. The prevalence declines in older individuals, possibly reflecting diminishing severity to subclinical levels. Development and Course The mean age at onset for panic attacks in the United States is approximately 22–23 years among adults. However, the course of panic attacks is likely influenced by the course of any cooccurring mental disorder(s) and stressful life events. Panic attacks are uncommon, and unexpected panic attacks are rare, in preadolescent children. Adolescents might be less willing than adults to openly discuss panic attacks, even though they present with episodes of intense fear or discomfort. Lower prevalence of panic attacks in older individuals may be related to a weaker autonomic response to emotional states relative to younger individuals. Older individuals may be less inclined to use the word "fear" and more inclined to use the word "discomfort" to describe panic attacks. Older individuals with "panicky feelings" may have a hybrid of limitedsymptom attacks and generalized anxiety. In addition, older individuals tend to attribute panic attacks to certain situations that are stressful (e.g., medical procedures, social settings) and may retrospectively endorse explanations for the panic attack even if it was unexpected in the moment. This may result in under-endorsement of unexpected panic attacks in older individuals.

Temperamental. Environmental. Genetic and physiological. Risk and Prognostic Factors Negative affectivity (neuroticism) (i.e., proneness to experiencing negative emotions), anxiety sensitivity (i.e., the disposition to believe that symptoms of anxiety are harmful), behavioral inhibition, and harm avoidance are risk factors for the onset of panic attacks. History of "fearful spells" (i.e., limited-symptom attacks that do not meet full criteria for a panic attack) may be a risk factor for later panic attacks. Smoking is a risk factor for panic attacks. Most individuals report identifiable stressors in the months before their first panic attack (e.g., interpersonal stressors and stressors related to physical well-being, such as negative experiences with illicit or prescription drugs, disease, or death in the family). Separation from parents, overprotective parenting, and parental rejection are risk factors for panic attacks. Individuals with chronic obstructive pulmonary disease who report low perceptions of control over the disease and negative beliefs about the consequences of unpredictable breathless attacks are more likely to have panic symptoms. Culture-Related Diagnostic Issues Cultural interpretations may influence the determination of panic

attacks as expected or unexpected. Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, and uncontrollable screaming or crying) may be seen; however, such symptoms should not count as one of the four required symptoms. Frequency of each of the 13 symptoms varies crossculturally (e.g., higher rates of paresthesias in African Americans, of dizziness in several Asian groups, and of trembling in non-Latinx Whites). Cultural concepts of distress also influence the cross-cultural presentation of panic attacks, resulting in different symptom profiles across different cultural groups. Examples include khyâl (wind) attacks, a Cambodian cultural syndrome involving dizziness, tinnitus, and neck soreness; and trúng gió (wind-related) attacks, a Vietnamese cultural syndrome associated with headaches. Cultural explanatory models can heighten the salience of specific panic symptoms. For example, traditional Cambodian views about the abnormal circulation of khyâl in the body are associated with the perceived dangerousness of some symptoms (e.g., neck soreness), which can trigger catastrophic cognitions and panic attacks. Ataque de nervios (attack of nerves) is a cultural syndrome among Latin Americans that may involve trembling, uncontrollable screaming or crying, aggressive or suicidal behavior, and depersonalization or derealization, and which may be experienced for longer than only a few minutes. Some clinical presentations of ataque de nervios fulfill criteria for conditions other than panic attack (e.g., other specified dissociative disorder). Also, cultural expectations may influence the classification of panic attacks as expected or unexpected, as cultural syndromes may create fear of certain situations, ranging from interpersonal arguments (associated with ataque de nervios), to types of exertion (associated with khyâl attacks), to atmospheric wind (associated with trúng gió attacks). Clarification of the details of cultural attributions may aid in distinguishing expected and unexpected panic attacks. For more information about cultural concepts of distress, see the “Culture and Psychiatric Diagnosis” chapter in Section III.

Other paroxysmal episodes (e.g., “anger attacks”). Anxiety disorder due to another medical condition. Sex- and Gender-Related Diagnostic Issues Panic attacks are more common in women than in men. Among those who report panic attacks, women are more likely to endorse symptoms of shortness of breath and nausea but less likely to endorse sweating than are men. Diagnostic Markers Physiological recordings of naturally occurring panic attacks in individuals with panic disorder indicate abrupt surges of arousal, usually of heart rate, that reach a peak within minutes and subside within minutes, and for a proportion of these individuals the panic attack may be preceded by cardiorespiratory instabilities. Panic attacks are characterized by heart rate and tidal volume increases and a drop in pCO2. Association With Suicidal Thoughts or Behavior Panic attacks are related to a higher rate of suicide attempts and suicidal thoughts even when comorbidity and other suicide risk factors are taken into account. Functional Consequences of Panic Attacks In the context of co-occurring mental disorders, including anxiety disorders, depressive disorders, bipolar disorder, substance use disorders, psychotic disorders, and personality disorders, panic attacks are associated with increased symptom severity, higher rates of comorbidity, and poorer treatment response. Recurrent panic attacks in particular are associated with increased odds of many mental health diagnoses. Furthermore, more severe panic attacks are associated with a greater likelihood of developing panic disorder and a variety of other mental health conditions, as well as greater persistence of mental illness and impaired functioning. Also, full-symptom panic attacks typically are associated with greater morbidity (e.g., greater health care utilization, more disability, poorer quality of life) than limited-symptom attacks. Differential Diagnosis Panic attacks should not be diagnosed if the episodes do not involve the essential feature of an abrupt surge of intense fear or intense discomfort, but rather other emotional states (e.g., anger, grief). Medical conditions that

can cause or be misdiagnosed as panic attacks include hyperthyroidism, hyperparathyroidism, pheochromocytoma, vestibular dysfunctions, seizure disorders, and cardiopulmonary conditions (e.g., arrhythmias, supraventricular tachycardia, asthma, chronic obstructive pulmonary disease). Appropriate laboratory tests (e.g., serum calcium levels for hyperparathyroidism; Holter monitor for arrhythmias) or physical examinations (e.g., for cardiac conditions) may be helpful in determining the etiological role of another medical condition.

Substance/medication-induced anxiety disorder. Panic disorder. F40.00 Intoxication with central nervous system stimulants (e.g., cocaine, amphetamine-type substances, caffeine) or cannabis and withdrawal from central nervous system depressants (e.g., alcohol, barbiturates) can precipitate a panic attack. A detailed history should be taken to determine if the individual had panic attacks prior to excessive substance use. Features such as onset after age 45 years or the presence of atypical symptoms during a panic attack (e.g., vertigo, loss of consciousness, loss of bladder or bowel control, slurred speech, or amnesia) suggest the possibility that a medical condition or a substance may be causing the panic attack symptoms. Repeated unexpected panic attacks are required but are not sufficient for the diagnosis of panic disorder (i.e., full diagnostic criteria for panic disorder must be met). Comorbidity Panic attacks are associated with increased likelihood of various comorbid mental disorders, including anxiety disorders, depressive disorders, bipolar disorders, impulse-control disorders, and substance use disorders. Panic attacks are associated with increased likelihood of later developing anxiety disorders, depressive disorders, bipolar disorders, alcohol use disorder, and possibly other disorders. Agoraphobia Diagnostic Criteria A. Marked fear or anxiety about two (or more) of the following five situations:

1. Using public transportation (e.g., automobiles, buses, trains, ships, planes).
2. Being in open spaces (e.g., parking lots, marketplaces, bridges).
3. Being in enclosed places (e.g., shops, theaters, cinemas).
4. Standing in line or being in a crowd.
5. Being outside of the home alone. B. The individual fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing paniclike symptoms or other incapacitating or embarrassing symptoms (e.g., fear of falling in the elderly; fear of incontinence). C. The agoraphobic situations almost always provoke fear or anxiety. D. The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety. E. The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context. F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or

more. G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. H. If another medical condition (e.g., inflammatory bowel disease, Parkinson’s disease) is present, the fear, anxiety, or avoidance is clearly excessive. I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder—for example, the symptoms are not confined to specific phobia, situational type; do not involve only social situations (as in social anxiety disorder); and are not related exclusively to obsessions (as in obsessivecompulsive disorder), perceived defects or flaws in physical appearance (as in body dysmorphic disorder), reminders of traumatic events (as in posttraumatic stress disorder), or fear of separation (as in separation anxiety disorder). Note:

Agoraphobia is diagnosed irrespective of the presence of panic disorder. If an individual's presentation meets criteria for panic disorder and agoraphobia, both diagnoses should be assigned. Diagnostic Features The essential feature of agoraphobia is marked fear or anxiety triggered by the real or anticipated exposure to a wide range of situations (Criterion A). The diagnosis requires endorsement of symptoms occurring in at least two of the following five situations: 1) using public transportation, such as automobiles, buses, trains, ships, or planes; 2) being in open spaces, such as parking lots, marketplaces, or bridges; 3) being in enclosed spaces, such as shops, theaters, or cinemas; 4) standing in line or being in a crowd; or 5) being outside of the home alone. The examples for each situation are not exhaustive; other situations may be feared. When experiencing fear and anxiety cued by such situations, individuals typically experience thoughts that something terrible might happen (Criterion B). Individuals frequently believe that escape from such situations might be difficult (e.g., "can't get out of here") or that help might be unavailable (e.g., "there is nobody to help me") when panic-like symptoms or other incapacitating or embarrassing symptoms occur. "Panic-like symptoms" refer to any of the 13 symptoms included in the criteria for panic attack, such as dizziness, faintness, and fear of dying. "Other incapacitating or embarrassing symptoms" include symptoms such as vomiting and inflammatory bowel symptoms, as well as, in older adults, a fear of falling or, in children, a sense of disorientation and getting lost. The amount of fear experienced may vary with proximity to the feared situation and may occur in anticipation of or in the actual presence of the agoraphobic situation. Also, the fear or anxiety may take the form of a full- or limited-symptom panic attack (i.e., an expected panic attack). Fear or anxiety is evoked nearly every time the individual comes into contact with the feared situation (Criterion C). Thus, an individual who becomes anxious only occasionally in an agoraphobic situation (e.g., becomes anxious when standing in line on only one out of every five occasions) would not be diagnosed with agoraphobia. The individual actively avoids the

situation, requires the presence of a companion, or, if he or she either is unable or decides not to avoid it, the situation evokes intense fear or anxiety (Criterion D). Active avoidance means the individual is currently behaving in ways that are intentionally designed to prevent or minimize contact with agoraphobic situations. Avoidance can be behavioral (e.g., changing daily routines, choosing a job nearby to avoid using public transportation, arranging for food delivery to avoid entering shops and supermarkets) as well as cognitive (e.g., using distraction to get through agoraphobic situations) in nature. The avoidance can become so severe that the individual is completely homebound. Often, an individual is better able to confront a feared situation when accompanied by a companion, such as a partner, friend, or health professional. Also, the individual may employ safety behaviors (e.g., sitting near exits when taking public transportation or at the movies) to better endure such situations. The fear, anxiety, or avoidance must be out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context (Criterion E). Differentiating disproportionate, clinically significant agoraphobic fears from reasonable fears (e.g., not wanting to leave the house during a bad storm) or from situations that are deemed dangerous (e.g., walking in a parking lot or using public transportation in a high-crime area) is important for a number of reasons. First, what constitutes avoidance may be difficult to judge across cultures and sociocultural contexts (e.g., it is socioculturally appropriate for orthodox Muslim women in certain parts of the world to avoid leaving the house alone, and thus such avoidance would not be considered indicative of agoraphobia). Second, older adults are likely to overattribute their fears to age-related constraints and are less likely to judge their fears as being out of proportion to the actual risk. Third, individuals with agoraphobia are likely to overestimate danger

in relation to panic-like or other bodily symptoms. Agoraphobia should be diagnosed only if the fear, anxiety, or avoidance is persistent (Criterion F) and if it causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion G). The duration of “typically lasting for 6 months or more” is meant to exclude individuals with shortlived, transient problems. Associated Features In its most severe forms, agoraphobia can cause individuals to become completely homebound, unable to leave their home and dependent on others for services or assistance to provide even for basic needs. Demoralization and depressive symptoms, as well as abuse of alcohol and sedative medication as inappropriate self-medication strategies, are common. Prevalence Every year approximately 1%–1.7% of adolescents and adults worldwide have symptoms that meet diagnostic criteria for agoraphobia. Women are twice as likely as men to experience agoraphobia. Agoraphobia may occur in childhood, but incidence peaks in late adolescence and early adulthood. Studies have shown the 12-month prevalence in individuals living in the United States who are older than 65 years is 0.4% and 0.5% among individuals in Europe and North America older than 55 years. Approximately 0.2%–0.8% of

Temperamental. the adult population in various countries has a past 12-month diagnosis of agoraphobia without panic disorder. Development and Course The percentage of individuals with agoraphobia reporting panic attacks or panic disorder preceding the onset of agoraphobia ranges from 30% in community samples to more than 50% in clinical samples. In two-thirds of all cases of agoraphobia, initial onset is before age 35 years, with 21 years the mean age at onset, although age at onset of agoraphobia without preceding panic attacks or panic disorder is 25–29 years. First onset in childhood is rare. There is a substantial incidence risk in adolescence and early adulthood, with indications for a second high incidence risk phase after age 40 years. Approximately 10% of older adults with agoraphobia reported their first episode of agoraphobia occurring after age 65. The course of agoraphobia is typically persistent and chronic. Complete remission is rare (10%), unless the agoraphobia is treated. Individuals with comorbid panic disorder and agoraphobia are more likely to experience recurrence of symptoms after a period of remission if they had an earlier age at onset (< 20 years old). With more severe agoraphobia, rates of full remission decrease, whereas rates of relapse and chronicity increase. Approximately 36% of individuals with agoraphobia who achieve remission eventually experience relapse. A range of other disorders, in particular other anxiety disorders, depressive disorders, substance use disorders, and personality disorders, may complicate the course of agoraphobia. The long-term course and outcome of agoraphobia are associated with substantially elevated risk of secondary major depressive disorder, persistent depressive disorder, and substance use disorders. The clinical features of agoraphobia are relatively consistent across the life span, although the type of agoraphobic situations triggering fear, anxiety, or avoidance, as well as the type of cognitions, may vary. For example, in children, being outside of the home alone is the most frequent situation feared, whereas in older adults, being in shops, standing in line, and being in open spaces are most often feared. Also, cognitions often pertain to becoming lost (in children), to experiencing panic-like symptoms (in adults), to falling (in older adults). The apparent low prevalence of agoraphobia in children could reflect difficulties in symptom reporting, and thus assessments in young children may require solicitation of information from multiple sources, including parents or teachers. Adolescents, particularly boys, may be less willing than adults to openly discuss agoraphobic fears and avoidance; however, agoraphobia can occur before adulthood and should be assessed in children and adolescents. In older adults, comorbid somatic symptom disorder, having medical complications, and motor disturbances (e.g., a sense of falling) are frequently mentioned by

individuals as the reason for their fear and avoidance. In these instances, care is to be taken in evaluating whether the fear and avoidance are out of proportion to the real danger involved. Risk and Prognostic Factors Behavioral inhibition, negative affectivity (neuroticism), anxiety sensitivity, and trait anxiety are closely associated with agoraphobia but are relevant to most anxiety disorders (specific phobia, social anxiety disorder, panic disorder, generalized anxiety disorder). Anxiety sensitivity (the disposition to believe that symptoms of anxiety are harmful) is also characteristic

Environmental. Genetic and physiological. Specific phobia, situational type. of individuals with agoraphobia. Negative events in childhood (e.g., separation, death of parent) and other stressful events, such as being attacked or mugged, are associated with the onset of agoraphobia. Furthermore, individuals with agoraphobia describe the family climate and child-rearing behavior as being characterized by reduced warmth and increased overprotection. Heritability for agoraphobia is 61%. Of the various phobias, agoraphobia has the strongest and most specific association with the genetic factor that represents proneness to phobias. Family history of anxiety disorders is associated with an earlier age at onset of agoraphobia (< 27 years old), and family history of panic disorder in particular is associated with agoraphobia. Sex- and Gender-Related Diagnostic Issues Women have different patterns of comorbid disorders than men. Consistent with gender differences in the prevalence of mental disorders, men have higher rates of comorbid substance use disorders. Association With Suicidal Thoughts or Behavior Approximately 15% of individuals with agoraphobia report suicidal thoughts or behavior. For individuals with panic disorder, symptoms of agoraphobia may be a risk factor for suicidal thoughts. Functional Consequences of Agoraphobia Like most other anxiety disorders, agoraphobia is associated with considerable impairment and disability in terms of role functioning, work productivity, and disability days. Agoraphobia severity is a strong determinant of the degree of disability, irrespective of the presence of comorbid panic disorder, panic attacks, and other comorbid conditions. Individuals with agoraphobia can be completely homebound or unable to work. Individuals with panic disorder with agoraphobia who have an early course of onset (< age 20 years) are less likely to be married. Differential Diagnosis Differentiating agoraphobia from situational specific phobia can be challenging in some cases, because these conditions share several symptom characteristics and criteria. Specific phobia, situational type, should be diagnosed versus agoraphobia if the fear, anxiety, or avoidance is limited to one of the agoraphobic situations. Requiring fears from two or more of the agoraphobic situations is a robust means for differentiating agoraphobia from specific phobias, particularly the situational subtype. Additional differentiating features include the content of the individual’s cognitions. Thus, if the situation is feared for reasons other than panic-like symptoms or other incapacitating or embarrassing symptoms (e.g., fears of being directly harmed by the situation itself, such as fear of the plane crashing for individuals who fear

Separation anxiety disorder. Social anxiety disorder. Panic disorder. Acute stress disorder and posttraumatic stress disorder. Major depressive disorder. Avoidance related to other medical conditions. flying), then a diagnosis of specific phobia may be more appropriate. Separation anxiety disorder can be best differentiated from agoraphobia by examining the individual’s cognitions. In separation anxiety disorder, the thoughts are about detachment from significant others and the home environment (i.e., parents or other attachment figures), whereas in agoraphobia the focus is on panic-like symptoms or other incapacitating or embarrassing symptoms in the feared situations. Agoraphobia should be differentiated from social anxiety disorder based primarily on the

situational clusters that trigger fear, anxiety, or avoidance and the individual's cognitions. In social anxiety disorder, the focus is on fear of being negatively evaluated. When criteria for panic disorder are met, agoraphobia should not be diagnosed if the avoidance behaviors associated with the panic attacks do not extend to avoidance of two or more agoraphobic situations. Acute stress disorder and posttraumatic stress disorder (PTSD) can be differentiated from agoraphobia by examining whether the fear, anxiety, or avoidance is related only to situations that remind the individual of a traumatic event. If the fear, anxiety, or avoidance is restricted to trauma reminders, and if the avoidance behavior does not extend to two or more agoraphobic situations, then a diagnosis of agoraphobia is not warranted. In major depressive disorder, the individual may avoid leaving home because of apathy, loss of energy, low self-esteem, and anhedonia. If the avoidance is unrelated to fears of panic-like or other incapacitating or embarrassing symptoms, then agoraphobia should not be diagnosed. Individuals with certain medical conditions may avoid situations because of realistic concerns about being incapacitated (e.g., fainting in an individual with transient ischemic attacks) or being embarrassed (e.g., diarrhea in an individual with Crohn's disease). The diagnosis of agoraphobia should be given only when the fear or avoidance is clearly in excess of that usually associated with these medical conditions. Comorbidity About 90% of individuals with agoraphobia also have other mental disorders. The most frequent additional diagnoses are other anxiety disorders (e.g., specific phobias, panic disorder, social anxiety disorder), depressive disorders (major depressive disorder), PTSD, and alcohol use disorder. Whereas other anxiety disorders (e.g., separation anxiety disorder, specific phobias, panic disorder) frequently precede onset of agoraphobia, depressive disorders and substance use disorders typically occur secondary to agoraphobia. In some individuals, a substance use disorder precedes agoraphobia. Individuals with comorbid agoraphobia and major depressive disorder tend to have a more treatment-resistant course of agoraphobia relative to individuals with agoraphobia alone.

F41.1 Generalized Anxiety Disorder Diagnostic Criteria A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance). B. The individual finds it difficult to control the worry. C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months): Note: Only one item is required in children.

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep). D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism). F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder, contamination or other obsessions in obsessivecompulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in

posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder). Diagnostic Features The essential feature of generalized anxiety disorder is excessive anxiety and worry (apprehensive expectation) about a number of events or activities. The intensity, duration, or

frequency of the anxiety and worry is out of proportion to the actual likelihood or impact of the anticipated event. The individual finds it difficult to control the worry and to keep worrisome thoughts from interfering with attention to tasks at hand. Adults with generalized anxiety disorder often worry about everyday, routine life circumstances, such as possible job responsibilities, health and finances, the health of family members, misfortune to their children, or minor matters (e.g., doing household chores or being late for appointments). Children with generalized anxiety disorder tend to worry excessively about their competence or the quality of their performance. During the course of the disorder, the focus of worry may shift from one concern to another. Several features distinguish generalized anxiety disorder from nonpathological anxiety. First, the worries associated with generalized anxiety disorder are excessive and typically interfere significantly with psychosocial functioning, whereas the worries of everyday life are not excessive and are perceived as more manageable and may be put off when more pressing matters arise. Second, the worries associated with generalized anxiety disorder are more pervasive, pronounced, and distressing; have longer duration; and frequently occur without precipitants. The greater the range of life circumstances about which a person worries (e.g., finances, children’s safety, job performance), the more likely his or her symptoms are to meet criteria for generalized anxiety disorder. Third, everyday worries are much less likely to be accompanied by physical symptoms (e.g., restlessness or feeling keyed up or on edge). Individuals with generalized anxiety disorder report subjective distress as a result of constant worry and related impairment in social, occupational, or other important areas of functioning. The anxiety and worry are accompanied by at least three of the following additional symptoms: restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension, and disturbed sleep, although only one additional symptom is required in children. Associated Features Associated with muscle tension, there may be trembling, twitching, feeling shaky, and muscle aches or soreness. Many individuals with generalized anxiety disorder also experience somatic symptoms (e.g., sweating, nausea, diarrhea) and an exaggerated startle response. Symptoms of autonomic hyperarousal (e.g., accelerated heart rate, shortness of breath, dizziness) are less prominent in generalized anxiety disorder than in other anxiety disorders, such as panic disorder. Other conditions that may be associated with stress (e.g., irritable bowel syndrome, headaches) frequently accompany generalized anxiety disorder. Prevalence The 12-month prevalence of generalized anxiety disorder is 0.9% among adolescents and 2.9% among adults in the general community of the United States. The mean 12-month prevalence for the disorder around the world is 1.3%, with a range of 0.2% to 4.3%. The lifetime morbid risk in the United States is 9.0%. Women and adolescent girls are at least twice as likely as men and adolescent boys to experience generalized anxiety disorder. The 12-month

Temperamental. Environmental. prevalence in older adults including individuals age 75 years and older ranges from 2.8% to 3.1% in the United States, Israel, and European countries. Individuals of European descent tend to have symptoms that meet criteria for generalized anxiety disorder more

frequently than do individuals of Asian and African descent. Furthermore, individuals from high-income countries are more likely than individuals from low- and middleincome countries to report that they have experienced symptoms that meet criteria for generalized anxiety disorder in their lifetime. Development and Course Many individuals with generalized anxiety disorder report that they have felt anxious and nervous all their lives. The mean age at onset for generalized anxiety disorder in North America is 35 years, later than that for the other anxiety disorders; the disorder rarely occurs prior to adolescence. However, age at onset is spread over a very broad range and tends to be older in lower-income countries worldwide. The symptoms of excessive worry and anxiety may occur early in life but are then manifested as an anxious temperament. Generalized anxiety disorder symptoms tend to be chronic and wax and wane across the life span, fluctuating between syndromal and subsyndromal forms of the disorder. Course is more persistent in lower-income countries, but impairment tends to be higher in high-income countries. Rates of full remission are very low. The earlier in life individuals have symptoms that meet criteria for generalized anxiety disorder, the more comorbidity and impairment they tend to have. Younger adults experience greater severity of symptoms than do older adults. The clinical expression of generalized anxiety disorder is relatively consistent across the life span. The primary difference across age groups is in the content of the individual’s worry; thus, the content of an individual’s worry tends to be age appropriate. In children and adolescents with generalized anxiety disorder, the anxieties and worries often concern the quality of their performance or competence at school or in sporting events, even when their performance is not being evaluated by others. There may be excessive concerns about punctuality. They may also worry about catastrophic events, such as earthquakes or nuclear war. Children with the disorder may be overly conforming, perfectionistic, and unsure of themselves and may tend to redo tasks because of excessive dissatisfaction with less-than-perfect performance. They may be overzealous in seeking reassurance and approval and require excessive reassurance about their performance and other things they are worried about. In the elderly, the advent of chronic physical disease can be a potent issue for excessive worry. In the frail elderly, worries about safety—and especially about falling—may limit activities. Risk and Prognostic Factors Behavioral inhibition, negative affectivity (neuroticism), harm avoidance, reward dependence, and attentional bias to threat have been associated with generalized anxiety disorder. Childhood adversities and parenting practices (e.g., overprotection, overcontrol, reinforcement of avoidance) have been associated with generalized anxiety disorder.

Genetic and physiological. One-third of the risk of experiencing generalized anxiety disorder is genetic, and these genetic factors overlap with the risk of negative affectivity (neuroticism) and are shared with other anxiety and mood disorders, particularly major depressive disorder. Culture-Related Diagnostic Issues There is considerable cultural variation in the expression of generalized anxiety disorder. For example, in some cultural contexts, somatic symptoms predominate in the expression of the disorder, whereas in other cultural contexts cognitive symptoms tend to predominate. This difference may be more evident on initial presentation than subsequently, as more symptoms are reported over time. There is no information as to whether the propensity for excessive worrying is related to cultural background, although the topic being worried about can be culturally specific. It is important to consider the social and cultural context when evaluating whether worries about certain situations are excessive. In the United States, higher prevalence is associated with exposure to racism and ethnic discrimination and, for some ethnoracial groups, with being born in the United States. Sex- and Gender-Related Diagnostic Issues In clinical settings, generalized anxiety disorder is diagnosed somewhat more frequently in women than in men (about

55%–60% of those presenting with the disorder are women). In epidemiological studies, approximately two-thirds are women. Women and men who experience generalized anxiety disorder appear to have similar symptoms but demonstrate different patterns of comorbidity consistent with gender differences in the prevalence of disorders. In women, comorbidity is largely confined to the anxiety disorders and unipolar depression, whereas in men, comorbidity is more likely to extend to the substance use disorders as well. Association With Suicidal Thoughts or Behavior Generalized anxiety disorder is associated with increased suicidal thoughts and behavior, even after adjustment for comorbid disorders and stressful life events. Psychological autopsy studies show that generalized anxiety disorder is the most frequent anxiety disorder diagnosed in suicides. Both subthreshold and threshold generalized anxiety disorder occurring in the past year may be associated with suicidal thoughts. Functional Consequences of Generalized Anxiety Disorder Excessive worrying impairs the individual's capacity to do things quickly and efficiently, whether at home or at work. The worrying takes time and energy; the associated symptoms of muscle tension and feeling keyed up or on edge, tiredness, difficulty concentrating, and disturbed sleep contribute to the impairment. Importantly the excessive worrying may impair the ability of individuals with generalized anxiety disorder to encourage confidence in their children. Generalized anxiety disorder is associated with significant disability and distress that is independent of comorbid disorders, and most non-institutionalized adults with the disorder are moderately to seriously disabled. Generalized anxiety disorder accounts for 110 million

Anxiety disorder due to another medical condition. Substance/medication-induced anxiety disorder. Social anxiety disorder. Separation anxiety disorder. Panic disorder. Illness anxiety disorder and somatic symptom disorder. Obsessive-compulsive disorder. Posttraumatic stress disorder and adjustment disorders. disability days per annum in the U.S. population. Generalized anxiety disorder is also linked to decreased work performance, increased medical resource use, and increased risk for coronary morbidity. Differential Diagnosis The diagnosis of anxiety disorder due to another medical condition should be assigned if the individual's anxiety and worry are judged, based on history, laboratory findings, or physical examination, to be a physiological effect of another specific medical condition (e.g., pheochromocytoma, hyperthyroidism). A substance/medication-induced anxiety disorder is distinguished from generalized anxiety disorder by the fact that a substance or medication (e.g., a drug of abuse, exposure to a toxin) is judged to be etiologically related to the anxiety. For example, severe anxiety that occurs only in the context of heavy coffee consumption would be diagnosed as caffeine-induced anxiety disorder. Individuals with social anxiety disorder often have anticipatory anxiety that is focused on upcoming social situations in which they must perform or be evaluated by others, whereas individuals with generalized anxiety disorder worry, whether or not they are being evaluated. Individuals with separation anxiety disorder worry excessively only about separation from attachment figures, whereas individuals with generalized anxiety disorder may worry about separation but present other excessive worry concerns as well. Panic attacks that are triggered by worry in generalized anxiety disorder would not qualify for panic disorder. However, if the individual experiences unexpected panic attacks as well and shows persistent concern and worry or behavioral change because of the attacks, then an additional diagnosis of panic disorder should be considered. Individuals with generalized anxiety disorder worry about multiple events, situations, or activities, only one of which may involve their health. If the individual's only fear is his or her own illness, then illness anxiety disorder should be diagnosed. Worry focusing on somatic symptoms is characteristic for somatic symptom disorder. Several features distinguish the excessive worry of

generalized anxiety disorder from the obsessional thoughts of obsessive-compulsive disorder. In generalized anxiety disorder the focus of the worry is about forthcoming problems, and it is the excessiveness of the worry about future events that is abnormal. In obsessive-compulsive disorder, the obsessions are inappropriate ideas that take the form of intrusive and unwanted thoughts, urges, or images. Anxiety is invariably present in posttraumatic stress disorder. Generalized anxiety disorder is not diagnosed if the anxiety and worry are better explained by symptoms of posttraumatic stress disorder. Although anxiety may manifest in adjustment disorder, this residual category should be used only when the criteria are not met for any other mental disorder (including generalized anxiety disorder). Moreover, in

Depressive, bipolar, and psychotic disorders. adjustment disorders, the anxiety occurs in response to an identifiable stressor within 3 months of the onset of the stressor and does not persist for more than 6 months after the termination of the stressor or its consequences. Although generalized anxiety/worry is a common associated feature of depressive, bipolar, and psychotic disorders, generalized anxiety disorder may be diagnosed comorbidly if the anxiety/worry is sufficiently severe to warrant clinical attention. Comorbidity Individuals whose presentation meets criteria for generalized anxiety disorder are likely to have met, or currently meet, criteria for other anxiety and unipolar depressive disorders. The negative affectivity (neuroticism) or emotional liability that underpins this pattern of comorbidity is associated with temperamental antecedents and genetic and environmental risk factors shared between these disorders, although independent pathways are also possible. Comorbidity with substance use, conduct, psychotic, neurodevelopmental, and neurocognitive disorders is less common. Substance/Medication-Induced Anxiety Disorder Diagnostic Criteria A. Panic attacks or anxiety is predominant in the clinical picture. B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to or withdrawal from a medication.
2. The involved substance/medication is capable of producing the symptoms in Criterion A. C. The disturbance is not better explained by an anxiety disorder that is not substance/medication-induced. Such evidence of an independent anxiety disorder could include the following: The symptoms precede the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent nonsubstance/medication-induced anxiety disorder (e.g., a history of recurrent non-substance/medication-related episodes). D. The disturbance does not occur exclusively during the course of a delirium.

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Note: This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and they are sufficiently severe to warrant clinical attention. Coding note: The ICD-10-CM codes for the [specific substance/medication]-induced anxiety disorders are indicated in the table below. Note that the ICD-10-CM code depends on whether or not there is a comorbid substance use disorder present for the same class of substance. In any case, an additional separate diagnosis of a substance use disorder is not given. If a mild substance

use disorder is comorbid with the substance-induced anxiety disorder, the 4th position character is "1," and the clinician should record "mild [substance] use disorder" before the substanceinduced anxiety disorder (e.g., "mild cocaine use disorder with cocaine-induced anxiety disorder"). If a moderate or severe substance use disorder is comorbid with the substance-induced anxiety disorder, the 4th position character is "2," and the clinician should record "moderate [substance] use disorder" or "severe [substance] use disorder," depending on the severity of the comorbid substance use disorder. If there is no comorbid substance use disorder (e.g., after a one-time heavy use of the substance), then the 4th position character is "9," and the clinician should record only the substance-induced anxiety disorder. ICD-10-CM With mild use disorder With moderate or severe use disorder Without use disorder Alcohol F10.180 F10.280 F10.980 Caffeine NA NA F15.980 Cannabis F12.180 F12.280 F12.980 Phencyclidine F16.180 F16.280 F16.980 Other hallucinogen F16.180 F16.280 F16.980 Inhalant F18.180 F18.280 F18.980 Opioid F11.188 F11.288 F11.988 Sedative, hypnotic, or anxiolytic F13.180 F13.280 F13.980 Amphetamine-type substance (or other stimulant) F15.180 F15.280 F15.980 Cocaine F14.180 F14.280 F14.980 Other (or unknown) substance F19.180 F19.280 F19.980 Specify (see Table 1 in the chapter "Substance-Related and Addictive Disorders," which indicates whether "with onset during intoxication" and/or "with onset during withdrawal" applies to a given substance class; or specify "with onset after medication use"): With onset during intoxication: If criteria are met for intoxication with the

substance and the symptoms develop during intoxication. With onset during withdrawal: If criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, withdrawal. With onset after medication use: If symptoms developed at initiation of medication, with a change in use of medication, or during withdrawal of medication. Recording Procedures The name of the substance/medication-induced anxiety disorder begins with the specific substance (e.g., cocaine, salbutamol) that is presumed to be causing the anxiety symptoms. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class and presence or absence of a comorbid substance use disorder. For substances that do not fit into any of the classes (e.g., salbutamol), the code for "other (or unknown) substance" should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the same code should also be used. To record the name of the disorder, the comorbid substance use disorder (if any) is listed first, followed by "with substance/medication-induced anxiety disorder" (incorporating the name of the specific etiological substance/medication), followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal, with onset after medication use). For example, in the case of anxiety symptoms occurring during withdrawal in a man with a severe lorazepam use disorder, the diagnosis is F13.280 severe lorazepam use disorder with lorazepaminduced anxiety disorder, with onset during withdrawal. A separate diagnosis of the comorbid severe lorazepam use disorder is not given. If the substance-induced anxiety disorder occurs without a comorbid substance use disorder (e.g., after a one-time heavy use of the substance), no accompanying substance use disorder is noted (e.g., F16.980 psilocybin-induced anxiety disorder, with onset during intoxication). When more than one substance is judged to play a significant role in the development of anxiety symptoms, each should be listed separately (e.g., F15.280 severe methylphenidate use disorder with methylphenidate-induced anxiety disorder, with onset during intoxication; F19.980 salbutamolinduced anxiety disorder, with onset after medication use). Diagnostic Features The essential features of substance/medication-induced anxiety disorder are prominent symptoms of panic or anxiety (Criterion A) that are judged to be due to the effects of a substance (e.g., a drug of abuse, a

medication, or a toxin exposure). The panic or anxiety symptoms must have developed during or soon after substance intoxication or withdrawal or after exposure to or withdrawal from a medication, and the substances or medications must be capable of producing the symptoms (Criterion B2). Substance/medication-induced anxiety disorder due to a prescribed treatment for a mental disorder or another medical condition must have its onset while the individual is receiving the medication (or during withdrawal, if a withdrawal is associated with

Substance intoxication and substance withdrawal. the medication). Once the treatment is discontinued, the panic or anxiety symptoms will usually improve or remit within days to several weeks to a month (depending on the half-life of the substance/medication and the presence of withdrawal). The diagnosis of substance/medicationinduced anxiety disorder should not be given if the onset of the panic or anxiety symptoms precedes the substance/medication intoxication or withdrawal, or if the symptoms persist for a substantial period of time (i.e., usually longer than 1 month) from the time of severe intoxication or withdrawal. If the panic or anxiety symptoms persist for substantial periods of time, other causes for the symptoms should be considered. The substance/medication-induced anxiety disorder diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A are predominant in the clinical picture and are sufficiently severe to warrant independent clinical attention. Associated Features Panic or anxiety can occur in association with intoxication with the following classes of substances: alcohol, caffeine, cannabis, phencyclidine, other hallucinogens, inhalants, stimulants (including cocaine), and other (or unknown) substances. Panic or anxiety can occur in association with withdrawal from the following classes of substances: alcohol; opioids; sedatives, hypnotics, and anxiolytics; stimulants (including cocaine); and other (or unknown) substances. Some medications that evoke anxiety symptoms include anesthetics and analgesics, sympathomimetics or other bronchodilators, anticholinergics, insulin, thyroid preparations, oral contraceptives, antihistamines, antiparkinsonian medications, corticosteroids, antihypertensive and cardiovascular medications, anticonvulsants, lithium carbonate, antipsychotic medications, and antidepressant medications. Heavy metals and toxins (e.g., organophosphate insecticide, nerve gases, carbon monoxide, CO2, volatile substances such as gasoline and paint) may also cause panic or anxiety symptoms. Prevalence The prevalence of substance/medication-induced anxiety disorder is not clear. General population data suggest that it may be rare, with a 12-month prevalence in the United States of approximately 0.002%. However, in clinical populations, the prevalence is likely to be higher. Diagnostic Markers Laboratory assessments (e.g., urine toxicology) may be useful to measure substance intoxication as part of an assessment for substance/medication-induced anxiety disorder. Differential Diagnosis Anxiety symptoms commonly occur in substance intoxication and substance withdrawal. The diagnosis of the substance-specific intoxication or substance-specific withdrawal will usually suffice to categorize the symptom presentation. A diagnosis of substance/medication-induced anxiety disorder either with onset during intoxication

Independent anxiety disorder (i.e., not induced by a substance/medication). Delirium. Anxiety disorder due to another medical condition. F06.4 or with onset during withdrawal should be made instead of a diagnosis of substance intoxication or substance withdrawal when the panic or anxiety symptoms are predominant in the clinical picture and are sufficiently severe to warrant clinical attention. For example, panic or anxiety symptoms are characteristic of alcohol withdrawal. An independent anxiety disorder co-occurring with substance/medication use is distinguished from a

substance/medication-induced anxiety disorder by the fact that even though a substance/medication may be taken in high enough amounts to be possibly etiologically related to the anxiety symptoms, the anxiety symptoms are observed at times other than during substance/medication use (i.e., preceding the onset of substance/medication use or persisting for a substantial period of time after substance intoxication, substance withdrawal, or medication use) and would warrant the diagnosis of an independent anxiety disorder. If panic or anxiety symptoms occur exclusively during the course of delirium, they are considered to be an associated feature of the delirium and are not diagnosed separately. If the panic or anxiety symptoms are attributed to the physiological consequences of another medical condition (i.e., rather than to the medication taken for the medical condition), anxiety disorder due to another medical condition should be diagnosed. The history often provides the basis for such a judgment. At times, a change in the treatment for the other medical condition (e.g., medication substitution or discontinuation) may be needed to determine whether the medication is the causative agent (in which case the symptoms may be better explained by substance/medication-induced anxiety disorder). If the disturbance is attributable to both another medical condition and substance use, both diagnoses (i.e., anxiety disorder due to another medical condition and substance/medication-induced anxiety disorder) may be given. When there is insufficient evidence to determine whether the panic or anxiety symptoms are attributable to a substance/medication or to another medical condition or are primary (i.e., not attributable to either a substance or another medical condition), a diagnosis of other specified or unspecified anxiety disorder would be indicated. Anxiety Disorder Due to Another Medical Condition Diagnostic Criteria A. Panic attacks or anxiety is predominant in the clinical picture. B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition. C. The disturbance is not better explained by another mental disorder. D. The disturbance does not occur exclusively during the course of a delirium. E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Coding note: Include the name of the other medical condition within the name of the

mental disorder (e.g., F06.4 anxiety disorder due to pheochromocytoma). The other medical condition should be coded and listed separately immediately before the anxiety disorder due to the medical condition (e.g., D35.00 pheochromocytoma; F06.4 anxiety disorder due to pheochromocytoma). Diagnostic Features The essential feature of anxiety disorder due to another medical condition is clinically significant anxiety that is judged to be best explained as a physiological effect of another medical condition. Symptoms can include prominent anxiety symptoms or panic attacks (Criterion A). The judgment that the symptoms are best explained by the associated physical condition must be based on evidence from the history, physical examination, or laboratory findings (Criterion B). Additionally, it must be judged that the symptoms are not better accounted for by another mental disorder (Criterion C)—in particular, adjustment disorder with anxiety, in which the stressor is the medical condition. In this case, an individual with adjustment disorder is especially distressed about the meaning or the consequences of the associated medical condition. By contrast, there is often a prominent physical component to the anxiety (e.g., shortness of breath) when the anxiety is due to another medical condition. The diagnosis is not made if the anxiety symptoms occur only during the course of a delirium (Criterion D). The anxiety symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion E). In determining whether the anxiety symptoms are attributable to another medical condition, the clinician must first establish

the presence of the medical condition. Furthermore, it must be established that anxiety symptoms can be etiologically related to the medical condition through a physiological mechanism before making a judgment that this is the best explanation for the symptoms in a specific individual. A careful and comprehensive assessment of multiple factors is necessary to make this judgment. Several aspects of the clinical presentation should be considered: 1) the presence of a clear temporal association between the onset, exacerbation, or remission of the medical condition and the anxiety symptoms; 2) the presence of features that are atypical of an independent anxiety disorder (e.g., atypical age at onset or course); and 3) evidence in the literature that a known physiological mechanism (e.g., hyperthyroidism) causes anxiety. In addition, the disturbance must not be better explained by an independent anxiety disorder, a substance/medication-induced anxiety disorder, or another mental disorder (e.g., adjustment disorder). A number of medical conditions are known to include anxiety as a symptomatic manifestation. Examples include endocrine disease (e.g., hyperthyroidism, pheochromocytoma, hypoglycemia, hyperadrenocortisolism), cardiovascular disorders (e.g., congestive heart failure, pulmonary embolism, arrhythmia such as atrial fibrillation), respiratory illness (e.g., chronic obstructive pulmonary disease, asthma, pneumonia), metabolic disturbances (e.g., vitamin B12 deficiency, porphyria), and neurological illness (e.g., neoplasms, vestibular dysfunction, encephalitis, seizure disorders).

Delirium and major or mild neurocognitive disorder. Mixed presentation of symptoms (e.g., mood and anxiety). Substance/medication-induced anxiety disorder. Prevalence The prevalence of anxiety disorder due to another medical condition is unclear. There appears to be an elevated prevalence of anxiety disorders among individuals with a variety of medical conditions, including asthma, hypertension, ulcers, and arthritis. However, this increased prevalence may be due to reasons other than the anxiety disorder directly causing the medical condition. Development and Course The development and course of anxiety disorder due to another medical condition generally follows the course of the underlying illness. This diagnosis is not meant to include primary anxiety disorders that arise in the context of chronic medical illness. This is important to consider with older adults, who may experience chronic medical illness and then develop independent anxiety disorders secondary to the chronic medical illness. Diagnostic Markers Laboratory assessments and/or medical examinations are necessary to confirm the diagnosis of the associated medical condition. Differential Diagnosis A separate diagnosis of anxiety disorder due to another medical condition is not given if the anxiety disturbance occurs exclusively during the course of a delirium. However, a diagnosis of anxiety disorder due to another medical condition may be given in addition to a diagnosis of major or mild neurocognitive disorder if the anxiety is judged to be a physiological consequence of the pathological process causing the neurocognitive disorder and if anxiety is a prominent part of the clinical presentation. If the presentation includes a mix of different types of symptoms, the specific mental disorder due to another medical condition depends on which symptoms predominate in the clinical picture. If there is evidence of recent or prolonged substance use (including medications with psychoactive effects), withdrawal from a substance, or exposure to a toxin, a substance/medication-induced anxiety disorder should be considered. Certain medications are known to increase anxiety (e.g., corticosteroids, estrogens, metoclopramide), and when this is the case, the medication may be the most likely etiology, although it may be difficult to distinguish whether the anxiety is attributable to the medications or to the medical illness itself. When a diagnosis of substance-induced anxiety is being made in relation to recreational or nonprescribed drugs, it may be useful to obtain a urine or blood drug screen or other appropriate

laboratory evaluation. Symptoms that develop during or soon after substance intoxication or withdrawal or after medication use may be especially indicative of a substance/medicationinduced anxiety disorder, depending on the type, duration, or amount of the substance used. If the disturbance is associated with both another medical condition and substance use, both

Anxiety disorder (not due to a known medical condition). Illness anxiety disorder. Adjustment disorders. diagnoses (i.e., anxiety disorder due to another medical condition and substance/medicationinduced anxiety disorder) can be given. Features such as onset after age 45 years or the presence of atypical symptoms during a panic attack (e.g., vertigo, loss of consciousness, loss of bladder or bowel control, slurred speech, amnesia) suggest the possibility that another medical condition or a substance may be causing the panic attack symptoms. Anxiety disorder due to another medical condition should be distinguished from other anxiety disorders (especially panic disorder and generalized anxiety disorder). In other anxiety disorders, no specific and direct causative physiological mechanisms associated with another medical condition can be demonstrated. Late age at onset, atypical symptoms, and the absence of a personal or family history of anxiety disorders suggest the need for a thorough assessment to rule out the diagnosis of anxiety disorder due to another medical condition. Anxiety disorders can exacerbate or pose increased risk for medical conditions such as cardiovascular events and myocardial infarction and should not be diagnosed as anxiety disorder due to another medical condition in these cases. Anxiety disorder due to another medical condition should be distinguished from illness anxiety disorder. Illness anxiety disorder is characterized by worry about illness, concern about pain, and bodily preoccupations. In the case of illness anxiety disorder, individuals may or may not have diagnosed medical conditions. Although an individual with illness anxiety disorder and a diagnosed medical condition is likely to experience anxiety about the medical condition, the medical condition is not physiologically related to the anxiety symptoms. Anxiety disorder due to another medical condition should be distinguished from adjustment disorders with anxiety or adjustment disorders with anxiety and depressed mood. Adjustment disorder is warranted when individuals experience a maladaptive response to the stress of being diagnosed with or having to manage the medical condition. The reaction to stress usually concerns the meaning or consequences of the medical condition, in contrast with the experience of anxiety or mood symptoms that occur as a physiological consequence of the medical condition. In adjustment disorder, the anxiety symptoms are typically related to coping with the stress of having the medical condition, whereas in anxiety disorder due to another medical condition, individuals are more likely to have prominent physical symptoms and to be focused on issues other than the stress of the illness itself. Other Specified Anxiety Disorder F41.8 This category applies to presentations in which symptoms characteristic of an anxiety disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the anxiety disorders diagnostic class, and

do not meet criteria for adjustment disorder with anxiety or adjustment disorder with mixed anxiety and depressed mood. The other specified anxiety disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific anxiety disorder. This is done by recording “other specified anxiety disorder” followed by the specific reason (e.g., “generalized anxiety occurring less often than ‘more days than not’ ”). Examples of presentations that can be specified using the “other specified” designation include the following:

1. Limited-symptom attacks.
2. Generalized anxiety occurring less often than “more days than not.”
3. Khyâl cap (wind attacks): See “Culture and Psychiatric Diagnosis” in Section III.
4. Ataque de nervios (attack of nerves): See “Culture and Psychiatric Diagnosis” in Section III. Unspecified Anxiety Disorder F41.9 This category applies to presentations in which symptoms characteristic of an anxiety disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the anxiety disorders diagnostic class, and do not meet criteria for adjustment disorder with anxiety or adjustment disorder with mixed anxiety and depressed mood. The unspecified anxiety disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific anxiety disorder and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

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