09 - Somatic Symptom and Related Disorders

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Somatic Symptom and Related Disorders This chapter includes the diagnoses of somatic symptom disorder, illness anxiety disorder, functional neurological symptom disorder (conversion disorder), psychological factors affecting other medical conditions, factitious disorder, other specified somatic symptom and related disorder, and unspecified somatic symptom and related disorder. All of the disorders in this chapter share a common feature: the prominence of somatic symptoms and/or illness anxiety associated with significant distress and impairment. Individuals with disorders with prominent somatic symptoms or illness anxiety are commonly encountered in primary care and other medical settings but are less commonly encountered in psychiatric and other mental health settings. These reconceptualized diagnoses, based on a reorganization of DSM-IV somatoform disorder diagnoses, are more useful for primary care and other medical (nonpsychiatric) clinicians. The major diagnosis in this diagnostic class, somatic symptom disorder, emphasizes diagnosis made on the basis of the presence of symptoms and signs (distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors in response to these symptoms) rather than the absence of a medical explanation for somatic symptoms. A distinctive characteristic of many individuals with somatic symptom disorder is not the somatic symptoms per se, but instead the way they present and interpret them. Incorporating affective, cognitive, and behavioral components into the criteria for somatic symptom disorder provides a more comprehensive and accurate reflection of the true clinical picture than can be achieved by assessing the somatic complaints alone. The principles behind the changes in the somatic symptom and related diagnoses from DSMIV are crucial in understanding the DSM-5 diagnoses. The DSM-IV term somatoform disorders was confusing and was replaced by somatic symptom and related disorders. In DSM-IV there was a great deal of overlap across the somatoform disorders and a lack of clarity about the boundaries of diagnoses. Although individuals with these disorders primarily present in medical rather than mental health settings, nonpsychiatric physicians found the DSM-IV somatoform diagnoses difficult to understand and use. The current DSM-5 classification recognizes this overlap by reducing the total number of disorders as well as their subcategories. The previous

criteria overemphasized the centrality of symptoms being unexplained by recognized pathophysiological processes. Such symptoms are present to various degrees, particularly in functional neurological symptom disorder, but somatic symptom disorders can also accompany recognized medical conditions (i.e., those disorders related to clearly recognized pathophysiological processes). The reliability of determining that a somatic symptom is unexplained by a recognized pathophysiological process related to a recognized medical condition is limited, and grounding a diagnosis on the absence of an explanation is problematic and reinforces mind-body dualism. It is not appropriate to give an individual a mental disorder diagnosis solely because a recognized medical condition cannot be demonstrated. Furthermore,

the presence of a recognized medical condition does not exclude the possibility of a comorbid mental disorder, including a somatic symptom and related disorder. Perhaps because of the predominant focus on lack of medical explanation in DSM-IV, individuals regarded these diagnoses as pejorative and demeaning, implying that their physical symptoms were not “real.” The DSM-5 classification defines the major diagnosis, somatic symptom disorder, on the basis of positive symptoms (distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors in response to these symptoms). In functional neurological symptom disorder and pseudocyesis (other specified somatic symptom and related disorder), the emphasis is on demonstrating clinical evidence of incompatibility with recognized pathophysiological processes. It is important to note that some other mental disorders may initially manifest with primarily somatic symptoms (e.g., major depressive disorder, panic disorder). Such diagnoses may account for the somatic symptoms, or they may occur alongside one of the somatic symptom and related disorders in this chapter. There is also considerable medical comorbidity among individuals with somatic symptom and related disorders. Although somatic symptoms are frequently associated with psychological distress and psychopathology, some somatic symptom and related disorders can arise spontaneously, and their causes can remain obscure. Anxiety disorders and depressive disorders may accompany somatic symptom and related disorders. The somatic component adds severity and complexity to depressive and anxiety disorders and results in higher severity, functional impairment, and even refractoriness to traditional treatments. In rare instances, the degree of preoccupation may be so severe as to warrant consideration of a delusional disorder diagnosis. A number of factors may contribute to somatic symptom and related disorders. These include genetic and biological vulnerability (e.g., increased sensitivity to pain), early traumatic experiences (e.g., violence, abuse, deprivation), medical iatrogenesis (e.g., reinforcement of the sick role, excessive referrals and diagnostic testing), and learning (e.g., lack of reinforcement of nonsomatic expressions of distress), as well as sociocultural norms that minimize or stigmatize psychological suffering as compared with physical suffering. Differences in medical care across cultural contexts affect the presentation, recognition, and management of these somatic presentations. Variations in symptom presentation are likely the result of the interaction of multiple factors within cultural contexts that affect how individuals identify and classify bodily sensations, perceive illness, and seek medical attention for them. All of these disorders are characterized by the prominent focus on somatic concerns and their initial presentation mainly in medical rather than mental health care settings. Somatic symptom disorder and illness anxiety disorder offer more clinically useful methods of characterizing individuals who may have been considered in the past for a diagnosis of somatization disorder and hypochondriasis. Furthermore, approximately two-thirds to three-fourths of individuals previously diagnosed with hypochondriasis are subsumed under the diagnosis of somatic symptom disorder. However, the remaining one-quarter to one-third of individuals with

previously diagnosed hypochondriasis have high health anxiety in the absence of somatic symptoms, and many such individuals' symptoms would not qualify for an anxiety disorder diagnosis. The DSM-5 diagnosis of illness anxiety disorder is for this latter group of individuals.

F45.1 Illness anxiety disorder can be considered either a somatic symptom and related disorder or an anxiety disorder. Because of the strong focus on somatic concerns, and because illness anxiety disorder is most often encountered in medical settings, for utility it is listed with the somatic symptom and related disorders. In functional neurological symptom disorder, the key to diagnosis is neurological symptoms that can be demonstrated, on the basis of positive clinical examination features, to be incompatible with recognized pathophysiology. This is now a "rulein" diagnosis, and not a diagnosis of exclusion, and can be made in the presence of a recognized neurological disorder. It no longer requires the presence of a recent psychological stressor, because such stressors are not always present. Psychological factors affecting other medical conditions is also included in this chapter. Its essential feature is the presence of one or more clinically significant psychological or behavioral factors that adversely affect a medical condition by increasing the risk for suffering, death, or disability. Like the other somatic symptom and related disorders, factitious disorder embodies persistent problems related to illness perception and identity. In the great majority of reported cases of factitious disorder, both imposed on self and imposed on another, individuals present with somatic symptoms and expressed medical disease conviction. Consequently, DSM-5 factitious disorder is included among the somatic symptom and related disorders. Other specified somatic symptom and related disorder and unspecified somatic symptom and related disorder include conditions for which some, but not all, of the criteria for somatic symptom disorder or illness anxiety disorder are met, as well as pseudocyesis. Somatic Symptom Disorder Diagnostic Criteria A. One or more somatic symptoms that are distressing or result in significant disruption of daily life. B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:

1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
2. Persistently high level of anxiety about health or symptoms.
3. Excessive time and energy devoted to these symptoms or health concerns. C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months). Specify if: With predominant pain (previously pain disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain.

Specify if: Persistent: A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months). Specify current severity: Mild: Only one of the symptoms specified in Criterion B is fulfilled. Moderate: Two or more of the symptoms specified in Criterion B are fulfilled. Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom). Diagnostic Features Individuals with somatic symptom disorder typically have multiple, current, somatic symptoms that are distressing or result in significant disruption of daily life (Criterion A), although sometimes only one severe symptom, most commonly pain, is present. Symptoms may be specific (e.g., localized pain) or relatively nonspecific (e.g., fatigue). The symptoms sometimes represent normal bodily sensations or discomfort that does not generally signify serious disease.

Somatic symptoms without an evident medical explanation are not sufficient to make this diagnosis. The individual's suffering is authentic, whether or not it is medically explained. The symptoms may or may not be associated with another medical condition. The diagnoses of somatic symptom disorder and a concurrent medical illness are not mutually exclusive, and these frequently occur together. For example, an individual may become seriously disabled by symptoms of somatic symptom disorder after an uncomplicated myocardial infarction even if the myocardial infarction itself did not result in any disability. If another medical condition or high risk for developing one is present (e.g., strong family history), the thoughts, feelings, and behaviors associated with this condition are excessive (Criterion B). Individuals with somatic symptom disorder tend to have very high levels of worry about illness (Criterion B). They appraise their bodily symptoms as unduly threatening, harmful, or troublesome and often think the worst about their health. Even when there is evidence to the contrary, some individuals still fear the medical seriousness of their symptoms. In severe somatic symptom disorder, health concerns may assume a central role in the individual's life, becoming a feature of his or her identity and dominating interpersonal relationships. Individuals typically experience distress that is principally focused on somatic symptoms and their significance. When asked directly about their distress, some individuals describe it in relation to other aspects of their lives, while others deny any source of distress other than the somatic symptoms. Health-related quality of life is often impaired, both physically and mentally. The diagnosis can further be specified by stating whether complaints predominantly involve pain and/or if complaints are marked by a persistent course. Additionally, severity of somatic symptom disorder can be specified by the number of fulfilled B criteria. Mild forms of somatic symptom disorder (one symptom as specified in Criterion B is fulfilled) are more prevalent, while moderate (two or more B criteria are present) and severe cases (two or more symptoms as specified in Criterion B are fulfilled in combination

with multiple somatic complaints or one very severe somatic symptom) are marked by higher levels of impairment. In severe somatic symptom disorder, the impairment is marked, and when persistent, the disorder can lead to invalidism. There is often a high level of medical care utilization, which rarely alleviates the individual's concerns. Consequently, the individual may seek care from multiple doctors for the same symptoms. These individuals often seem unresponsive to medical interventions, and new interventions may only exacerbate the presenting symptoms. Some individuals with the disorder seem unusually sensitive to medication side effects. Some feel that their medical assessment and treatment have been inadequate. The criteria for somatic symptom disorder appear suitable for use in children and adolescents, but they have been less studied in youth than among adults. Associated Features Cognitive features include attention focused on somatic symptoms, attribution of normal bodily sensations to physical illness (possibly with catastrophic interpretations), worry about illness, a self-concept of bodily weakness, and intolerance of bodily complaints. Besides health anxiety, emotional features may include negative affectivity, desperation, and demoralization related to somatic symptoms. The relevant associated behavioral features may include repeated bodily checking for abnormalities, repeated seeking of medical help and reassurance, and avoidance of physical activity. These behavioral features are most pronounced in severe, persistent somatic symptom disorder. These features are usually associated with frequent requests for medical help for different somatic symptoms. This may lead to medical consultations in which individuals are so focused on their concerns about somatic symptom(s) that they cannot be redirected to other matters. Any reassurance by the doctor that the symptoms are not indicative of serious physical illness tends to be short-lived and/or is

experienced by the individuals as the doctor not taking their symptoms with due seriousness. As the focus on somatic symptoms is a primary feature of the disorder, individuals with somatic symptom disorder typically present to general medical health services rather than mental health services. The suggestion of referral to a mental health specialist may be met with surprise or even frank refusal by individuals with somatic symptom disorder. Prevalence The prevalence of somatic symptom disorder is unclear. Estimates about the prevalence of somatic symptom disorder come from the limited epidemiological literature on DSM-IV-TR somatoform disorders. However, the prevalence of somatic symptom disorder is expected to be higher than that of the more restrictive DSM-IV-TR somatization disorder (<1%) but lower than that of undifferentiated somatoform disorder (approximately 19%). More recent population-based studies with a questionnaire-based strategy using DSM-5 diagnostic criteria for somatic symptom disorder in adult and adolescent samples report prevalence rates between 6.7% and 17.4%. Based on research conducted in Europe and North America, the prevalence of somatic symptom disorder in the general adult population can be approximated as 4%–6%.

Temperamental. Environmental. Somatic symptom disorder has a higher frequency in primary care patients than in the general population. Based on reviews and meta-analyses of studies from multiple countries that had still used DSM-IV or ICD-10 criteria, a 12-month prevalence of somatic symptom disorder and related conditions in primary care patients between 10% and 20% appears plausible. Prevalence rates are higher in clinical settings that specialize in psychosomatic or functional disorders, with reported frequencies of somatic symptom disorder between 40% and 60%. Women tend to report more somatic symptoms than do men, and the prevalence of somatic symptom disorder is consequently likely to be higher in women. Development and Course In a study of Danish children ages 5–7 years, functional somatic symptoms were common health complaints, which for a significant minority (roughly one-fifth) of those with complaints were severe enough to cause distress, impairment, school absences, or medical help-seeking. Age at onset does not seem to affect the duration of untreated illness. The course of somatic symptom disorder is likely to be chronic and fluctuating and influenced by the number of symptoms, individual’s age, level of impairment, and any comorbidity. The course is also influenced by personality traits, with less harm avoidance and greater cooperativeness associated with a shorter time to remission. In children, the most common symptoms are recurrent abdominal pain, headache, fatigue, and nausea. A single prominent symptom is more common in children than in adults. When the diagnosis is being made in younger individuals, it is important to obtain patient, family, and other assessments (e.g., school) of symptom presentation. Patient and caregiver engagement during evaluation and management is fundamental because parents’ interpretation of and response to symptoms may determine the level of associated distress, the demands for medical investigations and interventions, and time away from school. In older individuals, pain localized in several body regions appears to be the most common symptom. Somatic symptoms and concurrent medical illnesses are common as multimorbidity increases with age. Prevalence rates of somatic symptom disorder seem to be stable until age 65 years and might decrease thereafter. For making the diagnosis in older individuals, a focus on the requirement for excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns (Criterion B) is crucial. Somatic symptom disorder may be underdiagnosed in older adults either because certain somatic symptoms (e.g., pain, fatigue) are considered part of normal aging or because illness worry is considered “understandable” in older adults who have more general medical illnesses and medications than do younger people. Risk and Prognostic Factors The personality trait of negative

affectivity (neuroticism) has been identified as an independent correlate/risk factor of a high number of somatic symptoms. Comorbid anxiety or depression is common and may exacerbate symptoms and impairment. Somatic symptom disorder is more frequent in individuals with few years of education and low socioeconomic status, and in those who have recently experienced stressful or

Course modifiers. health-related life events. Early lifetime adversity such as childhood sexual abuse is also likely a risk factor for somatic symptom disorder in adults. Persistent somatic symptoms are associated with demographic features (women, older age, fewer years of education, lower socioeconomic status, unemployment), a reported history of sexual abuse or other childhood adversity, concurrent chronic physical illness or mental disorder (depression, anxiety, persistent depressive disorder, panic), social stress, and reinforcing social factors such as illness benefits. Total somatic symptom severity is probably associated with female gender, anxiety, depression and general medical illness. Cognitive factors that affect clinical course include sensitization to pain, heightened attention to bodily sensations, and attribution of bodily symptoms to a possible medical illness rather than recognizing them as a normal phenomenon or psychological stress. Culture-Related Diagnostic Issues High numbers of somatic symptoms are found in population-based and primary care studies around the world, with a similar pattern of the most commonly reported somatic symptoms, impairment, and treatment seeking. The relationship between number of somatic symptoms and illness worry is similar in different cultural contexts, and marked illness worry is associated with impairment and greater treatment seeking cross-culturally. In many cultural contexts, individuals with depression commonly present with somatic symptoms. Despite these similarities, there are differences in somatic symptoms across cultural contexts and ethnoracial groups. Sociocultural factors, particularly stigma related to mental disorders, may explain differences in somatic symptom reporting across cultural contexts. The description of somatic symptoms varies with linguistic and other local cultural factors. These somatic presentations have been described as “idioms of distress” because somatic symptoms may have special meanings and shape patient-clinician interactions in the particular cultural contexts. For example, sensations of heaviness, complaints of “gas,” too much heat in the body, or burning in the head are common in some cultures or ethnic groups but rare in others. Cultural explanations also vary, and somatic symptoms may be attributed variously to particular family, work (e.g., burnout), or other environmental stresses; general medical illness; the suppression of feelings of anger and resentment; or certain culturally specific attributions, such as semen loss. Certain somatic symptoms may be part of specific explanatory models in a given cultural context; for example, traditional understandings of shenjing shuairuo in China link concepts of “weakness of nerves” (neurasthenia) and hot-cold imbalance with prominent symptoms such as fatigue and low energy. There may also be differences in medical treatment seeking and utilization of nonmedical, traditional, alternative and complementary healing practices among cultural groups, in addition to differences due to variable access to medical care services. Cultural beliefs, previous illnesses, insurance status, health literacy, and health care experiences can influence individuals’ perception of somatic symptoms and health care use. Seeking treatment for multiple somatic symptoms in general medical clinics is a worldwide phenomenon. Sex- and Gender-Related Diagnostic Issues In population-based studies, women report more somatic symptoms than men, and in one study of primary care patients with chronic pain, women reported more severe somatic symptoms than men. While exposure to sexual trauma, intimate partner violence, and a childhood trauma history

Other medical conditions. Psychological factors affecting other medical conditions. is associated with increased somatic symptom expression in both women and men, a childhood history of multiple adverse childhood experiences is especially likely to increase somatic symptom expression in women. In women, gender is associated with an increased likelihood of developing persistent symptoms of somatic symptom disorder. There appears to be no evidence that gender is associated with the duration of untreated illness and response to psychological or pharmacological treatment. Association With Suicidal Thoughts or Behavior Somatic symptom disorder is associated with suicidal thoughts and suicide attempts. It is likely that suicidal thoughts and behaviors are partly explained by the diagnostic overlap and frequent comorbidity of somatic symptom disorder and depressive disorders. In addition, dysfunctional illness perceptions and the severity of somatic symptoms appear to be independently associated with an increased risk of suicidal ideation. Functional Consequences of Somatic Symptom Disorder The disorder is associated with marked impairment of health status and high psychological distress. Many individuals with severe somatic symptom disorder are likely to have impaired health status scores more than 2 standard deviations below population norms. Health status is particularly impaired in the presence of multiple or severe symptoms. Differential Diagnosis If the somatic symptoms are consistent with another mental disorder (e.g., panic disorder), and the diagnostic criteria for that disorder are fulfilled, then that mental disorder should be considered as an alternative or additional diagnosis. If, as commonly occurs, the criteria for both somatic symptom disorder and another mental disorder diagnosis are fulfilled, then both should be diagnosed, as both may require treatment. The presence of somatic symptoms of unclear etiology is not in itself sufficient to make the diagnosis of somatic symptom disorder. The symptoms of many individuals with disorders like irritable bowel syndrome or fibromyalgia would not satisfy the criterion necessary to diagnose somatic symptom disorder (Criterion B). Conversely, the presence of somatic symptoms of an established medical condition (e.g., diabetes or heart disease) does not exclude the diagnosis of somatic symptom disorder if the criteria are otherwise met. Factors that distinguish individuals with somatic symptom disorder from individuals with general medical conditions alone include the ineffectiveness of analgesics, a history of mental disorders, unclear provocative or palliative factors, persistence without cessation, and stress. The diagnosis of somatic symptom disorder requires distressing or impairing somatic symptoms that may or may not be associated with another medical condition but must be accompanied by excessive or disproportionate thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns. In contrast,

Panic disorder. Generalized anxiety disorder. Depressive disorders. Illness anxiety disorder. Functional neurological symptom disorder (conversion disorder). Delusional disorder. Body dysmorphic disorder. Obsessive-compulsive disorder. Factitious disorder and malingering. the diagnosis of psychological factors affecting other medical conditions requires the presence of a medical condition, as well as psychological factors that adversely affect its course or interfere with its treatment. In panic disorder, somatic symptoms and anxiety about health tend to occur in acute episodes, whereas in somatic symptom disorder, anxiety and somatic symptoms are more persistent. Individuals with generalized anxiety disorder worry about multiple events, situations, or activities, only one of which may involve their health. The main focus is not usually somatic symptoms or fear of illness as it is in somatic symptom disorder. Depressive disorders are commonly accompanied by somatic symptoms such as fatigue, headaches, or joint, abdominal, or other pains. However, depressive disorders are differentiated from somatic symptom disorder by the requirement of the presence of depressed mood or, in the case of major depressive disorder,

either depressed mood or decreased interest or pleasure in activities. In some cultural contexts, these core symptoms of depression may be initially denied or deemphasized by individuals whose presentations would otherwise meet criteria for a depressive disorder. Such individuals might instead emphasize somatic symptoms that may be idiomatic (e.g., heavy heart) and unfamiliar to clinicians. If the individual has extensive worries about health but no or minimal somatic symptoms, it may be more appropriate to consider illness anxiety disorder. In functional neurological symptom disorder, the presenting symptom is loss of function (e.g., of a limb), whereas in somatic symptom disorder, the focus is on the distress that particular symptoms cause. The features listed under Criterion B of somatic symptom disorder may be helpful in differentiating the two disorders. In somatic symptom disorder, the individual's beliefs that somatic symptoms might reflect serious underlying physical illness are not held with delusional intensity. Nonetheless, the individual's beliefs concerning the somatic symptoms can be firmly held. In contrast, in delusional disorder, somatic type, the individual's conviction that the somatic symptoms are indicative of having a serious underlying illness is stronger than that found in somatic symptom disorder. In body dysmorphic disorder, the individual is excessively concerned about, and preoccupied by, a perceived defect in his or her physical appearance. In contrast, in somatic symptom disorder, the concern about somatic symptoms reflects fear of underlying illness, not of a defect in appearance. In somatic symptom disorder, the recurrent ideas about somatic symptoms or illness are less intrusive, and individuals with this disorder do not exhibit the associated repetitive behaviors aimed at reducing anxiety that occur in obsessive-compulsive disorder. In factitious disorder and malingering, individuals present themselves as ill or impaired but have falsified presenting physical signs and symptoms with the

F45.21 intent to deceive. In contrast, the symptoms of somatic symptom disorder are not simulated or self-induced, and these individuals suffer authentically and seriously from their somatic complaints. Comorbidity Somatic symptom disorder is associated with high rates of comorbidity with other mental disorders as well as general medical conditions. The most relevant co-occurring mental disorders are anxiety and depressive disorders, each of which occurs in up to 50% of cases of somatic symptom disorders and significantly contributes to overall functional impairment and poorer quality of life. Other mental disorders that have been found to co-occur with somatic symptom disorder are posttraumatic stress disorder and obsessive-compulsive disorder. Other evidence indicates an association with sexual dysfunction in men. Elevated levels of the psychological features (Criterion B) of somatic symptom disorder have been found in several general medical conditions. When a concurrent general medical condition is present, the degree of impairment is more marked than would be expected from the physical illness alone. Moreover, somatization in medical illness has been shown to worsen disease and treatment outcomes, adherence, and quality of life and to increase health care utilization. Illness Anxiety Disorder Diagnostic Criteria A. Preoccupation with having or acquiring a serious illness. B. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate. C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status. D. The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals). E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time. F. The illness-related preoccupation is not

better explained by another mental disorder, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type. Specify whether:

Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is frequently used. Care-avoidant type: Medical care is rarely used. Diagnostic Features Most individuals who previously would have been diagnosed with hypochondriasis in DSM-IV (preoccupation with having a serious disease based on the individual's misinterpretation of bodily symptoms) are now classified as having somatic symptom disorder; however, in one-third of cases, the diagnosis of illness anxiety disorder applies instead. Illness anxiety disorder entails a preoccupation with having or acquiring a serious, undiagnosed medical illness (Criterion A). Somatic symptoms are not present or, if present, are only mild in intensity (Criterion B). A thorough evaluation fails to identify a serious medical condition that accounts for the individual's concerns. While the concern may be derived from a nonpathological physical sign or sensation, the individual's distress emanates not primarily from the physical complaint itself but rather from his or her anxiety about the meaning, significance, or cause of the complaint (i.e., the suspected medical diagnosis). If a physical sign or symptom is present, it is often a normal physiological sensation (e.g., orthostatic dizziness), a benign and self-limited dysfunction (e.g., transient tinnitus), or a bodily discomfort not generally considered indicative of disease (e.g., belching). If a diagnosable medical condition is present, the individual's anxiety and preoccupation are clearly excessive and disproportionate to the severity of the condition (Criterion B). Most empirical evidence and existing literature pertain to previously defined DSM hypochondriasis and health anxiety, and it is unclear to what extent and how precisely they apply to the description of this new diagnosis. The preoccupation with the idea that one is sick is accompanied by substantial anxiety about health and disease (Criterion C). Individuals with illness anxiety disorder are easily alarmed about illness, such as by hearing about someone else falling ill or reading a health-related news story. Their concerns about undiagnosed disease do not respond to appropriate medical reassurance, negative diagnostic tests, or benign course. The physician's attempts at reassurance and symptom palliation generally do not alleviate the individual's concerns and may heighten them. Illness concerns assume a prominent place in the individual's life, affecting daily activities, and may even result in invalidism. Illness becomes a central feature of the individual's identity and self-image, a frequent topic of social discourse, and a characteristic response to stressful life events. Individuals with the disorder often examine themselves repeatedly (e.g., examining one's throat in the mirror) (Criterion D). They research their suspected disease excessively (e.g., on the Internet) and repeatedly seek reassurance from family, friends, or physicians. This incessant worrying often becomes frustrating for othe rs and may result in considerable strain within the family. In some cases, the anxiety leads to maladaptive avoidance of situations (e.g., visiting sick family members) or activities (e.g., exercise) that these individuals fear might jeopardize their health.

Environmental. Associated Features Because they believe they are medically ill, individuals with illness anxiety disorder are encountered far more frequently in medical than in mental health settings. The majority of individuals with illness anxiety disorder have extensive yet unsatisfactory medical care. They generally have elevated rates of utilization of medical and mental health services compared with the general population. In a minority of cases of illness anxiety disorder, individuals are too anxious to seek medical attention and avoid medical health care. They often consult multiple physicians for the same problem and obtain repeatedly negative diagnostic test

results. At times, medical attention leads to a paradoxical exacerbation of anxiety or to iatrogenic complications from diagnostic tests and procedures. Individuals with the disorder are generally dissatisfied with their medical care and find it unhelpful, often feeling they are not being taken seriously by physicians. At times, these concerns may be justified, since physicians sometimes are dismissive or respond with frustration or hostility. This response can occasionally result in a failure to diagnose a medical condition that is present. Prevalence Prevalence estimates of illness anxiety disorder are based on estimates of the DSM-III and DSMIV diagnosis hypochondriasis and health anxiety. The 1- to 2-year prevalence of health anxiety and/or disease conviction in community surveys and population-based samples from highincome countries such as the United States and Germany ranges from 1.3% to 10%. In ambulatory medical populations, the 6-month/1-year prevalence rates are between 2.2% and 8% across a range of countries, with weighted mean prevalence rates of 3%. By contrast, in a study of patients in specialty clinics, about one-fifth of individuals reported illness anxiety. The prevalence of the disorder is similar in men and women. Development and Course The development and course of illness anxiety disorder are unclear. Illness anxiety disorder is generally thought to be a chronic, episodic, and relapsing condition with an age at onset in early and middle adulthood. The disorder is thought to be rare in children, although the onset of health-related anxieties can occur in childhood or adolescence. In some population-based samples, health-related anxiety increases with age, but in others, health anxiety peaks in middle age, before declining in older age. The ages of individuals with high health anxiety in medical settings do not appear to differ from those of other individuals in those settings. In older individuals, health-related anxiety often focuses on memory loss and sensory loss. Risk and Prognostic Factors Illness anxiety disorder may sometimes be precipitated by a major life stress or a serious but ultimately benign threat to the individual’s health. A history of childhood abuse or of a serious childhood illness, serious illness in a parent, or death of an ill parent during childhood may predispose to development of the disorder in adulthood.

Course modifiers. Other medical conditions. Adjustment disorders. Somatic symptom disorder. Anxiety disorders. Obsessive-compulsive and related disorders. Approximately one-third to one-half of individuals with illness anxiety disorder have a transient form, which is associated with less psychiatric comorbidity, more medical comorbidity, and less severe illness anxiety disorder. Culture-Related Diagnostic Issues The diagnosis should be made with caution in individuals whose ideas about disease are congruent with widely held cultural beliefs. The prevalence appears to be similar across different countries, although little is known about the cross-cultural variation in phenomenology. Functional Consequences of Illness Anxiety Disorder Illness anxiety disorder causes substantial role impairment and decrements in physical function and health-related quality of life. Health concerns often interfere with interpersonal relationships, disrupt family life, and damage occupational performance. Differential Diagnosis The first differential diagnostic consideration is an underlying medical condition, including neurological or endocrine conditions, occult malignancies, and other diseases that affect multiple body systems. The presence of a medical condition does not rule out the possibility of coexisting illness anxiety disorder. If a medical condition is present, the healthrelated anxiety and disease concerns are clearly disproportionate to its seriousness. Transient preoccupations related to a medical condition do not constitute illness anxiety disorder. Health-related anxiety is a normal response to serious illness and is not a mental disorder. Such nonpathological health anxiety is clearly related to the medical condition and is typically time-limited. If the health anxiety is severe enough to cause clinically significant distress or impairment in one or more important areas of functioning, an adjustment disorder may be

diagnosed. However, if disproportionate health-related anxiety persists for longer than 6 months, a diagnosis of illness anxiety disorder may apply. Both somatic symptom disorder and illness anxiety disorder may be characterized by a high level of anxiety about health and excessive health-related behaviors. They are differentiated by the fact that somatic symptom disorder requires the presence of somatic symptoms that are distressing or result in significant disruption of daily life, whereas in illness anxiety disorder, somatic symptoms either are not present or, if present, are only mild in intensity. In generalized anxiety disorder, individuals worry about multiple events, situations, or activities, only one of which may involve health. In panic disorder, the individual may be concerned that the panic attacks reflect the presence of a medical illness; however, although these individuals may have health anxiety, their anxiety is typically very acute and episodic. In illness anxiety disorder, the health anxiety and fears are more persistent and enduring. Individuals with illness anxiety disorder may experience panic attacks that are triggered by their illness concerns. Individuals with illness anxiety disorder may have intrusive thoughts about having a disease and also may have associated compulsive behaviors

Major depressive disorder. Psychotic disorders. (e.g., seeking reassurance). However, in illness anxiety disorder, the preoccupations are usually focused on having a disease, whereas in obsessive-compulsive disorder (OCD), the thoughts are intrusive and are usually focused on fears of getting a disease in the future. Most individuals with OCD have obsessions or compulsions involving other concerns in addition to fears about contracting disease. In body dysmorphic disorder, concerns are limited to the individual’s physical appearance, which is viewed as defective or flawed. Some individuals with a major depressive episode ruminate about their health and worry excessively about illness. A separate diagnosis of illness anxiety disorder is not made if these concerns occur only during major depressive episodes. However, if excessive illness worry persists after remission of an episode of major depressive disorder, the diagnosis of illness anxiety disorder should be considered. Individuals with illness anxiety disorder are not delusional and can acknowledge the possibility that the feared disease is not present. Their ideas do not attain the rigidity and intensity seen in the somatic delusions occurring in psychotic disorders (e.g., schizophrenia; delusional disorder, somatic type; major depressive disorder, with psychotic features). True somatic delusions are generally more bizarre (e.g., that an organ is rotting or dead) than the concerns seen in illness anxiety disorder. The concerns seen in illness anxiety disorder, though not founded in reality, are plausible. Comorbidity Illness anxiety disorder co-occurs with anxiety disorders (in particular, generalized anxiety disorder and panic disorder), OCD, and depressive disorders. Approximately two-thirds of individuals with illness anxiety disorder are likely to have at least one other comorbid major mental disorder. Individuals with illness anxiety disorder may have an elevated risk for personality disorders. Functional Neurological Symptom Disorder (Conversion Disorder) Diagnostic Criteria A. One or more symptoms of altered voluntary motor or sensory function. B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions. C. The symptom or deficit is not better explained by another medical or mental disorder. D. The symptom or deficit causes clinically significant distress or impairment in

social, occupational, or other important areas of functioning or warrants medical evaluation. Coding note: The ICD-10-CM code depends on the symptom type (see below). Specify symptom type: F44.4 With weakness or paralysis F44.4 With abnormal movement (e.g., tremor, dystonia, myoclonus, gait disorder) F44.4 With swallowing symptoms F44.4 With speech symptom (e.g.,

dysphonia, slurred speech) F44.5 With attacks or seizures F44.6 With anesthesia or sensory loss F44.6 With special sensory symptom (e.g., visual, olfactory, or hearing disturbance) F44.7 With mixed symptoms Specify if: Acute episode: Symptoms present for less than 6 months. Persistent: Symptoms occurring for 6 months or more. Specify if: With psychological stressor (specify stressor) Without psychological stressor Diagnostic Features In functional neurological symptom disorder (conversion disorder), there may be one or more neurological symptoms of various types. Motor symptoms include weakness or paralysis; abnormal movements, such as tremor, jerks, or dystonic movements; and gait abnormalities. Sensory symptoms include altered, reduced, or absent skin sensation, vision, or hearing. Episodes of apparent unresponsiveness with or without limb movements may resemble epileptic seizures, syncope, or coma (also called dissociative, psychogenic, or nonepileptic seizures or attacks). Other symptoms include reduced or absent speech volume (dysphonia/aphonia); altered speech articulation, prosody, or fluency; a sensation of a lump in the throat (globus); and diplopia. This disorder has been called “conversion disorder” in prior editions of DSM as well as in much of the psychiatric research literature. The term “conversion” originated in psychoanalytic theory, which proposes that unconscious psychic conflict is “converted” into physical symptoms. The diagnosis rests on clinical findings that show clear evidence of incompatibility with recognized neurological disease. These should usually be elicited and interpreted in the context of the whole clinical picture by a health care professional with expertise in the diagnosis of

neurological conditions. The diagnosis is not one of exclusion and can be made in individuals who also have neurological diseases like epilepsy or multiple sclerosis. The diagnosis should not be made simply because results from investigations are normal or because the symptom is “bizarre.” Internal inconsistency during examination is one way to demonstrate incompatibility (i.e., demonstrating that physical signs elicited through one examination method are no longer present when tested a different way). There are dozens of examples of such “positive” examination findings. Examples of examination findings that indicate incompatibility with recognized neurological disease include the following: For functional limb weakness or paralysis: Hoover’s sign, in which weakness of hip extension returns to normal strength with contralateral hip flexion against resistance; the hip abductor sign, in which weakness of thigh abduction returns to normal with contralateral hip abduction against resistance; or a discrepancy between on-the-bed performance (e.g., weakness of ankle plantar flexion) compared with another task (e.g., ability to walk on tiptoes). For functional tremor: the tremor entrainment test, in which a tremor changes when the individual is distracted by copying the examiner in making a rhythmical movement with the contralateral hand or foot. The test is positive when the tremor “entrains” the rhythm of the unaffected hand or foot, the tremor is suppressed, or the individual cannot copy simple rhythmical movements. Other features of functional limb tremor include variability in frequency or direction of the tremor. For functional dystonia: individuals typically present with fixed inverted position of the ankle, a clenched fist, or unilateral contraction of platysma, often with sudden onset. For attacks resembling epileptic seizures or syncope (also called functional or dissociative [nonepileptic] seizures): features suggestive of functional neurological symptom disorder include persistent eye closure sometimes with resistance to opening, bilateral motor movements with preserved awareness, or a duration longer than 5 minutes. Clinical features usually need to be combined and may be supported with a normal simultaneous ictal electroencephalogram (although this alone does not exclude all forms of epilepsy or syncope. For functional speech symptoms: internal inconsistencies in speech articulation and phonation. For functional visual symptoms: a tubular

visual field (i.e., tunnel vision) and tests that indicate internal inconsistency in visual acuity, such as the “fogging test” (i.e., while the individual views the eye chart with both eyes open, the “good” eye is subtly fogged so that any useful binocular vision must be a result of “bad” eye function). It is important to note that the diagnosis of functional neurological symptom disorder should be based on the overall clinical picture and not on a single clinical finding. Associated Features Several associated features can support the diagnosis of functional neurological symptom disorder, although none are specific. There may be a history of other functional somatic symptoms or disorders, especially involving pain and fatigue. Onset may be associated with stress or trauma, either psychological or physical in nature. The potential etiological relevance of this stress or trauma may be suggested by a close temporal relationship. However, while assessment for stress and trauma is important, it may be absent in up to 50% of individuals, and the diagnosis should not be withheld if none is found. Functional neurological symptom disorder is often associated with dissociative symptoms,

Temperamental. Environmental. Genetic and physiological. Course modifiers. such as depersonalization, derealization, and dissociative amnesia, particularly at symptom onset or during attacks. The phenomenon of la belle indifférence (i.e., lack of concern about the nature or implications of the symptom) has been associated with functional neurological symptom disorder, but it is not specific and should not be used to make the diagnosis. Similarly, the concept of secondary gain (i.e., when individuals derive external benefits such as money or release from responsibilities) is also not specific to functional neurological symptom disorder. Prevalence Transient functional neurological symptoms are common, but the precise prevalence of the disorder is unknown. Based on research in the United States and northern Europe, the incidence of individual persistent functional neurological symptoms is estimated to be 4–12/100,000 per year. Prevalence in specialty clinics appears to be higher, although data are limited. For example, 5% of outpatients ages 9–17 in a Japanese psychiatric clinic and 6% of adult and adolescent admissions to an inpatient psychiatric hospital in Oman received a diagnosis consistent with functional neurological symptom disorder. In neurology clinics, around 5%–15% of individuals have a diagnosis of functional neurological symptom disorder in studies from Scotland and Australia. Development and Course Onset has been reported throughout the life course. The mean onset of nonepileptic attacks peaks at ages 20–29 years, and motor symptoms have their mean onset at ages 30–39 years. The symptoms can be transient or persistent. The prognosis may be better in younger children than in adolescents and adults. Risk and Prognostic Factors Maladaptive personality traits, especially emotional instability, are commonly associated with functional neurological symptom disorder. There may be a history of childhood abuse and neglect. Stressful life events including physical injury are common but not universal triggering factors. The presence of neurological disease that causes similar symptoms is a risk factor (e.g., around one in five individuals with functional [nonepileptic] seizures also have epilepsy). Short duration of symptoms and agreement with the diagnosis are positive prognostic factors. Maladaptive personality traits, the presence of comorbid physical disease, and the receipt of disability benefits appear to be negative prognostic factors. Culture-Related Diagnostic Issues Episodes of unresponsiveness (including seizures) and motor symptoms are the most common functional neurological symptoms across cultural contexts. High comorbidity between functional

Recognized neurological disease. Somatic symptom disorder. Factitious disorder and malingering. neurological and dissociative symptoms is common cross-culturally, especially in individuals with

nonepileptic seizures. Changes resembling functional neurological (and dissociative) symptoms are common in certain culturally sanctioned rituals. If the symptoms are fully explained within the particular cultural context and do not result in clinically significant distress or disability, then the diagnosis of functional neurological symptom disorder is not made. Sex- and Gender-Related Diagnostic Issues Functional neurological symptom disorder is two to three times more common in women for most symptom presentations. One large clinical study found higher rates of cognitive impairment and weakness in men and increased past sexual and physical trauma in women. Association With Suicidal Thoughts or Behavior Cohort studies of functional neurological symptom disorder mostly show higher rates of suicidal thoughts and attempts. Individuals with functional symptoms in a neurology clinic have a higher rate of suicidal thoughts than individuals with recognized neurological disease. A study in Turkey of 100 consecutive psychiatric outpatients with functional neurological symptom disorder found that a history of suicide attempt was associated with risky use of alcohol, a history of childhood maltreatment, and greater severity of dissociative symptoms as compared with those who did not attempt suicide. Functional Consequences of Functional Neurological Symptom Disorder Individuals with functional neurological symptom disorder may have substantial physical disability. The severity of disability can be similar to that experienced by individuals with comparable recognized medical conditions. Differential Diagnosis The main differential diagnosis is recognized neurological disease that might better explain the symptoms. After a thorough neurological assessment, an unexpected neurological disease cause for the symptoms is rarely found at follow-up. However, reassessment may be required if the symptoms appear to be progressive. Functional neurological symptom disorder commonly coexists with recognized neurological disease and may be part of the prodromal state of some progressive neurological diseases. Functional neurological symptom disorder may be diagnosed in addition to somatic symptom disorder. Most of the somatic symptoms encountered in somatic symptom disorder cannot be demonstrated to be clearly incompatible with recognized neurological or medical disease, whereas in functional neurological symptom disorder, such incompatibility is required for the diagnosis. Functional neurological symptom disorder describes genuinely experienced symptoms that are not intentionally produced (i.e., not feigned). However, definite

Dissociative disorders. Body dysmorphic disorder. Depressive disorders. Panic disorder. F54 evidence of feigning (e.g., marked discrepancy between reported and observed activities of daily living) would suggest malingering if the individual’s apparent aim is to obtain an obvious external reward, or factitious disorder in the absence of such reward. Dissociative symptoms are common in individuals with functional neurological symptom disorder. If both functional neurological symptom disorder and a dissociative disorder are present, both diagnoses should be made. Individuals with body dysmorphic disorder are excessively concerned about a perceived defect in their physical appearance but do not complain of symptoms of sensory or motor functioning in the affected body part. In depressive disorders, individuals may report general heaviness of their limbs, whereas the weakness of functional neurological symptom disorder is more focal and prominent. Depressive disorders are also differentiated by the presence of core depressive symptoms. Episodic neurological symptoms (e.g., tremor and paresthesia) can occur in both functional neurological symptom disorder and panic attacks. In panic attacks, the neurological symptoms are typically associated with characteristic cardiorespiratory symptoms and retained awareness. Loss of awareness with amnesia for the attack occurs in functional seizures but not in panic attacks. Comorbidity Anxiety disorders, especially panic disorder, and depressive disorders commonly co-occur with functional neurological symptom disorder. Somatic symptom disorder may co-occur as

well. Personality disorders are more common in individuals with functional neurological symptom disorder than in the general population. Neurological or other medical conditions commonly coexist with functional neurological symptom disorder as well. Psychological Factors Affecting Other Medical Conditions Diagnostic Criteria A. A medical symptom or condition (other than a mental disorder) is present. B. Psychological or behavioral factors adversely affect the medical condition in one of the following ways:

1. The factors have influenced the course of the medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition.
2. The factors interfere with the treatment of the medical condition (e.g., poor adherence).
3. The factors constitute additional well-established health risks for the individual.
4. The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention. C. The psychological and behavioral factors in Criterion B are not better explained by another mental disorder (e.g., panic disorder, major depressive disorder, posttraumatic stress disorder). Specify current severity: Mild: Increases medical risk (e.g., inconsistent adherence with antihypertension treatment). Moderate: Aggravates underlying medical condition (e.g., anxiety aggravating asthma). Severe: Results in medical hospitalization or emergency room visit. Extreme: Results in severe, life-threatening risk (e.g., ignoring heart attack symptoms). Diagnostic Features The essential feature of psychological factors affecting other medical conditions is the presence of one or more clinically significant psychological or behavioral factors that adversely affect a medical condition by increasing the risk for suffering, death, or disability (Criterion B). These factors can adversely affect the medical condition by influencing its course or treatment, by constituting an additional well-established health risk factor, or by influencing the underlying pathophysiology to precipitate or exacerbate symptoms or to necessitate medical attention. Psychological or behavioral factors include psychological distress, patterns of interpersonal interaction, coping styles, and maladaptive health behaviors, such as denial of symptoms or poor adherence to medical recommendations. Common clinical examples are anxiety-exacerbating asthma, denial of need for treatment for acute chest pain, and manipulation of insulin by an individual with diabetes wishing to lose weight. Many different psychological factors have been demonstrated to adversely influence medical conditions—for example, symptoms of depression or anxiety, stressful life events, relationship style, personality traits, and coping styles. The adverse effects can range from acute, with immediate medical consequences (e.g., Takotsubo cardiomyopathy), to chronic, occurring over a long period of time (e.g., chronic occupational stress increasing risk for hypertension). Affected medical conditions can be those with clear pathophysiology (e.g., diabetes, cancer, coronary disease), functional syndromes (e.g., migraine, irritable bowel syndrome, fibromyalgia), or idiopathic medical symptoms (e.g., pain, fatigue, dizziness). This diagnosis should be reserved for situations in which the effect of the psychological factor on the medical condition is evident and the psychological factor has clinically significant effects on the course or outcome of the medical condition. Abnormal psychological or behavioral

Mental disorder due to another medical condition. symptoms that develop in response to a medical condition are more properly coded as an adjustment disorder (a clinically significant psychological response to an identifiable stressor). There must be reasonable evidence to suggest an association between the psychological factors and the medical condition, although it may often not be possible to demonstrate direct causality or the mechanisms underlying the relationship. Prevalence The prevalence of psychological factors affecting other medical conditions is unclear. In U.S. private insurance billing data, it was a more common diagnosis than DSM-IV somatic symptom disorders. Development and Course Psychological factors affecting other medical conditions can occur across the lifespan. Particularly with young children, corroborative history from parents or school can assist the diagnostic evaluation. Some conditions are characteristic of particular life stages (e.g., in older individuals, the stress associated with acting as a caregiver for an ill spouse or partner). Culture-Related Diagnostic Issues Many differences between cultural contexts may influence psychological factors and their effects on medical conditions, such as those in language and communication style, idioms of distress, explanatory models of illness, patterns of seeking health care, service availability and organization, doctor-patient relationships and other healing practices, family and gender roles, and attitudes toward pain and death. Psychological factors affecting other medical conditions must be differentiated from culturally specific coping behaviors such as accessing faith, spiritual, or traditional healers or other variations in illness management that are acceptable within cultural contexts and represent an attempt to help heal the medical condition. These local practices may complement rather than obstruct evidence-based interventions. Use of alternative healing practices may delay use of medical services and affect outcomes, but when the intent of the healing practice is to address the problem in a culturally sanctioned way, these practices should not be pathologized as psychological factors affecting other medical conditions. Functional Consequences of Psychological Factors Affecting Other Medical Conditions Psychological and behavioral factors have been demonstrated to affect the course of many medical diseases. Differential Diagnosis A temporal association between symptoms of a mental disorder and those of a medical condition is also characteristic of a mental disorder due to another medical condition, but the presumed causality is in the opposite direction. In a mental

Adjustment disorders. Somatic symptom disorder. Illness anxiety disorder. disorder due to another medical condition, the medical condition is judged to be causing the mental disorder through a direct physiological mechanism. In psychological factors affecting other medical conditions, the psychological or behavioral factors are judged to affect the course of the medical condition. Abnormal psychological or behavioral symptoms that develop in response to a medical condition are more properly coded as an adjustment disorder (a clinically significant psychological response to an identifiable stressor). For example, an individual with angina that is precipitated whenever he becomes enraged would be diagnosed as having psychological factors affecting other medical conditions, whereas an individual with angina who developed maladaptive anticipatory anxiety would be diagnosed as having an adjustment disorder with anxiety. In clinical practice, however, psychological factors and a medical condition are often mutually exacerbating (e.g., anxiety as both a precipitant and a consequence of angina), in which case the distinction is arbitrary. Other mental disorders frequently result in medical complications, most notably substance use disorders (e.g., alcohol use disorder, tobacco use disorder). If an individual has a coexisting major mental disorder that adversely affects or causes another medical condition, diagnoses of the mental disorder and the medical condition are usually sufficient. Psychological factors affecting other medical conditions is diagnosed when the psychological traits or behaviors do not meet criteria for

a mental diagnosis. Somatic symptom disorder is characterized by a combination of distressing somatic symptoms and excessive or maladaptive thoughts, feelings, and behavior in response to these symptoms or associated health concerns. The individual may or may not have a diagnosable medical condition. In contrast, in psychological factors affecting other medical conditions, the psychological factors adversely affect a medical condition; the individual's thoughts, feelings, and behavior are not necessarily excessive. The difference is one of emphasis, rather than a clear-cut distinction. In psychological factors affecting other medical conditions, the emphasis is on the exacerbation of the medical condition (e.g., an individual with angina that is precipitated whenever he becomes anxious). In somatic symptom disorder, the emphasis is on maladaptive thoughts, feelings, and behavior (e.g., an individual with angina who worries constantly that she will have a heart attack, takes her blood pressure multiple times per day, and restricts her activities). Illness anxiety disorder is characterized by high illness anxiety that is distressing and/or disruptive to daily life with minimal somatic symptoms. The focus of clinical concern is the individual's worry about having a disease; in most cases, no serious disease is present. In psychological factors affecting other medical conditions, anxiety may be a relevant psychological factor affecting a medical condition, but the clinical concern is the adverse effects on the medical condition. Comorbidity By definition, the diagnosis of psychological factors affecting other medical conditions entails a relevant psychological or behavioral syndrome or trait and a comorbid medical condition.

F68.10 F68.A Factitious Disorder Diagnostic Criteria Factitious Disorder Imposed on Self A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception. B. The individual presents himself or herself to others as ill, impaired, or injured. C. The deceptive behavior is evident even in the absence of obvious external rewards. D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder. Specify: Single episode Recurrent episodes (two or more events of falsification of illness and/or induction of injury) Factitious Disorder Imposed on Another (Previously Factitious Disorder by Proxy) A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception. B. The individual presents another individual (victim) to others as ill, impaired, or injured. C. The deceptive behavior is evident even in the absence of obvious external rewards. D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder. Note: The perpetrator, not the victim, receives this diagnosis. Specify: Single episode Recurrent episodes (two or more events of falsification of illness and/or induction of injury) Recording Procedures When an individual falsifies illness in another (e.g., children, adults, pets), the diagnosis is factitious disorder imposed on another. The perpetrator, not the victim, is given the diagnosis.

The victim may be given an abuse diagnosis (e.g., T74.12X; see the chapter "Other Conditions That May Be a Focus of Clinical Attention"). If an individual with factitious disorder imposed on another has also deceptively represented his or her own illness or injury, both factitious disorder imposed on self and on another can be diagnosed. Diagnostic Features The essential feature of factitious disorder is the falsification of medical or psychological signs and symptoms in the individual or others that are associated with the identified deception. Individuals with factitious disorder can also seek treatment for themselves or another following induction of injury or disease. The diagnosis requires demonstrating that the individual is taking surreptitious actions to misrepresent, simulate, or cause signs or symptoms of illness or injury even in the absence of obvious external rewards. The diagnosis of factitious disorder emphasizes the objective identification of falsification of signs

and symptoms of illness and not the individual motivations of the falsifier. Methods of illness falsification can include exaggeration, fabrication, simulation, and induction. While a preexisting medical condition may be present, the deceptive behavior or induction of injury associated with deception causes others to view such individuals (or, in the case of factitious disorder imposed on another, the victim) as more ill or impaired, and this can lead to excessive clinical intervention. Individuals with factitious disorder might, for example, report feelings of depression and suicidal thoughts or behavior following the death of a spouse despite the death not being true or the individual's not having a spouse; deceptively report episodes of neurological symptoms (e.g., seizures, dizziness, or blacking out); manipulate a laboratory test (e.g., by adding blood to urine) to falsely indicate an abnormality; falsify medical records to indicate an illness; ingest a substance (e.g., insulin or warfarin) to induce an abnormal laboratory result or illness; or physically injure themselves or induce illness in themselves or another (e.g., by injecting fecal material to produce an abscess or to induce sepsis). Although individuals with factitious disorder most often present to health care professionals for treatment of their factitious symptoms, some individuals with factitious disorder choose to mislead community members in person or online about illness or injury without necessarily engaging health care professionals. Associated Features Individuals with factitious disorder imposed on self or factitious disorder imposed on another are at risk for experiencing great psychological distress or functional impairment by causing harm to themselves and others. Family, friends, faith leaders, and health care professionals are also often adversely affected by their behavior (e.g., devoted time, attention, and resources to provide medical care and emotional support to the falsifier). Individuals with factitious disorder imposed on another sometimes falsely allege the presence of educational deficits or disabilities in their children for which they demand special attention, often at considerable inconvenience to education professionals. Whereas some aspects of factitious disorders might represent criminal behavior (e.g., factitious disorder imposed on another, in which the parent's actions represent abuse and maltreatment of a child), such criminal behavior and mental illness are not mutually exclusive. Moreover, such behaviors, including the induction of injury or disease, are associated with deception.

Deception to avoid legal liability. Somatic symptom and related disorders. Malingering. Prevalence The prevalence of factitious disorder is unknown, likely because of the role of deception in this population. Further complicating efforts at determining prevalence is the fact that health care professionals infrequently record the diagnosis, even in recognized cases. Based on a study of general hospital inpatients in the United States referred for psychiatric consultation, it is estimated that almost 1% have presentations that meet the criteria for factitious disorder. Factitious disorder imposed on self or another appears to be encountered more frequently in tertiary care settings than at primary care sites. Development and Course The course of factitious disorder is usually one of intermittent episodes. Single episodes and episodes that are characterized as persistent and unremitting are both less common. Onset is usually in early adulthood, often after hospitalization for a medical condition or a mental disorder. When imposed on another, the disorder may begin after hospitalization of the individual's child or other dependent. In individuals with recurrent episodes of falsification of signs and symptoms of illness and/or induction of injury, this pattern of successive deceptive contact with medical personnel, including hospitalizations, may become lifelong. Sex- and Gender-Related Diagnostic Issues While the prevalence is not known, a pooled analysis of all case series and studies finds that twothirds of individuals with factitious disorder are women and one-third are men. Differential Diagnosis Caregivers who lie about abuse injuries in

dependents solely to protect themselves from liability are not diagnosed with factitious disorder imposed on another because protection from liability is an external reward (Criterion C, the deceptive behavior is evident even in the absence of obvious external rewards). Such caregivers who, upon observation, analysis of medical records, and/or interviews with others, are found to lie more extensively than needed for immediate self-protection are diagnosed with factitious disorder imposed on another. In somatic symptom disorder and the care-seeking type of illness anxiety disorder, there may be excessive attention and treatment seeking for perceived medical concerns, but there is no evidence that the individual is providing false information or behaving deceptively. Malingering is differentiated from factitious disorder by the intentional reporting of symptoms for personal gain (e.g., money, time off work). In contrast, the diagnosis of factitious disorder requires that the illness falsification is not fully accounted for by external rewards. Factitious disorder and malingering are not mutually exclusive, however. The motives in any single case might be multiple and shifting depending on the circumstances and reactions of others.

Functional neurological symptom disorder (conversion disorder). Borderline personality disorder. Medical condition or mental disorder not associated with intentional symptom falsification. Functional neurological symptom disorder is characterized by neurological symptoms that are inconsistent with neurological pathophysiology. Factitious disorder with neurological symptoms is distinguished from functional neurological symptom disorder by evidence of deceptive falsification of symptoms. Deliberate physical self-harm in the absence of suicidal intent can also occur in association with other mental disorders such as borderline personality disorder. Factitious disorder requires that the induction of injury occur in association with deception. Presentation of signs and symptoms of illness that do not conform to an identifiable medical condition or mental disorder increases the likelihood of the presence of a factitious disorder. However, the diagnosis of factitious disorder does not exclude the presence of a true medical condition or mental disorder, as comorbid illness often occurs in the individual along with factitious disorder. For example, individuals who might manipulate blood sugar levels to produce symptoms may also have diabetes. Other Specified Somatic Symptom and Related Disorder F45.8 This category applies to presentations in which symptoms characteristic of a somatic symptom and related 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 somatic symptom and related disorders diagnostic class. Examples of presentations that can be specified using the “other specified” designation include the following:

1. Brief somatic symptom disorder: Duration of symptoms is less than 6 months.
2. Brief illness anxiety disorder: Duration of symptoms is less than 6 months.
3. Illness anxiety disorder without excessive health-related behaviors or maladaptive avoidance: Criterion D for illness anxiety disorder is not met.
4. Pseudocyesis: A false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy. Unspecified Somatic Symptom and Related Disorder F45.9 This category applies to presentations in which symptoms characteristic of a somatic

symptom and related 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 somatic symptom and related disorders diagnostic class. The unspecified somatic symptom and related disorder category should not be used unless there are

decidedly unusual situations where there is insufficient information to make a more specific diagnosis.

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