vidual 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. 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. 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.

Factitious Disorder

Diagnostic Criteria **300.19 (F68.10)**

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., 995.54 [T74.12X]; see the chapter "Other Conditions That May Be a Focus of Clinical Attention").

Diagnostic Features

The essential feature of factitious disorder is the falsification of medical or psychological signs and symptoms in oneself 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 in the absence of obvious external rewards. 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 another) 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 suicidality 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).

Associated Features Supporting Diagnosis

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, and health care professionals are also often adversely affected by their behavior. Factitious disorders have similarities to substance use disorders, eating disorders, impulse-control disorders, pedophilic disorder, and some other established disorders related to both the persistence of the behavior and the intentional efforts to conceal the disordered behavior through deception. Whereas some aspects of factitious disorders might represent criminal behavior (e.g., factitious dis-

order 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. The diagnosis of factitious disorder emphasizes the objective identification of falsification of signs and symptoms of illness, rather than an inference about intent or possible underlying motivation. Moreover, such behaviors, including the induction of injury or disease, are associated with deception.

Prevalence

The prevalence of factitious disorder is unknown, likely because of the role of deception in this population. Among patients in hospital settings, it is estimated that about 1% of individuals have presentations that meet the criteria for factitious disorder.

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.

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.

Somatic symptom disorder. In somatic symptom 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. 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 the absence of obvious rewards.

Conversion disorder (functional neurological symptom disorder). Conversion disorder is characterized by neurological symptoms that are inconsistent with neurological pathophysiology. Factitious disorder with neurological symptoms is distinguished from conversion disorder by evidence of deceptive falsification of symptoms.

Borderline personality disorder. 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.

Medical condition or mental disorder not associated with intentional symptom falsification. 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 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

300.89 (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:** 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

300.82 (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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Feeding and Eating Disorders

Feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning. Diagnostic criteria are provided for pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder.

The diagnostic criteria for rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder result in a classification scheme that is mutually exclusive, so that during a single episode, only one of these diagnoses can be assigned. The rationale for this approach is that, despite a number of common psychological and behavioral features, the disorders differ substantially in clinical course, outcome, and treatment needs. A diagnosis of pica, however, may be assigned in the presence of any other feeding and eating disorder.

Some individuals with disorders described in this chapter report eating-related symptoms resembling those typically endorsed by individuals with substance use disorders, such as craving and patterns of compulsive use. This resemblance may reflect the involvement of the same neural systems, including those implicated in regulatory self-control and reward, in both groups of disorders. However, the relative contributions of shared and distinct factors in the development and perpetuation of eating and substance use disorders remain insufficiently understood.

Finally, obesity is not included in DSM-5 as a mental disorder. Obesity (excess body fat) results from the long-term excess of energy intake relative to energy expenditure. A range of genetic, physiological, behavioral, and environmental factors that vary across individuals contributes to the development of obesity; thus, obesity is not considered a mental disorder. However, there are robust associations between obesity and a number of mental disorders (e.g., binge-eating disorder, depressive and bipolar disorders, schizophrenia). The side effects of some psychotropic medications contribute importantly to the development of obesity, and obesity may be a risk factor for the development of some mental disorders (e.g., depressive disorders).

Pica

Diagnostic Criteria

A. Persistent eating of nonnutritive, nonfood substances over a period of at least 1 month.
B. The eating of nonnutritive, nonfood substances is inappropriate to the developmental level of the individual.
C. The eating behavior is not part of a culturally supported or socially normative practice.
D. If the eating behavior occurs in the context of another mental disorder (e.g., intellectual disability [intellectual developmental disorder], autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.

Coding note: The ICD-9-CM code for pica is **307.52** and is used for children or adults. The ICD-10-CM codes for pica are **(F98.3)** in children and **(F50.8)** in adults.

Specify if:

In remission: After full criteria for pica were previously met, the criteria have not been met for a sustained period of time.

Diagnostic Features

The essential feature of pica is the eating of one or more nonnutritive, nonfood substances on a persistent basis over a period of at least 1 month (Criterion A) that is severe enough to warrant clinical attention. Typical substances ingested tend to vary with age and availability and might include paper, soap, cloth, hair, string, wool, soil, chalk, talcum powder, paint, gum, metal, pebbles, charcoal or coal, ash, clay, starch, or ice. The term *nonfood* is included because the diagnosis of pica does not apply to ingestion of diet products that have minimal nutritional content. There is typically no aversion to food in general. The eating of nonnutritive, nonfood substances must be developmentally inappropriate (Criterion B) and not part of a culturally supported or socially normative practice (Criterion C). A minimum age of 2 years is suggested for a pica diagnosis to exclude developmentally normal mouthing of objects by infants that results in ingestion. The eating of nonnutritive, nonfood substances can be an associated feature of other mental disorders (e.g., intellectual disability [intellectual developmental disorder], autism spectrum disorder, schizophrenia). If the eating behavior occurs exclusively in the context of another mental disorder, a separate diagnosis of pica should be made only if the eating behavior is sufficiently severe to warrant additional clinical attention (Criterion D).

Associated Features Supporting Diagnosis

Although deficiencies in vitamins or minerals (e.g., zinc, iron) have been reported in some instances, often no specific biological abnormalities are found. In some cases, pica comes to clinical attention only following general medical complications (e.g., mechanical bowel problems; intestinal obstruction, such as that resulting from a bezoar; intestinal perforation; infections such as toxoplasmosis and toxocariasis as a result of ingesting feces or dirt; poisoning, such as by ingestion of lead-based paint).

Prevalence

The prevalence of pica is unclear. Among individuals with intellectual disability, the prevalence of pica appears to increase with the severity of the condition.

Development and Course

Onset of pica can occur in childhood, adolescence, or adulthood, although childhood onset is most commonly reported. Pica can occur in otherwise normally developing children, whereas in adults, it appears more likely to occur in the context of intellectual disability or other mental disorders. The eating of nonnutritive, nonfood substances may also manifest in pregnancy, when specific cravings (e.g., chalk or ice) might occur. The diagnosis of pica during pregnancy is only appropriate if such cravings lead to the ingestion of nonnutritive, nonfood substances to the extent that the eating of these substances poses potential medical risks. The course of the disorder can be protracted and can result in medical emergencies (e.g., intestinal obstruction, acute weight loss, poisoning). The disorder can potentially be fatal depending on substances ingested.

Risk and Prognostic Factors

Environmental. Neglect, lack of supervision, and developmental delay can increase the risk for this condition.

Culture-Related Diagnostic Issues

In some populations, the eating of earth or other seemingly nonnutritive substances is believed to be of spiritual, medicinal, or other social value, or may be a culturally supported or socially normative practice. Such behavior does not warrant a diagnosis of pica (Criterion C).

Gender-Related Diagnostic Issues

Pica occurs in both males and females. It can occur in females during pregnancy; however, little is known about the course of pica in the postpartum period.

Diagnostic Markers

Abdominal flat plate radiography, ultrasound, and other scanning methods may reveal obstructions related to pica. Blood tests and other laboratory tests can be used to ascertain levels of poisoning or the nature of infection.

Functional Consequences of Pica

Pica can significantly impair physical functioning, but it is rarely the sole cause of impairment in social functioning. Pica often occurs with other disorders associated with impaired social functioning.

Differential Diagnosis

Eating of nonnutritive, nonfood substances may occur during the course of other mental disorders (e.g., autism spectrum disorder, schizophrenia) and in Kleine-Levin syndrome. In any such instance, an additional diagnosis of pica should be given only if the eating behavior is sufficiently persistent and severe to warrant additional clinical attention.

Anorexia nervosa. Pica can usually be distinguished from the other feeding and eating disorders by the consumption of nonnutritive, nonfood substances. It is important to note, however, that some presentations of anorexia nervosa include ingestion of nonnutritive, nonfood substances, such as paper tissues, as a means of attempting to control appetite. In such cases, when the eating of nonnutritive, nonfood substances is primarily used as a means of weight control, anorexia nervosa should be the primary diagnosis.

Factitious disorder. Some individuals with factitious disorder may intentionally ingest foreign objects as part of the pattern of falsification of physical symptoms. In such instances, there is an element of deception that is consistent with deliberate induction of injury or disease.

Nonsuicidal self-injury and nonsuicidal self-injury behaviors in personality disorders. Some individuals may swallow potentially harmful items (e.g., pins, needles, knives) in the context of maladaptive behavior patterns associated with personality disorders or nonsuicidal self-injury.

Comorbidity

Disorders most commonly comorbid with pica are autism spectrum disorder and intellectual disability (intellectual developmental disorder), and, to a lesser degree, schizophrenia and obsessive-compulsive disorder. Pica can be associated with trichotillomania (hair-pulling disorder) and excoriation (skin-picking) disorder. In comorbid presentations, the hair or skin is typically ingested. Pica can also be associated with avoidant/restrictive food intake disorder, particularly in individuals with a strong sensory component to their presentation. When an individual is known to have pica, assessment should include consideration of the possibility of gastrointestinal complications, poisoning, infection, and nutritional deficiency.

Rumination Disorder

Diagnostic Criteria **307.53 (F98.21)**

A. Repeated regurgitation of food over a period of at least 1 month. Regurgitated food may be re-chewed, re-swallowed, or spit out.
B. The repeated regurgitation is not attributable to an associated gastrointestinal or other medical condition (e.g., gastroesophageal reflux, pyloric stenosis).
C. The eating disturbance does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, binge-eating disorder, or avoidant/restrictive food intake disorder.
D. If the symptoms occur in the context of another mental disorder (e.g., intellectual disability [intellectual developmental disorder] or another neurodevelopmental disorder), they are sufficiently severe to warrant additional clinical attention.

Specify if:

In remission: After full criteria for rumination disorder were previously met, the criteria have not been met for a sustained period of time.

Diagnostic Features

The essential feature of rumination disorder is the repeated regurgitation of food occurring after feeding or eating over a period of at least 1 month (Criterion A). Previously swallowed food that may be partially digested is brought up into the mouth without apparent nausea, involuntary retching, or disgust. The food may be re-chewed and then ejected from the mouth or re-swallowed. Regurgitation in rumination disorder should be frequent, occurring at least several times per week, typically daily. The behavior is not better explained by an associated gastrointestinal or other medical condition (e.g., gastroesophageal reflux, pyloric stenosis) (Criterion B) and does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, binge-eating disorder, or avoidant/restrictive food intake disorder (Criterion C). If the symptoms occur in the context of another mental disorder (e.g., intellectual disability [intellectual developmental disorder], neurodevelopmental disorder), they must be sufficiently severe to warrant additional clinical attention (Criterion D) and should represent a primary aspect of the individual's presentation requiring intervention. The disorder may be diagnosed across the life span, particularly in individuals who also have intellectual disability. Many individuals with rumination disorder can be directly observed engaging in the behavior by the clinician. In other instances diagnosis can be made on the basis of self-report or corroborative information from parents or caregivers. Individuals may describe the behavior as habitual or outside of their control.

Associated Features Supporting Diagnosis

Infants with rumination disorder display a characteristic position of straining and arching the back with the head held back, making sucking movements with their tongue. They may give the impression of gaining satisfaction from the activity. They may be irritable and hungry between episodes of regurgitation. Weight loss and failure to make expected weight gains are common features in infants with rumination disorder. Malnutrition may occur despite the infant's apparent hunger and the ingestion of relatively large amounts of food, particularly in severe cases, when regurgitation immediately follows each feeding episode and regurgitated food is expelled. Malnutrition might also occur in older children and adults, particularly when the regurgitation is accompanied by restriction of intake. Adolescents and adults may attempt to disguise the regurgitation behavior by placing a

hand over the mouth or coughing. Some will avoid eating with others because of the acknowledged social undesirability of the behavior. This may extend to an avoidance of eating prior to social situations, such as work or school (e.g., avoiding breakfast because it may be followed by regurgitation).

Prevalence

Prevalence data for rumination disorder are inconclusive, but the disorder is commonly reported to be higher in certain groups, such as individuals with intellectual disability.

Development and Course

Onset of rumination disorder can occur in infancy, childhood, adolescence, or adulthood. The age at onset in infants is usually between ages 3 and 12 months. In infants, the disorder frequently remits spontaneously, but its course can be protracted and can result in medical emergencies (e.g., severe malnutrition). It can potentially be fatal, particularly in infancy. Rumination disorder can have an episodic course or occur continuously until treated. In infants, as well as in older individuals with intellectual disability (intellectual developmental disorder) or other neurodevelopmental disorders, the regurgitation and rumination behavior appears to have a self-soothing or self-stimulating function, similar to that of other repetitive motor behaviors such as head banging.

Risk and Prognostic Factors

Environmental. Psychosocial problems such as lack of stimulation, neglect, stressful life situations, and problems in the parent-child relationship may be predisposing factors in infants and young children.

Functional Consequences of Rumination Disorder

Malnutrition secondary to repeated regurgitation may be associated with growth delay and have a negative effect on development and learning potential. Some older individuals with rumination disorder deliberately restrict their food intake because of the social undesirability of regurgitation. They may therefore present with weight loss or low weight. In older children, adolescents, and adults, social functioning is more likely to be adversely affected.

Differential Diagnosis

Gastrointestinal conditions. It is important to differentiate regurgitation in rumination disorder from other conditions characterized by gastroesophageal reflux or vomiting. Conditions such as gastroparesis, pyloric stenosis, hiatal hernia, and Sandifer syndrome in infants should be ruled out by appropriate physical examinations and laboratory tests.

Anorexia nervosa and bulimia nervosa. Individuals with anorexia nervosa and bulimia nervosa may also engage in regurgitation with subsequent spitting out of food as a means of disposing of ingested calories because of concerns about weight gain.

Comorbidity

Regurgitation with associated rumination can occur in the context of a concurrent medical condition or another mental disorder (e.g., generalized anxiety disorder). When the regurgitation occurs in this context, a diagnosis of rumination disorder is appropriate only when the severity of the disturbance exceeds that routinely associated with such conditions or disorders and warrants additional clinical attention.