

diately induced by the phobic situation, to a degree that is persistent and out of proportion to the actual risk posed. There are various types of specific phobias: animal; natural environment; blood-injection-injury; situational; and other situations.

In social anxiety disorder (social phobia), the individual is fearful or anxious about or avoidant of social interactions and situations that involve the possibility of being scrutinized. These include social interactions such as meeting unfamiliar people, situations in which the individual may be observed eating or drinking, and situations in which the individual performs in front of others. The cognitive ideation is of being negatively evaluated by others, by being embarrassed, humiliated, or rejected, or offending others.

In panic disorder, the individual experiences recurrent unexpected panic attacks and is persistently concerned or worried about having more panic attacks or changes his or her behavior in maladaptive ways because of the panic attacks (e.g., avoidance of exercise or of unfamiliar locations). Panic attacks are abrupt surges of intense fear or intense discomfort that reach a peak within minutes, accompanied by physical and/or cognitive symptoms. Limited-symptom panic attacks include fewer than four symptoms. Panic attacks may be *expected*, such as in response to a typically feared object or situation, or *unexpected*, meaning that the panic attack occurs for no apparent reason. Panic attacks function as a marker and prognostic factor for severity of diagnosis, course, and comorbidity across an array of disorders, including, but not limited to, the anxiety disorders (e.g., substance use, depressive and psychotic disorders). Panic attack may therefore be used as a descriptive specifier for any anxiety disorder as well as other mental disorders.

Individuals with agoraphobia are fearful and anxious about two or more of the following situations: using public transportation; being in open spaces; being in enclosed places; standing in line or being in a crowd; or being outside of the home alone in other situations. The individual fears these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms. These situations almost always induce fear or anxiety and are often avoided and require the presence of a companion.

The key features of generalized anxiety disorder are persistent and excessive anxiety and worry about various domains, including work and school performance, that the individual finds difficult to control. In addition, the individual experiences physical symptoms, including restlessness or feeling keyed up or on edge; being easily fatigued; difficulty concentrating or mind going blank; irritability; muscle tension; and sleep disturbance.

Substance/medication-induced anxiety disorder involves anxiety due to substance intoxication or withdrawal or to a medication treatment. In anxiety disorder due to another medical condition, anxiety symptoms are the physiological consequence of another medical condition.

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

Separation Anxiety Disorder

Diagnostic Criteria	309.21 (F93.0)
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- A. Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:
1. Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.

2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.
 3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.
 4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.
 5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.
 6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.
 7. Repeated nightmares involving the theme of separation.
 8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated.
- B. The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in adults.
- C. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.
- D. The disturbance is not better explained by another mental disorder, such as refusing to leave home because of excessive resistance to change in autism spectrum disorder; delusions or hallucinations concerning separation in psychotic disorders; refusal to go outside without a trusted companion in agoraphobia; worries about ill health or other harm befalling significant others in generalized anxiety disorder; or concerns about having an illness in illness anxiety disorder.
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Diagnostic Features

The essential feature of separation anxiety disorder is excessive fear or anxiety concerning separation from home or attachment figures. The anxiety exceeds what may be expected given the person's developmental level (Criterion A). Individuals with separation anxiety disorder have symptoms that meet at least three of the following criteria: They experience recurrent excessive distress when separation from home or major attachment figures is anticipated or occurs (Criterion A1). They worry about the well-being or death of attachment figures, particularly when separated from them, and they need to know the whereabouts of their attachment figures and want to stay in touch with them (Criterion A2). They also worry about untoward events to themselves, such as getting lost, being kidnapped, or having an accident, that would keep them from ever being reunited with their major attachment figure (Criterion A3). Individuals with separation anxiety disorder are reluctant or refuse to go out by themselves because of separation fears (Criterion A4). They have persistent and excessive fear or reluctance about being alone or without major attachment figures at home or in other settings. Children with separation anxiety disorder may be unable to stay or go in a room by themselves and may display "clinging" behavior, staying close to or "shadowing" the parent around the house, or requiring someone to be with them when going to another room in the house (Criterion A5). They have persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home (Criterion A6). Children with this disorder often have difficulty at bedtime and may insist that someone stay with them until they fall asleep. During the night, they may make their way to their parents' bed (or that of a significant other, such as a sibling). Children may be reluctant or refuse to attend camp, to sleep at friends' homes, or to go on errands. Adults may be uncomfortable when traveling independently (e.g., sleeping in a hotel room). There may be repeated nightmares in which the content expresses the in-

dividual's separation anxiety (e.g., destruction of the family through fire, murder, or other catastrophe) (Criterion A7). Physical symptoms (e.g., headaches, abdominal complaints, nausea, vomiting) are common in children when separation from major attachment figures occurs or is anticipated (Criterion A8). Cardiovascular symptoms such as palpitations, dizziness, and feeling faint are rare in younger children but may occur in adolescents and adults.

The disturbance must last for a period of at least 4 weeks in children and adolescents younger than 18 years and is typically 6 months or longer in adults (Criterion B). However, the duration criterion for adults should be used as a general guide, with allowance for some degree of flexibility. The disturbance must cause clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning (Criterion C).

Associated Features Supporting Diagnosis

When separated from major attachment figures, children with separation anxiety disorder may exhibit social withdrawal, apathy, sadness, or difficulty concentrating on work or play. Depending on their age, individuals may have fears of animals, monsters, the dark, muggers, burglars, kidnappers, car accidents, plane travel, and other situations that are perceived as presenting danger to the family or themselves. Some individuals become homesick and uncomfortable to the point of misery when away from home. Separation anxiety disorder in children may lead to school refusal, which in turn may lead to academic difficulties and social isolation. When extremely upset at the prospect of separation, children may show anger or occasionally aggression toward someone who is forcing separation. When alone, especially in the evening or the dark, young children may report unusual perceptual experiences (e.g., seeing people peering into their room, frightening creatures reaching for them, feeling eyes staring at them). Children with this disorder may be described as demanding, intrusive, and in need of constant attention, and, as adults, may appear dependent and overprotective. The individual's excessive demands often become a source of frustration for family members, leading to resentment and conflict in the family.

Prevalence

The 12-month prevalence of separation anxiety disorder among adults in the United States is 0.9%–1.9%. In children, 6- to 12-month prevalence is estimated to be approximately 4%. In adolescents in the United States, the 12-month prevalence is 1.6%. Separation anxiety disorder decreases in prevalence from childhood through adolescence and adulthood and is the most prevalent anxiety disorder in children younger than 12 years. In clinical samples of children, the disorder is equally common in males and females. In the community, the disorder is more frequent in females.

Development and Course

Periods of heightened separation anxiety from attachment figures are part of normal early development and may indicate the development of secure attachment relationships (e.g., around 1 year of age, when infants may suffer from stranger anxiety). Onset of separation anxiety disorder may be as early as preschool age and may occur at any time during childhood and more rarely in adolescence. Typically there are periods of exacerbation and remission. In some cases, both the anxiety about possible separation and the avoidance of situations involving separation from the home or nuclear family (e.g., going away to college, moving away from attachment figures) may persist through adulthood. However, the majority of children with separation anxiety disorder are free of impairing anxiety disorders over their lifetimes. Many adults with separation anxiety disorder do not recall a childhood onset of separation anxiety disorder, although they may recall symptoms.

The manifestations of separation anxiety disorder vary with age. Younger children are more reluctant to go to school or may avoid school altogether. Younger children may not express worries or specific fears of definite threats to parents, home, or themselves, and the anxiety is manifested only when separation is experienced. As children age, worries emerge; these are often worries about specific dangers (e.g., accidents, kidnapping, mugging, death) or vague concerns about not being reunited with attachment figures. In adults, separation anxiety disorder may limit their ability to cope with changes in circumstances (e.g., moving, getting married). Adults with the disorder are typically overconcerned about their offspring and spouses and experience marked discomfort when separated from them. They may also experience significant disruption in work or social experiences because of needing to continuously check on the whereabouts of a significant other.

Risk and Prognostic Factors

Environmental. Separation anxiety disorder often develops after life stress, especially a loss (e.g., the death of a relative or pet; an illness of the individual or a relative; a change of schools; parental divorce; a move to a new neighborhood; immigration; a disaster that involved periods of separation from attachment figures). In young adults, other examples of life stress include leaving the parental home, entering into a romantic relationship, and becoming a parent. Parental overprotection and intrusiveness may be associated with separation anxiety disorder.

Genetic and physiological. Separation anxiety disorder in children may be heritable. Heritability was estimated at 73% in a community sample of 6-year-old twins, with higher rates in girls. Children with separation anxiety disorder display particularly enhanced sensitivity to respiratory stimulation using CO₂-enriched air.

Culture-Related Diagnostic Issues

There are cultural variations in the degree to which it is considered desirable to tolerate separation, so that demands and opportunities for separation between parents and children are avoided in some cultures. For example, there is wide variation across countries and cultures with respect to the age at which it is expected that offspring should leave the parental home. It is important to differentiate separation anxiety disorder from the high value some cultures place on strong interdependence among family members.

Gender-Related Diagnostic Issues

Girls manifest greater reluctance to attend or avoidance of school than boys. Indirect expression of fear of separation may be more common in males than in females, for example, by limited independent activity, reluctance to be away from home alone, or distress when spouse or offspring do things independently or when contact with spouse or offspring is not possible.

Suicide Risk

Separation anxiety disorder in children may be associated with an increased risk for suicide. In a community sample, the presence of mood disorders, anxiety disorders, or substance use has been associated with suicidal ideation and attempts. However, this association is not specific to separation anxiety disorder and is found in several anxiety disorders.

Functional Consequences of Separation Anxiety Disorder

Individuals with separation anxiety disorder often limit independent activities away from home or attachment figures (e.g., in children, avoiding school, not going to camp, having

difficulty sleeping alone; in adolescents, not going away to college; in adults, not leaving the parental home, not traveling, not working outside the home).

Differential Diagnosis

Generalized anxiety disorder. Separation anxiety disorder is distinguished from generalized anxiety disorder in that the anxiety predominantly concerns separation from attachment figures, and if other worries occur, they do not predominate the clinical picture.

Panic disorder. Threats of separation may lead to extreme anxiety and even a panic attack. In separation anxiety disorder, in contrast to panic disorder, the anxiety concerns the possibility of being away from attachment figures and worry about untoward events befalling them, rather than being incapacitated by an unexpected panic attack.

Agoraphobia. Unlike individuals with agoraphobia, those with separation anxiety disorder are not anxious about being trapped or incapacitated in situations from which escape is perceived as difficult in the event of panic-like symptoms or other incapacitating symptoms.

Conduct disorder. School avoidance (truancy) is common in conduct disorder, but anxiety about separation is not responsible for school absences, and the child or adolescent usually stays away from, rather than returns to, the home.

Social anxiety disorder. School refusal may be due to social anxiety disorder (social phobia). In such instances, the school avoidance is due to fear of being judged negatively by others rather than to worries about being separated from the attachment figures.

Posttraumatic stress disorder. Fear of separation from loved ones is common after traumatic events such as disasters, particularly when periods of separation from loved ones were experienced during the traumatic event. In posttraumatic stress disorder (PTSD), the central symptoms concern intrusions about, and avoidance of, memories associated with the traumatic event itself, whereas in separation anxiety disorder, the worries and avoidance concern the well-being of attachment figures and separation from them.

Illness anxiety disorder. Individuals with illness anxiety disorder worry about specific illnesses they may have, but the main concern is about the medical diagnosis itself, not about being separated from attachment figures.

Bereavement. Intense yearning or longing for the deceased, intense sorrow and emotional pain, and preoccupation with the deceased or the circumstances of the death are expected responses occurring in bereavement, whereas fear of separation from other attachment figures is central in separation anxiety disorder.

Depressive and bipolar disorders. These disorders may be associated with reluctance to leave home, but the main concern is not worry or fear of untoward events befalling attachment figures, but rather low motivation for engaging with the outside world. However, individuals with separation anxiety disorder may become depressed while being separated or in anticipation of separation.

Oppositional defiant disorder. Children and adolescents with separation anxiety disorder may be oppositional in the context of being forced to separate from attachment figures. Oppositional defiant disorder should be considered only when there is persistent oppositional behavior unrelated to the anticipation or occurrence of separation from attachment figures.

Psychotic disorders. Unlike the hallucinations in psychotic disorders, the unusual perceptual experiences that may occur in separation anxiety disorder are usually based on a misperception of an actual stimulus, occur only in certain situations (e.g., nighttime), and are reversed by the presence of an attachment figure.

Personality disorders. Dependent personality disorder is characterized by an indiscriminate tendency to rely on others, whereas separation anxiety disorder involves concern about the proximity and safety of main attachment figures. Borderline personality disorder is characterized by fear of abandonment by loved ones, but problems in identity, self-direction, interpersonal functioning, and impulsivity are additionally central to that disorder, whereas they are not central to separation anxiety disorder.

Comorbidity

In children, separation anxiety disorder is highly comorbid with generalized anxiety disorder and specific phobia. In adults, common comorbidities include specific phobia, PTSD, panic disorder, generalized anxiety disorder, social anxiety disorder, agoraphobia, obsessive-compulsive disorder, and personality disorders. Depressive and bipolar disorders are also comorbid with separation anxiety disorder in adults.

Selective Mutism

Diagnostic Criteria	313.23 (F94.0)
<p>A. Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations.</p> <p>B. The disturbance interferes with educational or occupational achievement or with social communication.</p> <p>C. The duration of the disturbance is at least 1 month (not limited to the first month of school).</p> <p>D. The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.</p> <p>E. The disturbance is not better explained by a communication disorder (e.g., childhood-onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.</p>	

Diagnostic Features

When encountering other individuals in social interactions, children with selective mutism do not initiate speech or reciprocally respond when spoken to by others. Lack of speech occurs in social interactions with children or adults. Children with selective mutism will speak in their home in the presence of immediate family members but often not even in front of close friends or second-degree relatives, such as grandparents or cousins. The disturbance is often marked by high social anxiety. Children with selective mutism often refuse to speak at school, leading to academic or educational impairment, as teachers often find it difficult to assess skills such as reading. The lack of speech may interfere with social communication, although children with this disorder sometimes use nonspeoken or nonverbal means (e.g., grunting, pointing, writing) to communicate and may be willing or eager to perform or engage in social encounters when speech is not required (e.g., nonverbal parts in school plays).

Associated Features Supporting Diagnosis

Associated features of selective mutism may include excessive shyness, fear of social embarrassment, social isolation and withdrawal, clinging, compulsive traits, negativism, temper tantrums, or mild oppositional behavior. Although children with this disorder generally have normal language skills, there may occasionally be an associated commu-

nication disorder, although no particular association with a specific communication disorder has been identified. Even when these disorders are present, anxiety is present as well. In clinical settings, children with selective mutism are almost always given an additional diagnosis of another anxiety disorder—most commonly, social anxiety disorder (social phobia).

Prevalence

Selective mutism is a relatively rare disorder and has not been included as a diagnostic category in epidemiological studies of prevalence of childhood disorders. Point prevalence using various clinic or school samples ranges between 0.03% and 1% depending on the setting (e.g., clinic vs. school vs. general population) and ages of the individuals in the sample. The prevalence of the disorder does not seem to vary by sex or race/ethnicity. The disorder is more likely to manifest in young children than in adolescents and adults.

Development and Course

The onset of selective mutism is usually before age 5 years, but the disturbance may not come to clinical attention until entry into school, where there is an increase in social interaction and performance tasks, such as reading aloud. The persistence of the disorder is variable. Although clinical reports suggest that many individuals “outgrow” selective mutism, the longitudinal course of the disorder is unknown. In some cases, particularly in individuals with social anxiety disorder, selective mutism may disappear, but symptoms of social anxiety disorder remain.

Risk and Prognostic Factors

Temperamental. Temperamental risk factors for selective mutism are not well identified. Negative affectivity (neuroticism) or behavioral inhibition may play a role, as may parental history of shyness, social isolation, and social anxiety. Children with selective mutism may have subtle receptive language difficulties compared with their peers, although receptive language is still within the normal range.

Environmental. Social inhibition on the part of parents may serve as a model for social reticence and selective mutism in children. Furthermore, parents of children with selective mutism have been described as overprotective or more controlling than parents of children with other anxiety disorders or no disorder.

Genetic and physiological factors. Because of the significant overlap between selective mutism and social anxiety disorder, there may be shared genetic factors between these conditions.

Culture-Related Diagnostic Issues

Children in families who have immigrated to a country where a different language is spoken may refuse to speak the new language because of lack of knowledge of the language. If comprehension of the new language is adequate but refusal to speak persists, a diagnosis of selective mutism may be warranted.

Functional Consequences of Selective Mutism

Selective mutism may result in social impairment, as children may be too anxious to engage in reciprocal social interaction with other children. As children with selective mutism mature, they may face increasing social isolation. In school settings, these children may suffer academic impairment, because often they do not communicate with teachers regarding their academic or personal needs (e.g., not understanding a class assignment, not

asking to use the restroom). Severe impairment in school and social functioning, including that resulting from teasing by peers, is common. In certain instances, selective mutism may serve as a compensatory strategy to decrease anxious arousal in social encounters.

Differential Diagnosis

Communication disorders. Selective mutism should be distinguished from speech disturbances that are better explained by a communication disorder, such as language disorder, speech sound disorder (previously phonological disorder), childhood-onset fluency disorder (stuttering), or pragmatic (social) communication disorder. Unlike selective mutism, the speech disturbance in these conditions is not restricted to a specific social situation.

Neurodevelopmental disorders and schizophrenia and other psychotic disorders. Individuals with an autism spectrum disorder, schizophrenia or another psychotic disorder, or severe intellectual disability may have problems in social communication and be unable to speak appropriately in social situations. In contrast, selective mutism should be diagnosed only when a child has an established capacity to speak in some social situations (e.g., typically at home).

Social anxiety disorder (social phobia). The social anxiety and social avoidance in social anxiety disorder may be associated with selective mutism. In such cases, both diagnoses may be given.

Comorbidity

The most common comorbid conditions are other anxiety disorders, most commonly social anxiety disorder, followed by separation anxiety disorder and specific phobia. Oppositional behaviors have been noted to occur in children with selective mutism, although oppositional behavior may be limited to situations requiring speech. Communication delays or disorders also may appear in some children with selective mutism.

Specific Phobia

Diagnostic Criteria

- A. Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging.
- B. The phobic object or situation almost always provokes immediate fear or anxiety.
- C. The phobic object or situation is actively avoided or endured with intense fear or anxiety.
- D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.
- E. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
- F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- G. The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in agoraphobia); objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in posttraumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder).

Specify if:

Code based on the phobic stimulus:

300.29 (F40.218) Animal (e.g., spiders, insects, dogs).

300.29 (F40.228) Natural environment (e.g., heights, storms, water).

300.29 (F40.23x) Blood-injection-injury (e.g., needles, invasive medical procedures).

Coding note: Select specific ICD-10-CM code as follows: **F40.230** fear of blood; **F40.231** fear of injections and transfusions; **F40.232** fear of other medical care; or **F40.233** fear of injury.

300.29 (F40.248) Situational (e.g., airplanes, elevators, enclosed places).

300.29 (F40.298) Other (e.g., situations that may lead to choking or vomiting; in children, e.g., loud sounds or costumed characters).

Coding note: When more than one phobic stimulus is present, code all ICD-10-CM codes that apply (e.g., for fear of snakes and flying, F40.218 specific phobia, animal, and F40.248 specific phobia, situational).

Specifiers

It is common for individuals to have multiple specific phobias. The average individual with specific phobia fears three objects or situations, and approximately 75% of individuals with specific phobia fear more than one situation or object. In such cases, multiple specific phobia diagnoses, each with its own diagnostic code reflecting the phobic stimulus, would need to be given. For example, if an individual fears thunderstorms and flying, then two diagnoses would be given: specific phobia, natural environment, and specific phobia, situational.

Diagnostic Features

A key feature of this disorder is that the fear or anxiety is circumscribed to the presence of a particular situation or object (Criterion A), which may be termed the *phobic stimulus*. The categories of feared situations or objects are provided as specifiers. Many individuals fear objects or situations from more than one category, or phobic stimulus. For the diagnosis of specific phobia, the response must differ from normal, transient fears that commonly occur in the population. To meet the criteria for a diagnosis, the fear or anxiety must be intense or severe (i.e., “marked”) (Criterion A). The amount of fear experienced may vary with proximity to the feared object or situation and may occur in anticipation of or in the actual presence of the object or situation. Also, the fear or anxiety may take the form of a full or limited symptom panic attack (i.e., expected panic attack). Another characteristic of specific phobias is that fear or anxiety is evoked nearly every time the individual comes into contact with the phobic stimulus (Criterion B). Thus, an individual who becomes anxious only occasionally upon being confronted with the situation or object (e.g., becomes anxious when flying only on one out of every five airplane flights) would not be diagnosed with specific phobia. However, the degree of fear or anxiety expressed may vary (from anticipatory anxiety to a full panic attack) across different occasions of encountering the phobic object or situation because of various contextual factors such as the presence of others, duration of exposure, and other threatening elements such as turbulence on a flight for individuals who fear flying. Fear and anxiety are often expressed differently between children and adults. Also, the fear or anxiety occurs as soon as the phobic object or situation is encountered (i.e., immediately rather than being delayed).

The individual actively avoids the situation, or if he or she either is unable or decides not to avoid it, the situation or object evokes intense fear or anxiety (Criterion C). *Active avoidance* means the individual intentionally behaves in ways that are designed to prevent or minimize contact with phobic objects or situations (e.g., takes tunnels instead of bridges on daily commute to work for fear of heights; avoids entering a dark room for fear of spiders; avoids accepting a job in a locale where a phobic stimulus is more common). Avoid-

ance behaviors are often obvious (e.g., an individual who fears blood refusing to go to the doctor) but are sometimes less obvious (e.g., an individual who fears snakes refusing to look at pictures that resemble the form or shape of snakes). Many individuals with specific phobias have suffered over many years and have changed their living circumstances in ways designed to avoid the phobic object or situation as much as possible (e.g., an individual diagnosed with specific phobia, animal, who moves to reside in an area devoid of the particular feared animal). Therefore, they no longer experience fear or anxiety in their daily life. In such instances, avoidance behaviors or ongoing refusal to engage in activities that would involve exposure to the phobic object or situation (e.g., repeated refusal to accept offers for work-related travel because of fear of flying) may be helpful in confirming the diagnosis in the absence of overt anxiety or panic.

The fear or anxiety is out of proportion to the actual danger that the object or situation poses, or more intense than is deemed necessary (Criterion D). Although individuals with specific phobia often recognize their reactions as disproportionate, they tend to overestimate the danger in their feared situations, and thus the judgment of being out of proportion is made by the clinician. The individual's sociocultural context should also be taken into account. For example, fears of the dark may be reasonable in a context of ongoing violence, and fear of insects may be more disproportionate in settings where insects are consumed in the diet. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more (Criterion E), which helps distinguish the disorder from transient fears that are common in the population, particularly among children. However, the duration criterion should be used as a general guide, with allowance for some degree of flexibility. The specific phobia must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning in order for the disorder to be diagnosed (Criterion F).

Associated Features Supporting Diagnosis

Individuals with specific phobia typically experience an increase in physiological arousal in anticipation of or during exposure to a phobic object or situation. However, the physiological response to the feared situation or object varies. Whereas individuals with situational, natural environment, and animal specific phobias are likely to show sympathetic nervous system arousal, individuals with blood-injection-injury specific phobia often demonstrate a vasovagal fainting or near-fainting response that is marked by initial brief acceleration of heart rate and elevation of blood pressure followed by a deceleration of heart rate and a drop in blood pressure. Current neural systems models for specific phobia emphasize the amygdala and related structures, much as in other anxiety disorders.

Prevalence

In the United States, the 12-month community prevalence estimate for specific phobia is approximately 7%–9%. Prevalence rates in European countries are largely similar to those in the United States (e.g., about 6%), but rates are generally lower in Asian, African, and Latin American countries (2%–4%). Prevalence rates are approximately 5% in children and are approximately 16% in 13- to 17-year-olds. Prevalence rates are lower in older individuals (about 3%–5%), possibly reflecting diminishing severity to subclinical levels. Females are more frequently affected than males, at a rate of approximately 2:1, although rates vary across different phobic stimuli. That is, animal, natural environment, and situational specific phobias are predominantly experienced by females, whereas blood-injection-injury phobia is experienced nearly equally by both genders.

Development and Course

Specific phobia sometimes develops following a traumatic event (e.g., being attacked by an animal or stuck in an elevator), observation of others going through a traumatic event (e.g.,

watching someone drown), an unexpected panic attack in the to be feared situation (e.g., an unexpected panic attack while on the subway), or informational transmission (e.g., extensive media coverage of a plane crash). However, many individuals with specific phobia are unable to recall the specific reason for the onset of their phobias. Specific phobia usually develops in early childhood, with the majority of cases developing prior to age 10 years. The median age at onset is between 7 and 11 years, with the mean at about 10 years. Situational specific phobias tend to have a later age at onset than natural environment, animal, or blood-injection-injury specific phobias. Specific phobias that develop in childhood and adolescence are likely to wax and wane during that period. However, phobias that do persist into adulthood are unlikely to remit for the majority of individuals.

When specific phobia is being diagnosed in children, two issues should be considered. First, young children may express their fear and anxiety by crying, tantrums, freezing, or clinging. Second, young children typically are not able to understand the concept of avoidance. Therefore, the clinician should assemble additional information from parents, teachers, or others who know the child well. Excessive fears are quite common in young children but are usually transitory and only mildly impairing and thus considered developmentally appropriate. In such cases a diagnosis of specific phobia would not be made. When the diagnosis of specific phobia is being considered in a child, it is important to assess the degree of impairment and the duration of the fear, anxiety, or avoidance, and whether it is typical for the child's particular developmental stage.

Although the prevalence of specific phobia is lower in older populations, it remains one of the more commonly experienced disorders in late life. Several issues should be considered when diagnosing specific phobia in older populations. First, older individuals may be more likely to endorse natural environment specific phobias, as well as phobias of falling. Second, specific phobia (like all anxiety disorders) tends to co-occur with medical concerns in older individuals, including coronary heart disease and chronic obstructive pulmonary disease. Third, older individuals may be more likely to attribute the symptoms of anxiety to medical conditions. Fourth, older individuals may be more likely to manifest anxiety in an atypical manner (e.g., involving symptoms of both anxiety and depression) and thus be more likely to warrant a diagnosis of unspecified anxiety disorder. Additionally, the presence of specific phobia in older adults is associated with decreased quality of life and may serve as a risk factor for major neurocognitive disorder.

Although most specific phobias develop in childhood and adolescence, it is possible for a specific phobia to develop at any age, often as the result of experiences that are traumatic. For example, phobias of choking almost always follow a near-choking event at any age.

Risk and Prognostic Factors

Temperamental. Temperamental risk factors for specific phobia, such as negative affectivity (neuroticism) or behavioral inhibition, are risk factors for other anxiety disorders as well.

Environmental. Environmental risk factors for specific phobias, such as parental over-protectiveness, parental loss and separation, and physical and sexual abuse, tend to predict other anxiety disorders as well. As noted earlier, negative or traumatic encounters with the feared object or situation sometimes (but not always) precede the development of specific phobia.

Genetic and physiological. There may be a genetic susceptibility to a certain category of specific phobia (e.g., an individual with a first-degree relative with a specific phobia of animals is significantly more likely to have the same specific phobia than any other category of phobia). Individuals with blood-injection-injury phobia show a unique propensity to vasovagal syncope (fainting) in the presence of the phobic stimulus.

Culture-Related Diagnostic Issues

In the United States, Asians and Latinos report significantly lower rates of specific phobia than non-Latino whites, African Americans, and Native Americans. In addition to having lower prevalence rates of specific phobia, some countries outside of the United States, particularly Asian and African countries, show differing phobia content, age at onset, and gender ratios.

Suicide Risk

Individuals with specific phobia are up to 60% more likely to make a suicide attempt than are individuals without the diagnosis. However, it is likely that these elevated rates are primarily due to comorbidity with personality disorders and other anxiety disorders.

Functional Consequences of Specific Phobia

Individuals with specific phobia show similar patterns of impairment in psychosocial functioning and decreased quality of life as individuals with other anxiety disorders and alcohol and substance use disorders, including impairments in occupational and interpersonal functioning. In older adults, impairment may be seen in caregiving duties and volunteer activities. Also, fear of falling in older adults can lead to reduced mobility and reduced physical and social functioning, and may lead to receiving formal or informal home support. The distress and impairment caused by specific phobias tend to increase with the number of feared objects and situations. Thus, an individual who fears four objects or situations is likely to have more impairment in his or her occupational and social roles and a lower quality of life than an individual who fears only one object or situation. Individuals with blood-injection-injury specific phobia are often reluctant to obtain medical care even when a medical concern is present. Additionally, fear of vomiting and choking may substantially reduce dietary intake.

Differential Diagnosis

Agoraphobia. Situational specific phobia may resemble agoraphobia in its clinical presentation, given the overlap in feared situations (e.g., flying, enclosed places, elevators). If an individual fears only one of the agoraphobia situations, then specific phobia, situational, may be diagnosed. If two or more agoraphobic situations are feared, a diagnosis of agoraphobia is likely warranted. For example, an individual who fears airplanes and elevators (which overlap with the “public transportation” agoraphobic situation) but does not fear other agoraphobic situations would be diagnosed with specific phobia, situational, whereas an individual who fears airplanes, elevators, and crowds (which overlap with two agoraphobic situations, “using public transportation” and “standing in line and or being in a crowd”) would be diagnosed with agoraphobia. Criterion B of agoraphobia (the situations are feared or avoided “because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms”) can also be useful in differentiating agoraphobia from specific phobia. If the situations are feared for other reasons, such as fear of being harmed directly by the object or situations (e.g., fear of the plane crashing, fear of the animal biting), a specific phobia diagnosis may be more appropriate.

Social anxiety disorder. If the situations are feared because of negative evaluation, social anxiety disorder should be diagnosed instead of specific phobia.

Separation anxiety disorder. If the situations are feared because of separation from a primary caregiver or attachment figure, separation anxiety disorder should be diagnosed instead of specific phobia.

Panic disorder. Individuals with specific phobia may experience panic attacks when confronted with their feared situation or object. A diagnosis of specific phobia would be given if the panic attacks only occurred in response to the specific object or situation, whereas a diagnosis of panic disorder would be given if the individual also experienced panic attacks that were unexpected (i.e., not in response to the specific phobia object or situation).

Obsessive-compulsive disorder. If an individual’s primary fear or anxiety is of an object or situation as a result of obsessions (e.g., fear of blood due to obsessive thoughts about contamination from blood-borne pathogens [i.e., HIV]; fear of driving due to obsessive images of harming others), and if other diagnostic criteria for obsessive-compulsive disorder are met, then obsessive-compulsive disorder should be diagnosed.

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

Eating disorders. A diagnosis of specific phobia is not given if the avoidance behavior is exclusively limited to avoidance of food and food-related cues, in which case a diagnosis of anorexia nervosa or bulimia nervosa should be considered.

Schizophrenia spectrum and other psychotic disorders. When the fear and avoidance are due to delusional thinking (as in schizophrenia or other schizophrenia spectrum and other psychotic disorders), a diagnosis of specific phobia is not warranted.

Comorbidity

Specific phobia is rarely seen in medical-clinical settings in the absence of other psychopathology and is more frequently seen in nonmedical mental health settings. Specific phobia is frequently associated with a range of other disorders, especially depression in older adults. Because of early onset, specific phobia is typically the temporally primary disorder. Individuals with specific phobia are at increased risk for the development of other disorders, including other anxiety disorders, depressive and bipolar disorders, substance-related disorders, somatic symptom and related disorders, and personality disorders (particularly dependent personality disorder).

Social Anxiety Disorder (Social Phobia)

Diagnostic Criteria	300.23 (F40.10)
<p>A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).</p> <p>Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.</p>	
<p>B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others).</p>	
<p>C. The social situations almost always provoke fear or anxiety.</p> <p>Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.</p>	
<p>D. The social situations are avoided or endured with intense fear or anxiety.</p>	

- E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.
- F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
- G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.
- J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

Specify if:

Performance only: If the fear is restricted to speaking or performing in public.

Specifiers

Individuals with the performance only type of social anxiety disorder have performance fears that are typically most impairing in their professional lives (e.g., musicians, dancers, performers, athletes) or in roles that require regular public speaking. Performance fears may also manifest in work, school, or academic settings in which regular public presentations are required. Individuals with performance only social anxiety disorder do not fear or avoid nonperformance social situations.

Diagnostic Features

The essential feature of social anxiety disorder is a marked, or intense, fear or anxiety of social situations in which the individual may be scrutinized by others. In children the fear or anxiety must occur in peer settings and not just during interactions with adults (Criterion A). When exposed to such social situations, the individual fears that he or she will be negatively evaluated. The individual is concerned that he or she will be judged as anxious, weak, crazy, stupid, boring, intimidating, dirty, or unlikable. The individual fears that he or she will act or appear in a certain way or show anxiety symptoms, such as blushing, trembling, sweating, stumbling over one's words, or staring, that will be negatively evaluated by others (Criterion B). Some individuals fear offending others or being rejected as a result. Fear of offending others—for example, by a gaze or by showing anxiety symptoms—may be the predominant fear in individuals from cultures with strong collectivistic orientations. An individual with fear of trembling of the hands may avoid drinking, eating, writing, or pointing in public; an individual with fear of sweating may avoid shaking hands or eating spicy foods; and an individual with fear of blushing may avoid public performance, bright lights, or discussion about intimate topics. Some individuals fear and avoid urinating in public restrooms when other individuals are present (i.e., paruresis, or “shy bladder syndrome”).

The social situations almost always provoke fear or anxiety (Criterion C). Thus, an individual who becomes anxious only occasionally in the social situation(s) would not be diagnosed with social anxiety disorder. However, the degree and type of fear and anxiety may vary (e.g., anticipatory anxiety, a panic attack) across different occasions. The anticipatory anxiety may occur sometimes far in advance of upcoming situations (e.g., worrying every day for weeks before attending a social event, repeating a speech for days in advance). In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, or shrinking in social situations. The individual will often avoid the feared social situations. Alternatively, the situations are endured with intense fear or anxiety (Criterion D). Avoid-

ance can be extensive (e.g., not going to parties, refusing school) or subtle (e.g., overpreparing the text of a speech, diverting attention to others, limiting eye contact).

The fear or anxiety is judged to be out of proportion to the actual risk of being negatively evaluated or to the consequences of such negative evaluation (Criterion E). Sometimes, the anxiety may not be judged to be excessive, because it is related to an actual danger (e.g., being bullied or tormented by others). However, individuals with social anxiety disorder often overestimate the negative consequences of social situations, and thus the judgment of being out of proportion is made by the clinician. The individual's socio-cultural context needs to be taken into account when this judgment is being made. For example, in certain cultures, behavior that might otherwise appear socially anxious may be considered appropriate in social situations (e.g., might be seen as a sign of respect).

The duration of the disturbance is typically at least 6 months (Criterion F). This duration threshold helps distinguish the disorder from transient social fears that are common, particularly among children and in the community. However, the duration criterion should be used as a general guide, with allowance for some degree of flexibility. The fear, anxiety, and avoidance must interfere significantly with the individual's normal routine, occupational or academic functioning, or social activities or relationships, or must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion G). For example, an individual who is afraid to speak in public would not receive a diagnosis of social anxiety disorder if this activity is not routinely encountered on the job or in classroom work, and if the individual is not significantly distressed about it. However, if the individual avoids, or is passed over for, the job or education he or she really wants because of social anxiety symptoms, Criterion G is met.

Associated Features Supporting Diagnosis

Individuals with social anxiety disorder may be inadequately assertive or excessively submissive or, less commonly, highly controlling of the conversation. They may show overly rigid body posture or inadequate eye contact, or speak with an overly soft voice. These individuals may be shy or withdrawn, and they may be less open in conversations and disclose little about themselves. They may seek employment in jobs that do not require social contact, although this is not the case for individuals with social anxiety disorder, performance only. They may live at home longer. Men may be delayed in marrying and having a family, whereas women who would want to work outside the home may live a life as homemaker and mother. Self-medication with substances is common (e.g., drinking before going to a party). Social anxiety among older adults may also include exacerbation of symptoms of medical illnesses, such as increased tremor or tachycardia. Blushing is a hallmark physical response of social anxiety disorder.

Prevalence

The 12-month prevalence estimate of social anxiety disorder for the United States is approximately 7%. Lower 12-month prevalence estimates are seen in much of the world using the same diagnostic instrument, clustering around 0.5%–2.0%; median prevalence in Europe is 2.3%. The 12-month prevalence rates in children and adolescents are comparable to those in adults. Prevalence rates decrease with age. The 12-month prevalence for older adults ranges from 2% to 5%. In general, higher rates of social anxiety disorder are found in females than in males in the general population (with odds ratios ranging from 1.5 to 2.2), and the gender difference in prevalence is more pronounced in adolescents and young adults. Gender rates are equivalent or slightly higher for males in clinical samples, and it is assumed that gender roles and social expectations play a significant role in explaining the heightened help-seeking behavior in male patients. Prevalence in the United States is higher in American Indians and lower in persons of Asian, Latino, African American, and Afro-Caribbean descent compared with non-Hispanic whites.