present, the degree of impairment is more marked than would be expected from the physical illness alone. When an individual's symptoms meet diagnostic criteria for somatic symptom disorder, the disorder should be diagnosed; however, in view of the frequent comorbidity, especially with anxiety and depressive disorders, evidence for these concurrent diagnoses should be sought.

Illness Anxiety Disorder

Diagnostic Criteria **300.7 (F45.21)**

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 with hypochondriasis are now classified as having somatic symptom disorder; however, in a minority 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). Empirical evidence and existing literature pertain to previously defined DSM hypochondriasis, 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 others 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.

Associated Features Supporting Diagnosis

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, though some may be too anxious to seek medical attention. They generally have elevated rates of medical utilization but do not utilize mental health services more than the general population. 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 DSM-IV diagnosis *hypochondriasis.* The 1- to 2-year prevalence of health anxiety and/or disease conviction in community surveys and population-based samples ranges from 1.3% to 10%. In ambulatory medical populations, the 6-month/1-year prevalence rates are between 3% and 8%. The prevalence of the disorder is similar in males and females.

Development and Course

The development and course of illness anxiety disorder are unclear. Illness anxiety disorder is generally thought to be a chronic and relapsing condition with an age at onset in early and middle adulthood. In population-based samples, health-related anxiety increases with age, but the ages of individuals with high health anxiety in medical settings do not appear to differ from those of other patients in those settings. In older individuals, health-related anxiety often focuses on memory loss; the disorder is thought to be rare in children.

Risk and Prognostic Factors

Environmental. 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 child-

hood abuse or of a serious childhood illness may predispose to development of the disorder in adulthood.

Course modifiers. 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, culturally sanctioned beliefs. Little is known about the phenomenology of the disorder across cultures, although the prevalence appears to be similar across different countries with diverse cultures.

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

Other medical conditions. 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 health-related anxiety and disease concerns are clearly disproportionate to its seriousness. Transient preoccupations related to a medical condition do not constitute illness anxiety disorder.

Adjustment disorders. 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, an adjustment disorder may be diagnosed. However, only when the health anxiety is of sufficient duration, severity, and distress can illness anxiety disorder be diagnosed. Thus, the diagnosis requires the continuous persistence of disproportionate health-related anxiety for at least 6 months.

Somatic symptom disorder. Somatic symptom disorder is diagnosed when significant somatic symptoms are present. In contrast, individuals with illness anxiety disorder have minimal somatic symptoms and are primarily concerned with the idea they are ill.

Anxiety disorders. 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.

Obsessive-compulsive and related disorders. Individuals with illness anxiety disorder may have intrusive thoughts about having a disease and also may have associated compulsive behaviors (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 dis-

order, concerns are limited to the individual's physical appearance, which is viewed as defective or flawed.

Major depressive disorder. 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.

Psychotic disorders. 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

Because illness anxiety disorder is a new disorder, exact comorbidities are unknown. Hypochondriasis co-occurs with anxiety disorders (in particular, generalized anxiety disorder, panic disorder, and 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 somatic symptom disorder and personality disorders.

Conversion Disorder (Functional Neurological Symptom 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-9-CM code for conversion disorder is **300.11,** which is assigned regardless of the symptom type. 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, dystonic movement, 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

Many clinicians use the alternative names of "functional" (referring to abnormal central nervous system functioning) or "psychogenic" (referring to an assumed etiology) to describe the symptoms of conversion disorder (functional neurological symptom disorder). In conversion disorder, there may be one or more symptoms of various types. Motor symptoms include weakness or paralysis; abnormal movements, such as tremor or dystonic movements; gait abnormalities; and abnormal limb posturing. Sensory symptoms include altered, reduced, or absent skin sensation, vision, or hearing. Episodes of abnormal generalized limb shaking with apparent impaired or loss of consciousness may resemble epileptic seizures (also called *psychogenic* or *non-epileptic seizures*). There may be episodes of unresponsiveness resembling syncope or coma. Other symptoms include reduced or absent speech volume (dysphonia/aphonia), altered articulation (dysarthria), a sensation of a lump in the throat (globus), and diplopia.

Although the diagnosis requires that the symptom is not explained by neurological disease, it should not be made simply because results from investigations are normal or because the symptom is "bizarre." There must be clinical findings that show clear evidence of incompatibility with neurological disease. Internal inconsistency at examination is one way to demonstrate incompatibility (i.e., demonstrating that physical signs elicited through one examination method are no longer positive when tested a different way). Examples of such examination findings include

- Hoover's sign, in which weakness of hip extension returns to normal strength with contralateral hip flexion against resistance.
- Marked weakness of ankle plantar-flexion when tested on the bed in an individual who is able to walk on tiptoes;
- Positive findings on the tremor entrainment test. On this test, a unilateral tremor may be identified as functional if the tremor changes when the individual is distracted away from it. This may be observed if the individual is asked to copy the examiner in making a rhythmical movement with their unaffected hand and this causes the functional tremor to change such that it copies or "entrains" to the rhythm of the unaffected hand or the functional tremor is suppressed, or no longer makes a simple rhythmical movement.
- In attacks resembling epilepsy or syncope ("psychogenic" non-epileptic attacks), the occurrence of closed eyes with resistance to opening or a normal simultaneous electroencephalogram (although this alone does not exclude all forms of epilepsy or syncope).
- For visual symptoms, a tubular visual field (i.e., tunnel vision).

It is important to note that the diagnosis of conversion disorder should be based on the overall clinical picture and not on a single clinical finding.

Associated Features Supporting Diagnosis

A number of associated features can support the diagnosis of conversion disorder. There may be a history of multiple similar somatic symptoms. Onset may be associated with stress or trauma, either psychological or physical in nature. The potential etiological rele-

vance of this stress or trauma may be suggested by a close temporal relationship. However, while assessment for stress and trauma is important, the diagnosis should not be withheld if none is found.

Conversion disorder is often associated with dissociative symptoms, such as depersonalization, derealization, and dissociative amnesia, particularly at symptom onset or during attacks.

The diagnosis of conversion disorder does not require the judgment that the symptoms are not intentionally produced (i.e., not feigned), as the definite absence of feigning may not be reliably discerned. The phenomenon of *la belle indifférence* (i.e., lack of concern about the nature or implications of the symptom) has been associated with conversion disorder but it is not specific for conversion disorder 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 conversion disorder and particularly in the context of definite evidence for feigning, the diagnoses that should be considered instead would include factitious disorder or malingering (see the section "Differential Diagnosis" for this disorder).

Prevalence

Transient conversion symptoms are common, but the precise prevalence of the disorder is unknown. This is partly because the diagnosis usually requires assessment in secondary care, where it is found in approximately 5% of referrals to neurology clinics. The incidence of individual persistent conversion symptoms is estimated to be 2–5/100,000 per year.

Development and Course

Onset has been reported throughout the life course. The onset of non-epileptic attacks peaks in the third decade, and motor symptoms have their peak onset in the fourth decade. The symptoms can be transient or persistent. The prognosis may be better in younger children than in adolescents and adults.

Risk and Prognostic Factors

Temperamental. Maladaptive personality traits are commonly associated with conversion disorder.

Environmental. There may be a history of childhood abuse and neglect. Stressful life events are often, but not always, present.

Genetic and physiological. The presence of neurological disease that causes similar symptoms is a risk factor (e.g., non-epileptic seizures are more common in patients who also have epilepsy).

Course modifiers. Short duration of symptoms and acceptance of the diagnosis are positive prognostic factors. Maladaptive personality traits, the presence of comorbid physical disease, and the receipt of disability benefits may be negative prognostic factors.

Culture-Related Diagnostic Issues

Changes resembling conversion (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 conversion disorder is not made.

Gender-Related Diagnostic Issues

Conversion disorder is two to three times more common in females.

Functional Consequences of Conversion Disorder

Individuals with conversion symptoms may have substantial disability. The severity of disability can be similar to that experienced by individuals with comparable medical diseases.

Differential Diagnosis

If another mental disorder better explains the symptoms, that diagnosis should be made. However the diagnosis of conversion disorder may be made in the presence of another mental disorder.

Neurological disease. The main differential diagnosis is 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. Conversion disorder may coexist with neurological disease.

Somatic symptom disorder. Conversion 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 pathophysiology (e.g., pain, fatigue), whereas in conversion disorder, such incompatibility is required for the diagnosis. The excessive thoughts, feelings, and behaviors characterizing somatic symptom disorder are often absent in conversion disorder.

Factitious disorder and malingering. The diagnosis of conversion disorder does not require the judgment that the symptoms are *not* intentionally produced (i.e., not feigned), because assessment of conscious intention is unreliable. However definite evidence of feigning (e.g., clear evidence that loss of function is present during the examination but not at home) would suggest a diagnosis of factitious disorder if the individual's apparent aim is to assume the sick role or malingering if the aim is to obtain an incentive such as money.

Dissociative disorders. Dissociative symptoms are common in individuals with conversion disorder. If both conversion disorder and a dissociative disorder are present, both diagnoses should be made.

Body dysmorphic disorder. Individuals with body dysmorphic disorder are excessively concerned about a perceived defect in their physical features but do not complain of symptoms of sensory or motor functioning in the affected body part.

Depressive disorders. In depressive disorders, individuals may report general heaviness of their limbs, whereas the weakness of conversion disorder is more focal and prominent. Depressive disorders are also differentiated by the presence of core depressive symptoms.

Panic disorder. Episodic neurological symptoms (e.g., tremors and paresthesias) can occur in both conversion disorder and panic attacks. In panic attacks, the neurological symptoms are typically transient and acutely episodic with characteristic cardiorespiratory symptoms. Loss of awareness with amnesia for the attack and violent limb movements occur in non-epileptic attacks, but not in panic attacks.

Comorbidity

Anxiety disorders, especially panic disorder, and depressive disorders commonly co-occur with conversion disorder. Somatic symptom disorder may co-occur as well. Psychosis, substance use disorder, and alcohol misuse are uncommon. Personality disorders are more common in individuals with conversion disorder than in the general population. Neurological or other medical conditions commonly coexist with conversion disorder as well.

Psychological Factors Affecting Other Medical Conditions

Diagnostic Criteria **316 (F54)**

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 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 is a more common diagnosis than 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 cultures may influence psychological factors and their effects on medical conditions, such as those in language and communication style, 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 behaviors such as using faith or spiritual healers or other variations in illness management that are acceptable within a culture and represent an attempt to help the medical condition rather than interfere with it. These local practices may complement rather than obstruct evidence-based interventions. If they do not adversely affect outcomes, they 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

Mental disorder due to another medical condition. 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 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.

Adjustment disorders. 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 indi-

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.