

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

- Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.
- The individual presents himself or herself to others as ill, impaired, or injured.
- The deceptive behavior is evident even in the absence of obvious external rewards.
- 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)

- Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.
- The individual presents another individual (victim) to others as ill, impaired, or injured.
- The deceptive behavior is evident even in the absence of obvious external rewards.
- The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

Note: The perpetrator, not the victim, receives this diagnosis.

Specify:

Single episode

Recurrent episodes (two or more events of falsification of illness and/or induction of injury)

Recording Procedures

When an individual falsifies illness in another (e.g., children, adults, pets), the diagnosis is factitious disorder imposed on another. The perpetrator, not the victim, is given the diagnosis. **The victim may be given an abuse diagnosis (e.g., 995.54 [T74.12X];** see the chapter "Other Conditions That May Be a Focus of Clinical Attention").

Diagnostic Features

The essential feature of factitious disorder is the falsification of medical or psychological signs and symptoms in oneself or others that are associated with the identified deception. Individuals with factitious disorder can also seek treatment for themselves or another following induction of injury or disease. The diagnosis requires demonstrating that the individual is taking **surreptitious actions to misrepresent**, simulate, or cause signs or symptoms of illness or injury in the absence of obvious external rewards. Methods of illness falsification can include exaggeration, fabrication, simulation, and induction. While a preexisting medical condition may be present, the deceptive behavior or induction of injury associated with deception causes others to view such individuals (or another) as more ill or impaired, and this can lead to excessive clinical intervention. Individuals with factitious disorder might, for example, report feelings of depression and suicidality following the death of a spouse despite the death not being true or the individual's not having a spouse; deceptively report episodes of neurological symptoms (e.g., seizures, dizziness, or blacking out); manipulate a laboratory test (e.g., by adding blood to urine) to falsely indicate an abnormality; falsify medical records to indicate an illness; ingest a substance (e.g., insulin or warfarin) to induce an abnormal laboratory result or illness; or physically injure themselves or induce illness in themselves or another (e.g., by injecting fecal material to produce an abscess or to induce sepsis).

Associated Features Supporting Diagnosis

Individuals with factitious disorder imposed on self or factitious disorder imposed on another are at risk for experiencing great psychological distress or functional impairment by causing harm to themselves and others. Family, friends, and health care professionals are also often adversely affected by their behavior. Factitious disorders have similarities to substance use disorders, eating disorders, impulse-control disorders, pedophilic disorder, and some other established disorders related to both the persistence of the behavior and the intentional efforts to conceal the disordered behavior through deception. Whereas some aspects of factitious disorders might represent criminal behavior (e.g., factitious dis-

order imposed on another, in which the parent's actions represent abuse and maltreatment of a child), such criminal behavior and mental illness are not mutually exclusive. The diagnosis of factitious disorder emphasizes the objective identification of falsification of signs and symptoms of illness, rather than an inference about intent or possible underlying motivation. Moreover, such behaviors, including the induction of injury or disease, are associated with deception.

Prevalence

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

Development and Course

The course of factitious disorder is usually one of intermittent episodes. Single episodes and episodes that are characterized as persistent and unremitting are both less common. Onset is usually in early adulthood, often after hospitalization for a medical condition or a mental disorder. When imposed on another, the disorder may begin after hospitalization of the individual's child or other dependent. In individuals with recurrent episodes of falsification of signs and symptoms of illness and/or induction of injury, this pattern of successive deceptive contact with medical personnel, including hospitalizations, may become lifelong.

Differential Diagnosis

Caregivers who lie about abuse injuries in dependents solely to protect themselves from liability are not diagnosed with factitious disorder imposed on another because protection from liability is an external reward (Criterion C, the deceptive behavior is evident even in the absence of obvious external rewards). Such caregivers who, upon observation, analysis of medical records, and/or interviews with others, are found to lie more extensively than needed for immediate self-protection are diagnosed with factitious disorder imposed on another.

Somatic symptom disorder. In somatic symptom disorder, there may be excessive attention and treatment seeking for perceived medical concerns, but there is no evidence that the individual is providing false information or behaving deceptively.

Malingering. Malingering is differentiated from factitious disorder by the intentional reporting of symptoms for personal gain (e.g., money, time off work). In contrast, the diagnosis of factitious disorder requires the absence of obvious rewards.

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

Borderline personality disorder. Deliberate physical self-harm in the absence of suicidal intent can also occur in association with other mental disorders such as borderline personality disorder. Factitious disorder requires that the induction of injury occur in association with deception.

Medical condition or mental disorder not associated with intentional symptom falsification. Presentation of signs and symptoms of illness that do not conform to an identifiable medical condition or mental disorder increases the likelihood of the presence of a factitious disorder. However, the diagnosis of factitious disorder does not exclude the presence of true medical condition or mental disorder, as comorbid illness often occurs in the individual along with factitious disorder. For example, individuals who might manipulate blood sugar levels to produce symptoms may also have diabetes.

Other Specified Somatic Symptom and Related Disorder

300.89 (F45.8)

This category applies to presentations in which symptoms characteristic of a somatic symptom and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the somatic symptom and related disorders diagnostic class.

Examples of presentations that can be specified using the "other specified" designation include the following:

1. **Brief somatic symptom disorder:** Duration of symptoms is less than 6 months.
2. **Brief illness anxiety disorder:** Duration of symptoms is less than 6 months.
3. **Illness anxiety disorder without excessive health-related behaviors:** Criterion D for illness anxiety disorder is not met.
4. **Pseudocyesis:** A false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy.

Unspecified Somatic Symptom and Related Disorder

300.82 (F45.9)

This category applies to presentations in which symptoms characteristic of a somatic symptom and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the somatic symptom and related disorders diagnostic class. The unspecified somatic symptom and related disorder category should not be used unless there are decidedly unusual situations where there is insufficient information to make a more specific diagnosis.

be best made in the context of a clinical relationship over time. In some individuals, avoidant/restrictive food intake disorder might precede the onset of anorexia nervosa.

Obsessive-compulsive disorder. Individuals with obsessive-compulsive disorder may present with avoidance or restriction of intake in relation to preoccupations with food or ritualized eating behavior. Avoidant/restrictive food intake disorder should be diagnosed concurrently only if all criteria are met for both disorders and when the aberrant eating is a major aspect of the clinical presentation requiring specific intervention.

Major depressive disorder. In major depressive disorder, appetite might be affected to such an extent that individuals present with significantly restricted food intake, usually in relation to overall energy intake and often associated with weight loss. Usually appetite loss and related reduction of intake abate with resolution of mood problems. Avoidant/restrictive food intake disorder should only be used concurrently if full criteria are met for both disorders and when the eating disturbance requires specific treatment.

Schizophrenia spectrum disorders. Individuals with schizophrenia, delusional disorder, or other psychotic disorders may exhibit odd eating behaviors, avoidance of specific foods because of delusional beliefs, or other manifestations of avoidant or restrictive intake. In some cases, delusional beliefs may contribute to a concern about negative consequences of ingesting certain foods. Avoidant/restrictive food intake disorder should be used concurrently only if all criteria are met for both disorders and when the eating disturbance requires specific treatment.

Factitious disorder or factitious disorder imposed on another. Avoidant/restrictive food intake disorder should be differentiated from factitious disorder or factitious disorder imposed on another. In order to assume the sick role, some individuals with factitious disorder may intentionally describe diets that are much more restrictive than those they are actually able to consume, as well as complications of such behavior, such as a need for enteral feedings or nutritional supplements, an inability to tolerate a normal range of foods, and/or an inability to participate normally in age-appropriate situations involving food. The presentation may be impressively dramatic and engaging, and the symptoms reported inconsistently. In factitious disorder imposed on another, the caregiver describes symptoms consistent with avoidant/restrictive food intake disorder and may induce physical symptoms such as failure to gain weight. As with any diagnosis of factitious disorder imposed on another, the caregiver receives the diagnosis rather than the affected individual, and diagnosis should be made only on the basis of a careful, comprehensive assessment of the affected individual, the caregiver, and their interaction.

Comorbidity

The most commonly observed disorders comorbid with avoidant/restrictive food intake disorder are anxiety disorders, obsessive-compulsive disorder, and neurodevelopmental disorders (specifically autism spectrum disorder, attention-deficit/hyperactivity disorder, and intellectual disability [intellectual developmental disorder]).

Anorexia Nervosa

Diagnostic Criteria

- A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. *Significantly low weight* is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
- B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

- C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Coding note: The ICD-9-CM code for anorexia nervosa is **307.1**, which is assigned regardless of the subtype. The ICD-10-CM code depends on the subtype (see below).

Specify whether:

(F50.01) Restricting type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

(F50.02) Binge-eating/purging type: During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Specify if:

In partial remission: After full criteria for anorexia nervosa were previously met, Criterion A (low body weight) has not been met for a sustained period, but either Criterion B (intense fear of gaining weight or becoming fat or behavior that interferes with weight gain) or Criterion C (disturbances in self-perception of weight and shape) is still met.

In full remission: After full criteria for anorexia nervosa were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, on BMI percentile. The ranges below are derived from World Health Organization categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

Mild: BMI ≥ 17 kg/m²

Moderate: BMI 16–16.99 kg/m²

Severe: BMI 15–15.99 kg/m²

Extreme: BMI < 15 kg/m²

Subtypes

Most individuals with the binge-eating/purging type of anorexia nervosa who binge eat also purge through self-induced vomiting or the misuse of laxatives, diuretics, or enemas. Some individuals with this subtype of anorexia nervosa do not binge eat but do regularly purge after the consumption of small amounts of food.

Crossover between the subtypes over the course of the disorder is not uncommon; therefore, subtype description should be used to describe current symptoms rather than longitudinal course.

Diagnostic Features

There are three essential features of anorexia nervosa: persistent energy intake restriction; intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain; and a disturbance in self-perceived weight or shape. The individual maintains a body weight that is below a minimally normal level for age, sex, developmental trajectory, and physical health (Criterion A). Individuals' body weights frequently meet this criterion following a significant weight loss, but among children and adolescents, there may alternatively be failure to make expected weight gain or to maintain a normal developmental trajectory (i.e., while growing in height) instead of weight loss.