ICD-11 DIAGNOSTIC GUIDELINES

Anxiety or Fear-Related Disorders

Note: This document contains a pre-publication version of the ICD-11 diagnostic guidelines for Anxiety or Fear-Related Disorders. There may be further edits to these guidelines prior to their publication.

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ANXIETY OR FEAR-RELATED DISORDERS

Anxiety or Fear-Related Disorders are characterized by excessive fear and anxiety and related behavioural disturbances, with symptoms severe enough to result in significant distress or impairment in functioning. Fear and anxiety are closely related phenomena; fear represents a reaction to perceived imminent threat in the present, whereas anxiety is more future-oriented, referring to perceived anticipated threat. One of the major ways in which different Anxiety or Fear-Related Disorders are distinguished from one another is the focus of apprehension, that is, the stimuli or situations that trigger the fear or anxiety. The focus of apprehension may be highly specific as in Specific Phobia or relate to a broader class of situations as in Generalized Anxiety Disorder. The clinical presentation of Anxiety or Fear-Related Disorders typically includes specific associated cognitions that can assist in differentiating among the disorders by clarifying the focus of apprehension.

Anxiety or Fear-Related Disorders include the following:

6B00 Generalized Anxiety Disorder
6B01 Panic Disorder
6B02 Agoraphobia
6B03 Specific Phobia
6B04 Social Anxiety Disorder
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6B0Y Other Specified Anxiety or Fear-Related Disorders

General Cultural Considerations

- For many cultural groups, somatic complaints rather than cognitive symptoms may predominate the clinical presentation.
- In some cultural contexts, symptoms of fear and anxiety may be described primarily in terms of external forces or factors (e.g., witchcraft, sorcery, malign magic or envy) and not as an internal experience or psychological state.

6B00 Generalized Anxiety Disorder

Essential (Required) Features:

- Marked symptoms of anxiety manifested by either:
  - General apprehensiveness that is not restricted to any particular environmental circumstance (i.e., 'free-floating anxiety'); or
  - Excessive worry (apprehensive expectation) about negative events occurring in several different aspects of everyday life (e.g., work, finances, health, family).
- Anxiety and general apprehensiveness or worry are accompanied by additional characteristic symptoms, such as:
  - Muscle tension or motor restlessness.
  - Sympathetic autonomic overactivity as evidenced by frequent gastrointestinal symptoms such as nausea and/or abdominal distress, heart palpitations, sweating, trembling, shaking, and/or dry mouth.

    - Subjective experience of nervousness, restlessness, or being ‘on edge’.
    - Difficulty concentrating.
    - Irritability.
    - Sleep disturbances (difficulty falling or staying asleep, or restless, unsatisfying sleep).
- The symptoms are not transient and persist for at least several months, for more days than not.
- The symptoms are not better accounted for by another mental disorder (e.g., a Depressive Disorder).
- The symptoms are not a manifestation of another medical condition (e.g., hyperthyroidism) and are not due to the effects of a substance or medication on the central nervous system (e.g., caffeine, cocaine), including withdrawal effects (e.g., alcohol, benzodiazepines).
- The symptoms result in significant distress about experiencing persistent anxiety symptoms or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional Clinical Features:

- Some individuals with Generalized Anxiety Disorder may only report general apprehensiveness accompanied by chronic somatic symptoms without being able to articulate specific worry content.
- Behavioural changes such as avoidance, frequent need for reassurance (especially in children), and procrastination may be seen. These behaviours typically represent an effort to reduce apprehension or prevent untoward events from occurring.

Boundary with Normality (Threshold):

- Anxiety and worry are normal emotional/cognitive states that commonly occur when people are under stress. At optimal levels, anxiety and worry may help to direct problem-solving efforts, focus attention adaptively, and increase alertness. Normal anxiety and worry are usually sufficiently self-regulated that they do not interfere with functioning or cause marked distress. In Generalized Anxiety Disorder, the anxiety or worry is excessive, persistent, and intense, and may have a significant negative impact on functioning. Individuals under extremely stressful circumstances (e.g., living in a war zone) may experience intense and impairing anxiety and worry that is appropriate to their environmental circumstances. These experiences should not be regarded as symptomatic of Generalized Anxiety Disorder if they occur only under such circumstances.

Course Features:

- Onset of Generalized Anxiety Disorder may occur at any age. However, the typical age of onset is during the early-to-mid 30s.
- Earlier onset of symptoms is associated with greater impairment of functioning and presence of co-occurring mental disorders.

- Severity of Generalized Anxiety Disorder symptoms often fluctuates between threshold and subthreshold forms of the disorder and full remission of symptoms is uncommon.
- Although the clinical features of Generalized Anxiety Disorder generally remain consistent across the lifespan, the content of the individual's worry may vary over time and there are differences in worry content among different age groups. Children and adolescents tend to worry about the quality of academic and sports-related performance, whereas adults tend to worry more about their own well-being or that of their loved ones.

Developmental Presentations:

- Anxiety or Fear-Related Disorders are the most prevalent mental disorders of childhood and adolescence. Among these disorders, Generalized Anxiety Disorder is one of the most common in late childhood and adolescence.
- Occurrence of Generalized Anxiety Disorder increases across late childhood and adolescence with development of cognitive abilities that support the capacity for worry, which is a core feature of the disorder. As a result of their less developed cognitive abilities, Generalized Anxiety Disorder is uncommon in children younger than 5. Girls tend to have an earlier symptom onset than their same age male peers.
- While the essential features of Generalized Anxiety Disorder still apply to children and adolescents, specific manifestations of worry in children may include being overly concerned and compliant with rules as well as a strong desire to please others. Affected children may become upset when they perceive peers as acting out or being disobedient. Consequently, children and adolescents with Generalized Anxiety Disorder may be more likely to report excessively on their peers' misbehaviour or to act as an authority figure around peers, condemning misbehaviour. This may have a negative effect on affected individuals' interpersonal relationships.
- Children and adolescents with Generalized Anxiety Disorder may engage in excessive reassurance seeking from others, repeatedly asking questions, and may exhibit distress when faced with uncertainty. They may be overly perfectionistic, taking additional time to complete tasks, such as homework or classwork. Sensitivity to perceived criticism is common.
- When Generalized Anxiety Disorder does occur in children, somatic symptoms, particularly those related to sympathetic autonomic overactivity, may be prominent aspects of the clinical presentation. Common somatic symptoms in children with Generalized Anxiety Disorder include frequent headaches, abdominal pain, and gastrointestinal distress. Similar to adults, children and adolescents also experience sleep disturbances, including delayed sleep onset and night-time wakefulness.
- The number and content of worries typically manifests differently across childhood and adolescence. Younger children may endorse more concerns about their safety or their health or the health of others. Adolescents typically report a greater number of worries with content shifting to performance, perfectionism, and whether they will be able to meet the expectations of others.
- Adolescents with Generalized Anxiety Disorder may demonstrate excessive irritability and have an increased risk of co-occurring depressive symptoms.

Culture-Related Features:

- For many cultural groups, somatic complaints rather than excessive worry may predominate in the clinical presentation. These symptoms may involve a range of physical complaints not typically associated with Generalized Anxiety Disorder such as dizziness and heat in the head.
- Realistic worries may be misjudged as excessive without appropriate contextual information. For example, migrant workers may worry greatly about being deported, but this may be related to actual deportation threats by their employer. On the other hand, evidence of worries across several different aspects of everyday life may be difficult to establish when an individual places emphasis on a single overwhelming source of worry (e.g., financial concerns).
- Worry content may vary by cultural group, related to topics that are salient in the milieu. For example, in societies where relationships with deceased relatives are important, worry may focus on their spiritual status in the afterlife. Worry in more individualistic cultures may emphasize personal achievement, fulfilment of expectations, or self-confidence.

Gender-Related Features:

- Lifetime prevalence of Generalized Anxiety Disorder is approximately twice as high among women.
- Although symptom presentation does not vary by gender including the common co-occurrence of Generalized Anxiety Disorder and Depressive Disorders, men are more likely to experience co-occurring Disorders due to Substance Use.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Panic Disorder:*** Panic Disorder is characterized by recurrent, unexpected, self-limited episodes of intense fear or anxiety. Generalized Anxiety Disorder is differentiated by a more persistent and less circumscribed chronic feeling of apprehensiveness usually associated with worry about a variety of different everyday life events. Individuals with Generalized Anxiety Disorder may experience panic attacks that are triggered by specific worries. If an individual with Generalized Anxiety Disorder experiences panic attacks exclusively in the context of the worry about a variety of everyday life events or general apprehensiveness without the presence of unexpected panic attacks, an additional diagnosis of Panic Disorder is not warranted and the presence of panic attacks may be indicated using the 'with panic attacks' qualifier. However, if unexpected panic attacks also occur, an additional diagnosis of Panic Disorder may be assigned.
- ***Boundary with Social Anxiety Disorder:*** In Social Anxiety Disorder, symptoms occur in response to feared social situations (e.g., speaking in public, initiating a conversation) and the primary focus of apprehension is being negatively evaluated by others. Individuals with Generalized Anxiety Disorder may worry about the implications of performing poorly or failing an examination but are not exclusively concerned about being negatively evaluated by others.

- ***Boundary with Separation Anxiety Disorder:*** Individuals with Generalized Anxiety Disorder may worry about the health and safety of attachment figures, as in Separation Anxiety Disorder, but their worry also extends to other aspects of everyday life.
- ***Boundary with Depressive Disorders:*** Generalized Anxiety Disorder and Depressive Disorders can share several features such as somatic symptoms of anxiety, difficulty with concentration, sleep disruption, and feelings of dread associated with pessimistic thoughts. Depressive Disorders are differentiated by the presence of low mood or loss of pleasure in previously enjoyable activities and other characteristic symptoms of Depressive Disorders (e.g., appetite changes, feelings of worthlessness, suicidal ideation). Generalized Anxiety Disorder may co-occur with Depressive Disorders, but should only be diagnosed if the diagnostic requirements for Generalized Anxiety Disorder were met prior to the onset of or following complete remission of a Depressive Episode.
- ***Boundary with Adjustment Disorder:*** Adjustment Disorder involves maladaptive reactions to an identifiable psychosocial stressor or multiple stressors characterized by preoccupation with the stressor or its consequences. Reactions may include excessive worry, recurrent and distressing thoughts about the stressor, or constant rumination about its implications. Adjustment Disorder centres on the identifiable stressor or its consequences, whereas in Generalized Anxiety Disorder, worry typically encompasses multiple areas of daily life and may include hypothetical concerns (e.g., that a negative life event may occur). Unlike individuals with Generalized Anxiety Disorder, those with Adjustment Disorder typically have normal functioning prior to the onset of the stressor(s). Symptoms of Adjustment Disorder generally resolve within 6 months.
- ***Boundary with Obsessive-Compulsive Disorder:*** In Obsessive-Compulsive Disorder, the focus of apprehension is on intrusive and unwanted thoughts, urges, or images (obsessions), whereas in Generalized Anxiety Disorder the focus is on everyday life events. In contrast to obsessions in Obsessive-Compulsive Disorder, which are usually experienced as unwanted and intrusive, individuals with Generalized Anxiety Disorder may experience their worry as a helpful strategy in averting negative outcomes.
- ***Boundary with Hypochondriasis (Health Anxiety Disorder) and Bodily Distress Disorder:*** In Hypochondriasis and Bodily Distress Disorder, individuals worry about real or perceived physical symptoms and their potential significance to their health status. Individuals with Generalized Anxiety Disorder experience somatic symptoms associated with anxiety and may worry about their health but their worry extends to other aspects of everyday life.
- ***Boundary with Post-Traumatic Stress Disorder:*** Individuals with Post-Traumatic Stress Disorder develop hypervigilance as a consequence of exposure to the traumatic stressor and may become apprehensive that they or others close to them may be under immediate threat either in specific situations or more generally. Individuals with Post-Traumatic Stress Disorder may also experience anxiety triggered by reminders of the traumatic event (e.g., fear and avoidance of a place where an individual was assaulted). In contrast, the anxiety and worry in individuals with Generalized Anxiety Disorder is directed toward the possibility of untoward events in a variety of life domains (e.g., health, finances, work).

6B01 Panic Disorder

Essential (Required) Features:

- Recurrent panic attacks, which are discrete episodes of intense fear or apprehension characterized by the rapid and concurrent onset of several characteristic symptoms. These symptoms may include, but are not limited to, the following:
    - Palpitations or increased heart rate
    - Sweating
    - Trembling
    - Sensations of shortness of breath
    - Feelings of choking
    - Chest pain
    - Nausea or abdominal distress
    - Feelings of dizziness or light-headedness
    - Chills or hot flushes
    - Tingling or lack of sensation in extremities (i.e., paraesthesias)
    - Depersonalization or derealization
    - Fear of losing control or going mad
    - Fear of imminent death
- At least some of the panic attacks are unexpected, that is they are not restricted to particular stimuli or situations but rather seem to arise 'out of the blue'.
- Panic attacks are followed by persistent concern or worry (e.g., for several weeks) about their recurrence or their perceived negative significance (e.g., that the physiological symptoms may be those of a myocardial infarction), or behaviours intended to avoid their recurrence (e.g., only leaving the home with a trusted companion).
- Panic attacks are not limited to anxiety-provoking situations in the context of another mental disorder.
- The symptoms are not a manifestation of another medical condition (e.g., pheochromocytoma) and are not due to the direct effects of a substance or medication on the central nervous system (e.g., coffee, cocaine), including withdrawal effects (e.g., alcohol, benzodiazepines).
- The symptoms result in significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Note: Panic attacks can occur in other *Anxiety or Fear-Related Disorders* as well as other mental disorders and therefore the presence of panic attacks is not in itself sufficient to assign a diagnosis of Panic Disorder.

Additional Clinical Features:

- Individual panic attacks usually only last for minutes, though some may last longer. The frequency and severity of panic attacks varies widely (e.g., many times a day to a few per month) within and across individuals.
- In Panic Disorder, it is common for panic attacks to become more 'expected' over time as they become associated with particular stimuli or contexts, which may originally have been coincidental. (For example, an individual who has an unexpected panic attack when

crossing a bridge may subsequently become anxious when crossing bridges, which could then lead to 'expected' panic attacks in response to bridges.)

- Limited-symptom attacks (i.e., attacks that are similar to panic attacks, except that they are accompanied by only a few symptoms characteristic of a panic attack without the characteristic intense peak of symptoms) are common in individuals with Panic Disorder, particularly as behavioural strategies (e.g., avoidance) are used to curtail anxiety symptoms. However, in order to qualify for a diagnosis of Panic Disorder, there must be a history of recurrent panic attacks that meet the full diagnostic requirements.
- Some individuals with Panic Disorder experience nocturnal panic attacks, that is, waking from sleep in a state of panic.
- Although the pattern of symptoms (e.g., mainly respiratory, nocturnal, etc.), the severity of the anxiety, and the extent of avoidance behaviours are variable, Panic Disorder is one of the most impairing of the Anxiety Disorders. Individuals often present repeatedly for emergency care and may undergo a range of unnecessary and costly special medical investigations despite repeated negative findings.

Boundary with Normality (Threshold):

- Panic attacks are common in the general population, particularly in response to anxiety-provoking life events. Panic attacks in response to real threats to an individual's physical or psychological integrity are considered part of the normative continuum of reactions, and a diagnosis is not warranted in such cases. Panic Disorder is differentiated from normal fear reactions by: frequent recurrence of panic attacks; persistent worry or concern about the panic attacks or their meaning or alterations in behaviour (e.g., avoidance); and associated significant impairment in functioning.
- The sudden onset, rapid peaking, unexpected nature, and intense severity of panic attacks differentiate them from normal situationally-bound anxiety that may be experienced in everyday life (e.g., during stressful life transitions such as moving to a new city).

Course Features:

- Onset of Panic Disorder typically occurs during the early 20s.
- Some individuals experience episodic symptom outbreaks with long periods of remission, while others experience persistent, severe symptoms.
- The presence of co-occurring disorders (e.g., other Anxiety or Fear-Related Disorders, Depressive Disorders, and Disorders Due to Substance Use) has been associated with poorer long-term course trajectory.
- A co-occurring diagnosis of Agoraphobia is generally associated with greater symptom severity and poorer long-term prognosis.

Developmental Presentations:

- Although some children report physical symptoms of panic attacks, Panic Disorder is very rare in younger children because cognitive capacity for catastrophizing about the significance of symptoms is not yet fully developed. The prevalence of Panic Disorder increases across adolescence and early adulthood.
- Adolescents with Panic Disorder are at greater risk for a co-occurring Depressive Disorder including suicidality as well as for Disorders Due to Substance Use.

Culture-Related Features;

- The symptom presentation of panic attacks may vary across cultures, influenced by cultural attributions about their aetiology. For example, individuals of Cambodian origin may emphasize panic symptoms attributed to dysregulation of *khyâl*, a wind-like substance in traditional Cambodian ethnophysiology (e.g., dizziness, tinnitus, neck soreness).
- There are several notable cultural concepts of distress related to panic disorder, which link panic, fear, or anxiety to etiological attributions regarding specific social and environmental influences. Examples include attributions related to interpersonal conflict (e.g., *ataque de nervios* among Latin American people), exertion or orthostasis (*khyâl cap* among Cambodians), and atmospheric wind (*trúng gió* among Vietnamese individuals). These cultural labels may be applied to symptom presentations other than panic (e.g., anger paroxysms, in the case of *ataque de nervios*) but they often constitute panic episodes or presentations with partial phenomenological overlap with panic attacks.
- Clarifying cultural attributions and the context of the experience of symptoms can inform whether panic attacks should be considered unexpected, as must be the case in Panic Disorder. For example, panic attacks may involve specific foci of apprehension that are better accounted for by another disorder (e.g., social situations in Social Anxiety Disorder). Moreover, the cultural linkage of the apprehension focus with specific exposures (e.g., wind or cold and *trúng gió* panic attacks) may suggest that acute anxiety is expected when considered within the individual's cultural framework.

Gender-Related Features:

- Panic Disorder is twice as common in females than in males, with gender differences in prevalence rates beginning during puberty.
- Gender differences in clinical features or symptom presentation have not been observed.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Generalized Anxiety Disorder:*** Some individuals with Panic Disorder may experience anxiety and worry between panic attacks. If the focus of the anxiety and worry is confined to fear of having a panic attack or the possible implications of panic attacks (e.g., that the individual may be suffering from a cardiovascular illness), an additional diagnosis of Generalized Anxiety Disorder is not warranted. If, however, the individual is more generally anxious about a number of life events in addition to experiencing unexpected panic attacks, an additional diagnosis of Generalized Anxiety Disorder may be appropriate.
- ***Boundary with Agoraphobia:*** The perceived unpredictability of panic attacks often reflects the early phase of the disorder. However, over time, with the recurrence of panic attacks in specific situations, individuals often develop anticipatory anxiety about having panic attacks in those situations or may experience panic attacks triggered by exposure to them. In particular, it is common for individuals to develop some degree of agoraphobic symptoms over time in the context of Panic Disorder. If the individual develops fears that panic attacks or other incapacitating or embarrassing symptoms will occur in

multiple situations, and as a result actively avoids these situations, requires the presence of a companion, or endures them only with intense fear or anxiety and all other diagnostic requirements for Agoraphobia are met, an additional diagnosis of Agoraphobia may be assigned.

- ***Boundary with Depressive Disorders:*** Panic attacks can occur in Depressive Disorders, particularly in those with Prominent Anxiety Symptoms, including Mixed Depressive and Anxiety Disorder, and may be triggered by depressive ruminations. If unexpected panic attacks occur in the context of these disorders and the main concern is about recurrence of panic attacks or the significance of panic symptoms, an additional diagnosis of Panic Disorder may be appropriate.
- ***Boundary with Hypochondriasis (Health Anxiety Disorder):*** Individuals with Hypochondriasis often misinterpret bodily symptoms as evidence that they may have one or more life-threatening illnesses. Although individuals with Panic Disorder may also manifest concerns that physical manifestations of anxiety are indicative of life-threatening illnesses (e.g., myocardial infarction), these symptoms typically occur in the midst of a panic attack. Individuals with Panic Disorder are more concerned about the recurrence of panic attacks or the significance of panic symptoms, are less likely to report somatic concerns attributable to bodily symptoms other than those associated with anxiety, and are less likely to engage in repetitive and excessive health-related behaviours. However, panic attacks can occur in Hypochondriasis and if they are exclusively associated with fears of having a life-threatening illness, an additional diagnosis of Panic Disorder is not warranted. In this situation, the 'with panic attacks' qualifier can be applied to the diagnosis of Hypochondriasis. If there are persistent and repetitive panic attacks in the context of Hypochondriasis that are unexpected in the sense that they are not in response to illness-related concerns, both diagnoses should be assigned.
- ***Boundary with Oppositional Defiant Disorder:*** Irritability, anger, and noncompliance are sometimes associated with Panic Disorder in children and adolescents. For example, children may exhibit angry outbursts when presented with a task or situations that make them feel anxious (e.g., being asked to leave the home without a trusted companion such as a parent or caregiver). If the defiant behaviours only occur when triggered by a situation or stimulus that elicits anxiety, fear, or panic, a diagnosis of Oppositional Defiant Disorder is generally not appropriate.
- ***Boundary with other Mental, Behavioural or Neurodevelopmental Disorders:*** Panic attacks can occur in the context of a variety of other mental disorders, particularly other Anxiety or Fear-Related Disorders, Disorders Specifically Associated with Stress, and Obsessive-Compulsive or Related Disorders. When panic attacks occur in the context of these disorders, they are generally part of an intense anxiety response to a distressing internal or external stimulus that represents a focus of apprehension in that disorder (e.g., a particular object or situation in Specific Phobia, fear of negative social evaluation in Social Anxiety Disorder, fear of being contaminated by germs in Obsessive-Compulsive Disorder, fear of having a serious illness in Hypochondriasis, reminders of a traumatic event in Post-Traumatic Stress Disorder). If panic attacks are limited to such situations in the context of another disorder, a separate diagnosis of Panic Disorder is not warranted. If some panic attacks over the course of the disorder have been unexpected and not exclusively in response to stimuli associated with the focus of apprehension related to another disorder, an additional diagnosis of Panic Disorder may be assigned.

6B02 Agoraphobia

Essential (Required) Features:

- Marked and excessive fear or anxiety that occurs in, or in anticipation of, multiple situations where escape might be difficult or help might not be available, such as using public transportation, being in crowds, being outside the home alone, in shops, theatres, or standing in line.
- The individual is consistently fearful or anxious about these situations due to a fear of specific negative outcomes such as panic attacks, symptoms of panic, or other incapacitating (e.g., falling) or embarrassing physical symptoms (e.g., incontinence).
- The situations are actively avoided, are entered only under specific circumstances (e.g., in the presence of a companion), or else are endured with intense fear or anxiety.
- The symptoms are not transient, that is, they persist for an extended period of time (e.g., at least several months).
- The symptoms are not better accounted for by another mental disorder (e.g., paranoid ideation in Delusional Disorder; social withdrawal in Depressive Disorders).
- The symptoms result in significant distress about experiencing persistent anxiety symptoms or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional Clinical Features:

- The experiences feared by individuals with Agoraphobia may include symptoms of a panic attack as described in Panic Disorder (e.g., palpitations or increased heart rate, chest pain, feelings of dizziness or light-headedness) or other symptoms that may be incapacitating, frightening, difficult to manage, or embarrassing (e.g., incontinence, changes in vision, vomiting). It is often important to establish quite specifically the nature of the feared outcome in Agoraphobia, as this may inform the specific choice of treatment strategies.
- It is common for individuals with Agoraphobia to have a history of panic attacks, although they may not currently meet the diagnostic requirements for Panic Disorder or indeed have panic attacks at all because they avoid situations in which panic attacks may occur. Establishing that an individual's focus of apprehension relates specifically to experiencing the bodily symptoms of a panic attack would be important in considering whether to add components of Panic Disorder treatment (e.g., interoceptive exposure) to the treatment of Agoraphobia, even when there is no current Panic Disorder diagnosis.
- Individuals with Agoraphobia may employ a variety of different behavioural strategies if required to enter feared situations. One such 'safety' behaviour is to require the presence of a companion. Other strategies may include going to certain places only at particular times of day or carrying specific materials (e.g., medications, towels) in case of the feared negative outcome. These strategies may change over the course of the disorder and from one occasion to the next. For example, on different occasions in the same situation an individual may insist on having a companion, endure the situation with distress, or use various safety behaviours to cope with their anxiety.

- Although the pattern of symptoms, the severity of the anxiety, and the extent of avoidance are variable, Agoraphobia is one of the most impairing of the Anxiety or Fear-Related Disorders to the extent that some individuals become completely housebound, which has an impact on opportunities for employment, seeking medical care, and the ability to form and maintain relationships.

Boundary with Normality (Threshold):

- Individuals may exhibit transient avoidance behaviours in the context of normal development or in periods of increased stress. These behaviours are differentiated from Agoraphobia because they are limited in duration and do not lead to significant impact on functioning.
- Individuals with disabilities or medical conditions may avoid certain situations because of reasonable concerns about being incapacitated or embarrassed (e.g., a person with a mobility limitation who is concerned that an unfamiliar location won't be accessible, a person with Crohn's disease who is concerned about experiencing sudden diarrhoea). Agoraphobia should only be diagnosed if the anxiety and avoidance result in functional impairment that is greater than expected given the disability or heath condition.

Course Features:

- The typical age of onset for Agoraphobia is in late adolescence, with the majority of individuals experiencing onset before age 35 years. However, age of onset is later (during the mid to late 20s) for individuals without a history of panic attacks or pre-existing diagnosis of Panic Disorder. Onset during childhood is considered rare.
- Agoraphobia is generally considered a chronic and persistent condition. The long-term course and outcome of Agoraphobia is associated with increased risk of developing Depressive Disorders, Dysthymic Disorder, and Disorders Due to Substance Use.
- Greater symptom severity (e.g., avoidance of most activities, being housebound) is associated with higher rates of relapse and chronicity, and poorer long-term prognosis.
- The presence of co-occurring disorders, particularly other Anxiety or Fear-Related Disorder, Depressive Disorders, Personality Disorders, and Disorders due to Substance Use has been associated with poorer long-term prognosis.

Developmental Presentations:

- Although the clinical features of Agoraphobia generally remain consistent across the lifespan, specific triggers and related cognitions can vary across age groups. For example, whereas fear of being outside of the home alone or becoming lost are common during childhood, adults are more likely to fear standing in line, being in crowded or open spaces, or experiencing a panic attack. Among older adults, fear of falling is common.
- Similar to adults, children and adolescents with Agoraphobia may demonstrate excessive avoidance of certain situations or locations, or require the presence of a close friend or family member to enter these situations. Children with Agoraphobia are likely to resist leaving the home without a parent or caregiver. A common focus of apprehension is becoming lost and not being able to obtain help. Soliciting information from collateral

informants who know the child well can assist in clarifying the child's focus of apprehension.

Culture-Related Features:

- Assessment of Agoraphobia should incorporate information on cultural and gender norms. For example, fear of leaving the home among populations and contexts in which violence is common should not be assigned this diagnosis unless the fear is in excess of what is culturally normative. Likewise, for individuals in cultures who spend most of their time at home, anxiety when in open areas (e.g., markets) may be expected; the disorder should only be diagnosed when the fear exceeds cultural norms.

Gender-Related Features:

- Lifetime prevalence of Agoraphobia is approximately twice as high in women. Among children, it is more frequently reported in girls, with symptom onset occurring earlier for girls than boys.
- Men with Agoraphobia are more likely to report co-occurring Disorders due to Substance Use.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Panic Disorder:*** It is common for individuals with Panic Disorder to develop some degree of agoraphobic symptoms over time. If the individual experiences recurrent unexpected panic attacks that are not restricted to particular stimuli or situations, and agoraphobic symptoms do not meet the full diagnostic requirements for Agoraphobia, then Panic Disorder is the appropriate diagnosis. Conversely, many individuals with Agoraphobia have experienced recurrent panic attacks. If an individual with Agoraphobia experiences panic attacks exclusively in the context of the multiple agoraphobic situations without the presence of unexpected panic attacks, an additional diagnosis of Panic Disorder is not warranted and the presence of panic attacks may be indicated using the 'with panic attacks' qualifier. However, if unexpected panic attacks also occur, an additional diagnosis of Panic Disorder may be assigned.
- ***Boundary with Specific Phobia:*** Specific Phobia is differentiated from Agoraphobia because it involves fear of circumscribed situations or stimuli themselves (e.g., heights, animals, blood or injury) rather than fear or anxiety of imminent perceived dangerous outcomes (e.g., panic attacks, symptoms of panic, incapacitation, or embarrassing physical symptoms) that are anticipated to occur in multiple situations where obtaining help or escaping might be difficult.
- ***Boundary with Social Anxiety Disorder:*** In Social Anxiety Disorder, symptoms in response to feared social situations (e.g., speaking in public, initiating a conversation) and the primary focus of apprehension is on being negatively evaluated by others.
- ***Boundary with Separation Anxiety Disorder:*** Similar to Agoraphobia, individuals with Separation Anxiety Disorder avoid situations but, in contrast, they do so to prevent or limit being away from individuals to whom they are attached (e.g., parent, spouse, or child) for fear of losing them.
- ***Boundary with Schizophrenia or Other Primary Psychotic Disorders:*** Individuals with Schizophrenia or Other Primary Psychotic Disorders may avoid situations as a

consequence of persecutory or paranoid delusions rather than because of fear or anxiety of imminent perceived dangerous outcomes (e.g., panic attacks, symptoms of panic, incapacitation, or embarrassing physical symptoms) that are anticipated to occur in multiple situations where obtaining help or escaping might be difficult.

- ***Boundary with Depressive Disorders:*** In Depressive Disorders, individuals may avoid multiple situations but do so because of loss of interest in previously pleasurable activities or due to lack of energy rather than because of fear or anxiety of imminent perceived dangerous outcomes (e.g., panic attacks, symptoms of panic, incapacitation, or embarrassing physical symptoms) that are anticipated to occur in multiple situations where obtaining help or escaping might be difficult.
- ***Boundary with Post-Traumatic Stress Disorder:*** In Post-Traumatic Stress Disorder, the individual deliberately avoids reminders likely to produce re-experiencing of the traumatic event(s). In contrast, situations are avoided in Agoraphobia because of fear or anxiety of imminent perceived dangerous outcomes (e.g., panic attacks, symptoms of panic, incapacitation, or embarrassing physical symptoms) that are anticipated to occur in multiple situations where obtaining help or escaping might be difficult.
- ***Boundary with Oppositional Defiant Disorder:*** Irritability, anger, and noncompliance are sometimes associated with anxiety in children and adolescents. For example, children may exhibit angry outbursts when asked to enter situations that make them feel anxious (e.g., being asked to leave the home without a trusted companion such as a parent or caregiver). If the defiant behaviours only occur when triggered by a situation or stimulus that elicits anxiety, fear, or panic, a diagnosis of Oppositional Defiant Disorder is generally not appropriate.

6B03 Specific Phobia

Essential (Required) Features:

- Marked and excessive fear or anxiety that consistently occurs upon exposure or anticipation of exposure to one or more specific objects or situations (e.g., proximity to certain kinds of animals, heights, enclosed spaces, sight of blood or injury) that is out of proportion to the actual danger posed by the specific object or situation.
- The phobic object or situation is actively avoided or else endured with intense fear or anxiety.
- A pattern of fear, anxiety, or avoidance related to specific objects or situations is not transient, that is, it persists for an extended period of time (e.g., at least several months).
- The symptoms are not better accounted for by another mental disorder (e.g., Social Anxiety Disorder, a primary psychotic disorder).
- The symptoms result in significant distress about experiencing persistent anxiety symptoms or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional Clinical Features:

- Specific Phobia encompasses fears of a broad and heterogeneous group of phobic stimuli. The most common are for particular animals (animal phobia), heights

(acrophobia), enclosed spaces (claustrophobia), sight of blood or injury (blood-injury phobia), flying, driving, storms, darkness, and medical/dental procedures. Individuals' reactions to phobic stimuli can range from feelings of disgust and revulsion (often occurring in animal phobias or blood-injury phobias), anticipation of danger or harm (common across most types of Specific phobia), and physical symptoms such as fainting (most common in response to blood or injury).

- The majority of individuals diagnosed with Specific Phobia report fear of multiple objects or situations. A single diagnosis of Specific Phobia is assigned regardless of the number of feared objects or situations. Unlike most phobic stimuli, which upon presentation or anticipation typically result in significant physiological arousal, individuals who fear the sight of blood, invasive medical procedures, or injury, may experience a vasovagal response that can result in a fainting spell.
- Some individuals with Specific Phobia may report a history of having observed another person (e.g., caregiver) react with fear or anxiety when confronted by an object or situation, resulting in vicarious learning of a fear response to the object or situation. Others may have had direct negative experience with an object or situation (e.g., having been bitten by a dog). However, previous negative experiences (direct or vicarious) are not necessary for the development of the disorder.
- Some individuals report that their fear or anxiety for an object or situation is not excessive. As such, clinicians must consider whether the reported fear, anxiety, or avoidance behaviour is disproportionate to the reasonable risk of harm, taking into consideration both accepted cultural norms as well as the specific environmental conditions that the individual is normally subjected to (e.g., fear of darkness may be justified in a neighbourhood where assaults are common at night).

Boundary with Normality (Threshold):

- In children and adolescents, some fears may be part of normal development (e.g., a young child who is afraid of dogs). Specific Phobia should only be diagnosed if the fear or anxiety is excessive in comparison to that of other individuals at a similar developmental level.

Course Features:

- Onset of Specific Phobia can occur at any age; however, initial onset is most common during early childhood (between 7 and 10 years of age) typically as a result of witnessing or experiencing a fear-provoking situation or event (e.g., choking, being attacked by an animal, witnessing someone drown).
- Younger age of onset has been associated with phobias related to animal and natural phenomena (fear of still water/weather, closed spaces); whereas, fear of flying- and height-related phobias generally have an older age of onset.
- Younger age of onset is also associated with an increased number of feared situations or stimuli.
- Individuals with Specific Phobia report high lifetime rates of co-occurring disorders, particularly, Depressive Disorders and other Anxiety or Fear-Related Disorders. In the majority of cases, Specific Phobia precedes the onset of other mental disorders.
- Specific phobias that persist from childhood into adolescence and adulthood rarely remit spontaneously.

Developmental Presentations:

- Anxiety or Fear-Related Disorders are the most prevalent mental disorders of childhood and adolescence. Among these conditions, Specific Phobia is one of the most common in young children, and may present in children as young as 3 years of age.
- In children, the diagnosis of Specific Phobia should not be assigned when the fears are developmentally normative (e.g., fear of the dark in young children).
- In preschool age children, phobic responses may include freezing, tantrums, or crying. Duration, frequency, and intensity of these reactions may be used to distinguish between age-typical fears and anxiety responses in Specific Phobia.
- Specific Phobias related to tangible objects (e.g., animals) are more common in younger children whereas those relating to possible harm to oneself or others (e.g., environmental, blood/injection) are more common in adolescents and adults.
- Similar to adults, excessive avoidance is seen in both children and adolescents, and may be driven by both the actual presence of the phobic stimuli, or anticipatory anxiety (e.g., refusing to go outside because of the possible presence of bees).

Culture-Related Features:

- Culture may play a role in shaping the fear response to specific stimuli. A diagnosis of Specific Phobia should not be assigned if a stimulus is feared by most people in a cultural group, unless the fear exceeds cultural norms. For example, people from some cultural groups may avoid walking at night in certain areas where they fear ghosts or spirits may be present.
- The salience of specific feared stimuli may differ by cultural group and environmental context. Common threats in the environment (e.g., poisonous snakes) may account for some of the cultural variation in feared stimuli.

Gender-Related Features:

- Lifetime prevalence of Specific Phobia is approximately twice as high in females.
- Whereas males and females are equally likely to experience phobias related to blood, injection, and injury, situationally specific phobias and those related to animals and natural environments are more common among females.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Panic Disorder:*** If an individual with Specific Phobia experiences panic attacks exclusively in the context of actual or anticipated encounters with the specific object or situation that represents the focus of apprehension, an additional diagnosis of Panic Disorder is not warranted and the presence of panic attacks may be indicated using the 'with panic attacks' qualifier. However, if unexpected panic attacks also occur, an additional diagnosis of Panic Disorder may be assigned.
- ***Boundary with Agoraphobia:*** Specific Phobia is differentiated from Agoraphobia because it involves fear of circumscribed situations or stimuli (e.g., heights, animals, blood-injury) rather than because of fear or anxiety of imminent perceived dangerous outcomes (e.g., panic attacks, symptoms of panic, incapacitation, or embarrassing

physical symptoms) that are anticipated to occur in multiple situations where obtaining help or escaping might be difficult.

- ***Boundary with Social Anxiety Disorder:*** In Social Anxiety Disorder, the fear and avoidance is triggered by social situations (e.g., speaking in public, initiating a conversation) and the primary focus of apprehension is about being negatively evaluated by others, whereas in Specific Phobia, the fear and avoidance is in response to other specific objects or situations.
- ***Boundary with Obsessive-Compulsive Disorder:*** In Obsessive-Compulsive Disorder, individuals may avoid specific stimuli or situations related to obsessions or compulsions (e.g., avoiding 'contaminated' situations in someone with a hand-washing compulsion) whereas in Specific Phobia, objects or situations are avoided because of fear associated with them and not because of obsessions or compulsions.
- ***Boundary with Hypochondriasis (Health Anxiety Disorder):*** In Hypochondriasis, individuals may avoid medical consultations or hospitals because of a fear that it will exacerbate their preoccupation with having a serious disease. In contrast, in Specific Phobia the fear and avoidance are related to the specific object or situation itself.
- ***Boundary with Post-Traumatic Stress Disorder and Complex Post-Traumatic Stress Disorder:*** Both Specific Phobia and Post-Traumatic Stress Disorder involve avoidance of stimuli that cause anxiety, and both may arise following exposure to a traumatic event. Post-Traumatic Stress Disorder can be differentiated from Specific Phobia by the presence of the other core symptoms of Post-Traumatic Stress Disorder (i.e., re-experiencing the trauma and persistent perceptions of heightened current threat). They are further differentiated by the fact that, unlike Specific Phobia in which the memories of the related traumatic event are experienced as belonging to the past, in Post-Traumatic Stress Disorder and Complex Post-Traumatic Stress Disorder, the traumatic event is experienced as if it were occurring again in the here and now (i.e., re-experiencing).
- ***Boundary with Feeding or Eating Disorders:*** Individuals with Feeding or Eating Disorders exhibit abnormal eating behaviour and/or preoccupation with food as well as prominent body weight and shape concerns and may avoid food because they fear it will lead to weight gain or because of its specific sensory qualities. In some Specific Phobias, individuals may avoid eating or food stimuli, but the avoidance is related to the anticipated direct effect of the phobic stimulus (e.g., eating may lead to choking or vomiting) rather than because of the caloric content or sensory qualities of the food itself.
- ***Boundary with Oppositional Defiant Disorder:*** Irritability, anger, and noncompliance are sometimes associated with anxiety in children and adolescents. For example, children may exhibit angry outbursts when asked to interact with a stimulus or enter situations that make them feel anxious (e.g., asking a child who fears dogs to go to the park where there might be dogs present). If the defiant behaviours only occur when triggered by a situation or stimulus that elicits anxiety, fear, or panic, a diagnosis of Oppositional Defiant Disorder is generally not appropriate.

6B04 Social Anxiety Disorder

Essential (Required) Features:

- Marked and excessive fear or anxiety that occurs consistently in one or more social situations such as social interactions (e.g., having a conversation), doing something while feeling observed (e.g., eating or drinking in the presence of others), or performing in front of others (e.g., giving a speech).
- The individual is concerned that he or she will act in a way, or show anxiety symptoms, that will be negatively evaluated by others (i.e., be humiliating, embarrassing, lead to rejection, or be offensive).
- Relevant social situations are consistently avoided or endured with intense fear or anxiety.
- The symptoms are not transient; that is, they persist for an extended period of time (e.g., at least several months).
- The symptoms are not better accounted for by another mental disorder (e.g., Agoraphobia, Body Dysmorphic Disorder, Olfactory Reference Disorder).
- The symptoms result in significant distress about experiencing persistent anxiety symptoms or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional Clinical Features:

- Individuals with Social Anxiety Disorder may report concerns about physical symptoms, such as blushing, sweating, or trembling rather than initially endorsing fears of negative evaluation.
- Social Anxiety Disorder frequently co-occurs with other Anxiety or Fear-Related Disorders as well as Depressive Disorders.
- Individuals with Social Anxiety Disorder are at higher risk for developing Disorders due to Substance Use, which may arise subsequent to use for the purposes of attenuating anxiety symptoms in social situations.
- Individuals with Social Anxiety Disorder may not view their fear or anxiety in response to social situations as excessive. As such, clinical judgment should be applied to determine whether the reported fear, anxiety, or avoidance behaviour is disproportionate to what the social situation warrants, taking into consideration both accepted cultural norms and the specific environmental circumstances to which that the individual is subjected (e.g., fear of interacting with peers may be appropriate if the individual is being bullied).

Boundary with Normality (Threshold):

- Social Anxiety Disorder can be differentiated from normal developmental fears (e.g., a child's reluctance to interact with unfamiliar people in novel situations) by fear and anxiety reactions that are typically excessive, interfere with functioning, and persist over time (e.g., lasting more than several months).
- Many individuals experience fear in social situations (e.g., it is common for individuals to experience anxiety about speaking in public) or manifest the normal personality trait

of shyness. Social Anxiety Disorder should only be considered in cases in which the individual reports social fear, anxiety, and avoidance that are clearly in excess of what is normative for the specific cultural context and result in significant distress or impairment.

Course Features:

- Although onset of Social Anxiety Disorder can occur during early childhood, onset typically occurs during childhood and adolescence, with a large majority of cases emerging between 8 and 15 years of age.
- Onset of Social Anxiety Disorder can be gradual or occur precipitously subsequent to a stressful or humiliating social experience.
- Social Anxiety Disorder is generally considered to be a chronic condition; however, later age of onset, less severe level of impairment, and absence of co-occurring disorders have been associated with spontaneous remission among individuals in the community.
- High rates of co-occurring mental disorders make it difficult to distinguish long-term prognosis attributable specifically to Social Anxiety Disorder. Poorer long-term prognosis has been associated with greater symptom severity, and co-occurring Disorders due to Use of Alcohol, Personality Disorders, Generalized Anxiety Disorder, Panic Disorder, and Agoraphobia.
- Remission rates for Social Anxiety Disorder vary widely with some individuals experiencing spontaneous remission of symptoms.

Developmental Presentations:

- Social Anxiety Disorder is less common in young children under the age of 10, with occurrence of the disorder increasing significantly during adolescence.
- In children, the diagnosis of Social Anxiety Disorder should not be used to describe developmentally normative stranger anxiety or shyness.
- Social Anxiety Disorder is associated with the temperamental trait of behavioural inhibition, that is, the tendency for some individuals to experience novel situations as distressing and to withdraw from or avoid unfamiliar contexts or people. Behaviourally inhibited children are ‘slow to warm up’ to new people and new situations. Behavioural inhibition is considered to be a normal variation in temperament, but is also a risk factor for the development of Social Anxiety Disorder.
- Similar to adults, children and adolescents may employ subtle avoidance strategies during social situations to manage their anxiety, including limiting speech or making poor eye contact with others. Children and adolescents with Social Anxiety Disorder may also evidence social skills deficits, such as difficulty with starting or maintaining conversations or asserting their wishes or opinions.
- Social Anxiety Disorder symptoms may only become evident with the start of school, with the onset of demands to interact socially with unfamiliar peers and teachers. The manifestations of Social Anxiety Disorder may also vary across age groups, with younger children more likely to exhibit social anxiety primarily with adults, and adolescents more likely to experience increased social anxiety with peers. There are also individual differences with respect to the degree of social anxiety experienced when interacting with members of the same or opposite sex. Soliciting information from

collateral informants who know the child well about how they react in various situations and contexts can assist in making the diagnosis.

- Social Anxiety Disorder symptoms may become more evident with age as social demands exceed individuals' capabilities to cope with and manage their anxiety. Adolescents may exhibit various associated difficulties, including social withdrawal, school refusal, and reluctance to assert their needs. Some adolescents may participate in social situations for fear of the consequences to their social status if they do not, but do so with significant distress.

Culture-Related Features:

- Identification of Social Anxiety Disorder may depend on assessment of social situations relevant for the cultural group (e.g., being expected to dance in public among some Latin American cultures) that may be associated with excessive anxiety and whether the degree of anxiety is outside the cultural norms for the individual. To avoid stereotyping, individuals should be asked openly about social situations associated with excessive anxiety.
- Anxiety and avoidance of certain social situations may be considered normative in some cultural groups (e.g., public speaking or voicing dissent in some Asian cultures) and therefore may not indicate a disorder unless this fear or anxiety is out of proportion to the actual danger posed by the social situation when considering the sociocultural context.
- There are cultural concepts of distress that are related to Social Anxiety Disorder. For example, among Japanese *taijin kyofusho,* and related conditions among Koreans, may represent a form of Social Anxiety Disorder associated with the fear that others will be offended by one's own inappropriate social behaviour (e.g., inappropriate gaze or facial expression, blushing, body odour, loud bowel sounds). Other presentations of *taijin kyofusho* may be better captured by a diagnosis of Delusional Disorder, Body Dysmorphic Disorder, or Olfactory Reference Disorder.
- Prevalence rates of Social Anxiety Disorder may not follow self-reported social anxiety levels in the same culture; that is, societies with strong collectivistic orientations may report high levels of social anxiety but lower prevalence of Social Anxiety Disorder. This may be due to higher tolerance for socially reticent and withdrawn behaviours, resulting in better psychosocial functioning, or to lower recognition of Social Anxiety Disorder.

Gender-Related Features:

- Whereas prevalence rates for Social Anxiety Disorder are higher for women in community samples, gender differences are not observed in clinical samples. The disparity in prevalence across settings has been attributed to gender role expectations such that men experiencing greater severity of symptoms are more willing to seek professional services.
- Women report greater symptom severity and a greater variety of social fears, whereas men are more likely to fear dating and urinating in public.
- Co-occurring Depressive, Bipolar, and Anxiety or Fear-Related Disorders are more common among women; whereas, men are more likely to experience co-occurring

Oppositional Defiant Disorder, Conduct-Dissocial Disorder, and Disorders Due to Substance Use.
- The use of alcohol and illicit drugs to relieve symptoms of Social Anxiety Disorder is common among men.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Generalized Anxiety Disorder:*** Generalized Anxiety Disorder can be differentiated from Social Anxiety Disorder because the main focus of worry is negative consequences that can occur in multiple everyday situations (e.g., work, relationships, finances) rather than being restricted to concerns about one's behaviour or appearance being negatively evaluated in social situations.
- ***Boundary with Panic Disorder:*** If an individual with Social Anxiety Disorder experiences panic attacks exclusively in the context of actual or anticipated social or performance situations, an additional diagnosis of Panic Disorder is not warranted and the presence of panic attacks may be indicated using the 'with panic attacks' qualifier. However, if unexpected panic attacks also occur, an additional diagnosis of Panic Disorder may be assigned.
- ***Boundary with Agoraphobia:*** Fear or anxiety in Agoraphobia centres on imminent perceived dangerous outcomes (e.g., panic attacks, symptoms of panic, incapacitation, or embarrassing physical symptoms) that are anticipated to occur in multiple situations where obtaining help or escaping might be difficult rather than on concerns that others are negatively evaluating them. Unlike Social Anxiety Disorder, embarrassment in Agoraphobia is secondary to the concerns that escape or obtaining assistance may not be possible should symptoms (e.g., diarrhoea in a public place) occur.
- ***Boundary with Specific Phobia:*** Specific Phobia can be differentiated from Social Anxiety Disorder because, in general, fears are of specific situations or stimuli (e.g., heights, animals, blood-injury) and not of social situations.
- ***Boundary with Selective Mutism:*** Selective Mutism is characterized by a failure to speak in specific situations whereas in Social Anxiety Disorder fear and anxiety result in avoidance of multiple social contexts.
- ***Boundary with Autism Spectrum Disorder:*** Individuals with Autism Spectrum Disorder and Social Anxiety Disorder may both appear to be socially withdrawn. However, those with Autism Spectrum Disorder can be differentiated because of the presence of social communication deficits and typically a lack of interest in social interactions.
- ***Boundary with Depressive Disorders:*** Beliefs of social inadequacy, rejection, and failure are common in Depressive Disorders and may be associated with avoidance of social situations. However, unlike in Social Anxiety Disorder, these symptoms occur almost exclusively during a Depressive Episode.
- ***Boundary with Body Dysmorphic Disorder:*** In Body Dysmorphic Disorder, individuals worry about a perceived physical defect that is often undetectable or very minor from the point of view of others. These individuals may be concerned about others' negative judgment of the perceived defect. However, unlike in Social Anxiety Disorder, their concerns are restricted to how others will evaluate the perceived defect rather than other aspects of their behaviour or appearance across social contexts.
- ***Boundary with Olfactory Reference Disorder:*** In Social Anxiety Disorder, social situations are avoided because the individual is concerned that he or she will act in a way, or show anxiety symptoms, that will be negatively evaluated by others (i.e., be

humiliating, embarrassing, lead to rejection, or be offensive). In contrast, individuals with Olfactory Reference Disorder may avoid social situations specifically because they believe they are emitting a foul odour.

- ***Boundary with Oppositional Defiant Disorder:*** Irritability, anger, and noncompliance are sometimes associated with anxiety in children and adolescents. For example, children may exhibit angry outbursts when asked to enter situations that make them feel anxious (e.g., being asked to attend a social gathering). If the defiant behaviours only occur when triggered by a situation or stimulus that elicits anxiety, fear, or panic, a diagnosis of Oppositional Defiant Disorder is generally not appropriate.
- ***Boundary with other Mental and Behavioural Syndromes due to another medical condition:*** Individuals with certain medical conditions (e.g., Parkinson Disease) as well as those with other Mental, Behavioural or Neurodevelopmental Disorders (e.g., Schizophrenia) may demonstrate avoidance of social situations because of concerns that others will negatively evaluate their symptoms (e.g., tremor, unusual behaviours). An additional diagnosis of Social Anxiety Disorder should only be assigned if all diagnostic requirements are met taking into consideration that it is normal for individuals with visible symptoms of a medical condition to experience some concerns about how others perceive their symptoms. Typically, individuals with medical conditions adapt to concerns related to their manifest symptoms and do not display persistent excessive fear or anxiety in social situations.

6B05 Separation Anxiety Disorder

Essential (Required) Features:

- Marked and excessive fear or anxiety about separation from those individuals to whom the person is attached (i.e., with whom the individual has a deep emotional bond). In children and adolescents, key attachment figures that are most commonly the focus of separation anxiety include parents, caregivers, and other family members, and the fear or anxiety is beyond what would be considered developmentally normative. In adults, separation anxiety most often involves a spouse, romantic partner, or children. Manifestations of fear or anxiety related to separation depend on the individual's developmental level, but may include:
    - Persistent thoughts that harm or some other untoward event (e.g., being kidnapped) will lead to separation.
    - Reluctance or refusal to go to school or work.
    - Recurrent excessive distress (e.g., tantrums, social withdrawal) related to being separated from the attachment figure.
    - Reluctance or refusal to go to sleep without being near the attachment figure.
    - Recurrent nightmares about separation.
    - Physical symptoms such as nausea, vomiting, stomachache, headache, on occasions that involve separation from the attachment figure, such as leaving home to go to school or work.
- The symptoms are not transient, that is, they persist for an extended period of time (e.g., at least several months).
- The symptoms are not better by another mental disorder (e.g., Agoraphobia, Personality Disorder).

- The symptoms result in significant distress about experiencing persistent anxiety symptoms or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional Clinical Features:

- Separation Anxiety Disorder frequently co-occurs with other Mental, Behavioural or Neurodevelopmental Disorders. In children and youth, common co-occurring disorders include Generalized Anxiety Disorder and Specific Phobia. In adults, frequently co-occurring disorders include Mood Disorders and Anxiety or Fear-Related Disorders, Post-Traumatic Stress Disorder, and Personality Disorder.
- Although Separation Anxiety Disorder may exhibit a lifelong course with onset in childhood, a significant proportion of adults with Separation Anxiety Disorder do not recall a childhood onset.
- Separation Anxiety Disorder in childhood is frequently associated with a parenting style that interferes with the development of autonomy and self-mastery expected for that person's cultural context (e.g., parent does not permit child to independently engage in basic activities of daily living such as dressing and bathing).

Boundary with Normality (Threshold):

- Many situations involving separation are associated with other potential stressors or are normal sources of anxiety (e.g., leaving home to start a job or attend university in a new city). Separation Anxiety Disorder is differentiated based on the focus of apprehension being on separation from a key attachment figure rather than on other aspects of adjusting to novel circumstances.
- Strong attachment to loved ones is a normal and healthy part of life and separation from these individuals may be associated with transient sadness or anxiety. Preschool children may show a moderate or even greater degree of anxiety over real or threatened separation from people to whom they are attached. These reactions are considered developmentally appropriate and differentiated from Separation Anxiety Disorder on the basis of the persistence of the symptoms (e.g., lasting for several months) with repeated separations, evidence of excessive preoccupations about the well-being of attachment figures, persistent avoidance, and significant distress or impairment in functioning as a consequence of the symptoms.
- Among children and youth, school refusal is a common occurrence and may be based on transient anxiety about separation from a loved one or be symptomatic of Separation Anxiety Disorder. However, especially in adolescence, anxiety about school or school refusal is not typically related to fear of separation but rather to other factors such as truancy, peer rejection, or bullying.

Course Features:

- The typical onset of Separation Anxiety Disorder is during childhood and the disorder can persist into adulthood. Initial disorder onset during adolescence and adulthood may be less common.

- Separation Anxiety Disorder has been associated with elevated risk of developing a wide range of internalizing disorders including Depressive Disorders, and Bipolar Disorders, and Anxiety or Fear-Related Disorders. There is also evidence of elevated risk of Disruptive Behaviour or Dissocial Disorders, and Attention Deficit Hyperactivity Disorder.

Developmental Presentations:

- Anxiety or Fear-Related Disorders are the most prevalent mental disorders of childhood and adolescence. Among these disorders, Separation Anxiety Disorder is one of the most common in young children.
- In children, the diagnosis of Separation Anxiety Disorder should not be used to describe developmentally normative phenomena.
- The focus of apprehension in Separation Anxiety Disorder may differ across age groups, such that younger children may demonstrate less credible fears (e.g., worrying about sleeping alone for fear they will be kidnapped in the middle of the night) whereas older children and adolescents may have more credible fears (e.g., parents getting into a car accident).
- Symptom presentation varies with age. In younger children, who are less able to express worries or fears, behavioural manifestations of recurrent excessive distress are typically more prominent, such as tantrums or crying when separated from parents and caregivers. When at home, younger children may insist on following caregivers closely, exhibiting distress even when in a different room or on a different floor from parents or caregivers. Older children are usually able to express their preoccupations about separation from attachment figures or fears related to specific dangers (e.g., accidents, kidnapping, mugging, death). Older children and adolescents may be more likely to demonstrate social withdrawal, insisting on staying at home with family members rather than spending time with peers.

Culture-Related Features:

- Cultural variation exists with regard to tolerating separation from attachment figures. In some cultural groups, it would be considered inappropriate to spend time apart from family or loved ones. Distress associated with separation in this sociocultural context should not be considered excessive if it is culturally normative.
- Children in some cultures remain in their parental home longer than in other cultures, and generally this trend is increasing globally, so the assignment of disorder should take into account cultural norms.

Gender-Related Features:

- Although lifetime prevalence rates for Separation Anxiety Disorder is slightly higher among females (5.6% versus 4%), during childhood, school refusal is equally prevalent for both genders.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Generalized Anxiety Disorder:*** Individuals with Generalized Anxiety Disorder experience chronic and excessive worry about a variety of everyday life events that can include preoccupation about the safety of key attachment figures. However, these concerns seldom occur without additional worries regarding other domains of everyday life.
- ***Boundary with Panic Disorder:*** If an individual with Separation Anxiety Disorder experiences panic attacks exclusively in the context of separation from key attachment figures, an additional diagnosis of Panic Disorder is not warranted and the presence of panic attacks may be indicated using the 'with panic attacks' qualifier. However, if unexpected panic attacks also occur, an additional diagnosis of Panic Disorder may be assigned.
- ***Boundary with Agoraphobia:*** In Agoraphobia, individuals avoid a variety of situations including leaving home alone but the fear or anxiety is centred on the possibility that help will not be available in the event of a panic attack or other incapacitating or embarrassing symptoms rather than concerns about separation from key attachment figures.
- ***Boundary with Social Anxiety Disorder:*** In Social Anxiety Disorder, the avoidance of social situations is in response to fear or anxiety about being negatively evaluated by others rather than concerns about being separated from key attachment figures.
- ***Boundary with Depressive Disorders:*** Beliefs of social inadequacy, rejection, and failure are common in Depressive Disorders and may be associated with avoidance of leaving the home and being separated from loved ones. However, unlike in Separation Anxiety Disorder, these symptoms occur almost exclusively during a Depressive Episode.
- ***Boundary with Post-Traumatic Stress Disorder:*** In Post-Traumatic Stress Disorder, individuals have a history of exposure to a traumatic event that may have involved the loss of a key attachment figure. However, the focus of apprehension is on intrusive re-experiencing of the traumatic event from memory and avoidance of associated stimuli rather than concerns about future loss of or harm coming to the key attachment figure. However, Separation Anxiety Disorder rather than Post-Traumatic Stress Disorder may occur subsequent to the experience of a traumatic event and if all diagnostic requirements are met the diagnosis can be assigned.
- ***Boundary with Disruptive Behaviour or Dissocial Disorders:*** Individuals with Oppositional Defiant Disorder can exhibit similar behaviours as those observed in Separation Anxiety Disorder such as anger, irritability, and temper outbursts, or defiant and headstrong behaviour (e.g., refusal to leave home or go to school). However, in Separation Anxiety Disorder these occur exclusively as a result of anticipated or actual separation from a key attachment figure. School refusal or truancy may occur in the context of Conduct Disorder but the behaviour is not related to concerns for the well-being of a key attachment figure.
- ***Boundary with Personality Disorder:*** Fear of abandonment or dependency on others can occur as symptoms of an enduring maladaptive pattern of behaviour associated with Personality Disorder. These symptoms tend to occur with other broader disruptions to interpersonal functioning, emotion regulation, as well as identity formation and definition. Personality Disorder may co-occur with Separation Anxiety Disorder and if present, can be diagnosed separately.

6B06 Selective Mutism

Essential (Required) Features:

- Consistent selectivity in speaking, such that a child demonstrates adequate language competence in specific social situations, typically at home, but consistently fails to speak in others, typically at school.
- The duration of the disturbance is at least 1 month, not limited to the first month of school.
- The disturbance is not due to a lack of knowledge of, or comfort with, the spoken language demanded in the social situation.
- The symptoms are not better accounted for by another mental disorder (e.g., a Neurodevelopmental Disorder such as Autism Spectrum Disorder or Developmental Language Disorder).
- Selectivity of speech is sufficiently severe so as to interfere with educational achievement or with social communication or is associated with significant impairment in other important areas of functioning.

Additional Clinical Features:

- Symptoms of Selective Mutism may interfere with direct assessment of expressive language. However, many affected children cooperate with receptive language testing if communication is restricted to carrying out commands or pointing to pictures, which can provide valuable information about a child's general language levels. Furthermore, reports from informants who know the child well (e.g., parent or caregiver) may be necessary to establish that the child can speak in certain social situations.
- Selective Mutism is often regarded as a variant of Social Anxiety Disorder because affected individuals experience significant anxiety in social situations and when able to express themselves indicate that they fear negative evaluation, in particular of their speech. However, unlike Social Anxiety Disorder, children with Selective Mutism are more likely to display these difficulties at an earlier age of onset (in most cases before the age of 5 years but may only become apparent when starting school), be more likely to have associated subtle language impairments, and exhibit oppositional behaviour in response to being asked to speak in feared situations.
- Co-occurrence with other Anxiety or Fear-Related Disorders (particularly Social Anxiety Disorder, Separation Anxiety Disorder, and Specific Phobias) is very common among individuals with Selective Mutism.
- Selective Mutism is associated with severe impairment in academic and social functioning that can manifest as inability to complete expected school work, not getting personal needs met, inability to initiate or reciprocate social interactions with peers, or becoming the target of bullying.
- Social anxiety, withdrawal, and avoidance in Selective Mutism may be related to temperamental factors such as behavioural inhibition and negative affectivity.

Boundary with Normality (Threshold):

- Transient reluctance to speak at the time of first starting school is a common occurrence. Selective Mutism should only be diagnosed if symptoms persist beyond the first month of schooling. Immigrant children who are unfamiliar with or uncomfortable in the official language of their new host country may, for a discrete period of time, refuse to speak to strangers in their new environment. This may also occur with children from linguistic minorities. Selective Mutism should not be diagnosed in such cases.

Course Features:

- Although the onset of Selective Mutism typically occurs during early childhood (i.e., prior to age 5), significant impairment of functioning may not manifest until entry into school when children experience increased demands to speak publicly (e.g., reading aloud) and engage socially.
- A majority of children with Selective Mutism will present with symptoms of another Anxiety or Fear-Related Disorder, particularly, Social Anxiety Disorder.
- Children with Selective Mutism may also display signs of oppositionality, particularly in situations requiring speech. A co-occurring diagnosis of Oppositional Defiant Disorder should not be assigned if refusal to speak can be entirely accounted for by features of Selective Mutism.
- The course of Selective Mutism varies among individuals. Although the average duration of the disorder is 8 years, after which symptoms begin to dissipate or remit completely, some individuals may experience a persistence of symptoms or manifestation of another disorder, primarily Social Anxiety Disorder.
- Even after the core symptoms of Selective Mutism resolve, individuals often continue to experience difficulties related to social communication and anxiety.
- Prognosis is worse when there is a family history of Selective Mutism.

Culture-Related Features:

- People in cultures with a high level of shame-based emotions may avoid speaking about particular topics or in situations that would evoke shame for themselves or others. When this is culturally normative, it should not be considered to be reflective of Selective Mutism.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Developmental Speech and Language Disorders:*** Selective Mutism is differentiated from the range of Developmental Speech and Language Disorders (i.e., Language Disorders or Speech Fluency Disorder) that involve impairments in expressive language across all social situations. Although some children with Selective Mutism exhibit expressive language difficulties or phonological problems, these are often subtle and functioning is usually found to be in the normal range. Selective Mutism may occur in the presence of Developmental Speech and Language Disorders and both can be diagnosed if warranted.
- ***Boundary with Autism Spectrum Disorder and Disorders of Intellectual Development:*** Some individuals affected by Autism Spectrum Disorder or Disorders of Intellectual

Development exhibit impairments in language and social communication. However, unlike in Selective Mutism, when language and communication impairments are present in Autism Spectrum Disorder and Disorders of Intellectual Development, they are notable across environments and social situations.

- ***Boundary with Schizophrenia or Other Primary Psychotic Disorders:*** Individuals with Schizophrenia or Other Primary Psychotic Disorders may exhibit disruptions in speech and social communication as a function of symptoms of disordered thought. Unlike individuals with Selective Mutism, those with disrupted communication in the context of psychotic disorders display similar disruptions to speech across all social situations.
- ***Boundary with Social Anxiety Disorder:*** Selective Mutism is characterized by a failure to speak in specific situations whereas in Social Anxiety Disorder fear and anxiety result in avoidance of multiple social contexts.

6B0Y Other Specified Anxiety or Fear-Related Disorders

Essential (Required) Features:

- The presentation is characterized by anxiety symptoms that share primary clinical features with other Anxiety or Fear-Related Disorders (e.g., physiological symptoms of excessive arousal, apprehension, and avoidance behaviour).
- The symptoms do not fulfil the diagnostic requirements for any other disorder in the Anxiety or Fear-Related Disorders grouping.
- The symptoms are not better accounted for by another Mental, Behavioural or Neurodevelopmental Disorder (e.g., a Mood Disorder, an Obsessive-Compulsive or Related Disorder).
- The symptoms or behaviours are not developmentally appropriate or culturally sanctioned.
- The symptoms or behaviours are not a manifestation of another medical condition and are not due to the effects of a substance or medication on the central nervous system, including withdrawal effects.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Qualifier:

MB23.H with panic attacks

This qualifier can be applied to indicate the presence of panic attacks within the past month that manifest in the context of Anxiety or Fear-Related Disorders, as well as other disorders such as Obsessive-Compulsive or Related Disorders. The ‘with panic attacks’ qualifier should not be assigned when panic attacks can be entirely explained by a Panic Disorder diagnosis. Recurrent panic attacks that occur in the context of other mental disorders may be indicative of greater severity of psychopathology, poorer response to treatment, and greater risk for suicide in the context of Mood Disorders.

When panic attacks occur in the context of other *Anxiety or Fear-Related Disorders*, they are conceptualized as episodes of severe anxiety that occur specifically in response to exposure to or anticipation of exposure to the feared stimulus or stimuli (i.e., reflect the focus of apprehension specific to the disorder). For example, panic attacks may occur in Separation Anxiety Disorder during separation from a caregiver or partner, when exposed to the phobic situation or stimulus in Specific Phobia, when entering social situations or speaking in public in Social Anxiety Disorder, etc. If panic attacks are limited to these types of situations, the 'with panic attacks' qualifier should be applied rather than an additional co-occurring diagnosis of Panic Disorder. If some panic attacks over the course of the disorder have been unexpected and not exclusively in response to stimuli associated with the focus of apprehension related to the relevant disorder, a separate diagnosis of Panic Disorder should be assigned. In such cases, it is not necessary to apply the 'with panic attacks' qualifier.

For Anxiety or Fear-Related Disorders, application of the 'with panic attacks' qualifier produces the following combinations. (The 'with panic attacks' qualifier is not generally applicable to Selective Mutism.)

6B00/MB23.H	Generalized Anxiety Disorder with panic attacks
6B01/MB23.H	Agoraphobia with panic attacks
6B03/MB23.H	Specific Phobia with panic attacks
6B04/MB23.H	Social Anxiety Disorder with panic attacks
6B05/MB23.H	Separation Anxiety Disorder with panic attacks
6B0Y/MB23.H	Other Anxiety or Fear-Related Disorder with panic attacks