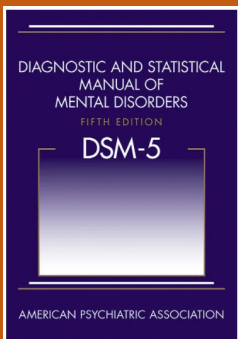


What is Paruresis?

Whenever I try to use a public restroom, everything freezes up! No matter how badly I need to go, nothing happens if I'm not at home. I can urinate when I'm alone at home, no problem. But if I'm away at a ball game, someone else's home, or wherever, or even if I'm at home and somebody's over visiting, I can't pee. This crazy problem has done nothing but interfere with my life!



Shy Bladder, Bashful Bladder, Pee Shy



Not being able to relieve yourself in the presence of others is called Paruresis ("par-YOU-ree-sis") –

a legitimate medical condition affecting hundreds of millions of people worldwide. Those suffering from this phobia often live uncomfortable, severely restricted lives. The term "shy bladder" does not do it justice. Paruresis is classified as a social phobia in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5 300.23)

Who suffers from Paruresis?

Paruresis affects about 7% of the population: 20 million people in the U.S., another 2 million in Canada, and countless other people - both men and women - worldwide.

7%



Thousands of U.S. workers have been **unjustly fired** because they were unable to urinate on demand during a random drug test. Many potential employees have been **denied employment**. Federal drug testing rules must be changed to permit affordable alternative testing (hair, saliva, blood).

I couldn't provide a sample for my urine drug test – what can I do?

Until the regulations change to require that alternative drug testing methods be made available to all, here are a few recommendations:

- Get an independent alternate method test
- Demand a list of procedures and make sure they are followed
- Enlist the support of a urologist and mental health professional
- Enlist the support of a legal professional
- Request a letter of support from IPA

*Test for drugs –
not my ability to pee!*

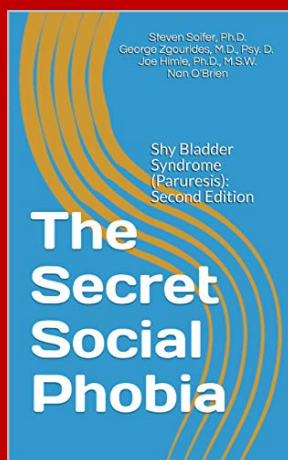


Click above to see the PSA video!



The IPA Can Help!

- [Workshops](#)
- [Support Groups](#)
- [Videos](#)
- [Publications](#)



Let your voice be heard. Click here to share your story. We are actively working to change legislation at all levels to ensure choice in drug testing!

About the International Paruresis Association (IPA): Founded in 1996, we are the world's first and only nonprofit organization working to raise public awareness of this disorder. Learn more at www.paruresis.org. U.S. [contributions](#) to IPA are tax-deductible per IRS code 501(c)(3) . EIN#06-1509744.



PO Box 21237 • Catonsville, MD 21228 • 800-247-3864 • getinfo@paruresis.org
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WARNING AND DISCLAIMER: These materials are NOT a substitute for medical or legal advice and does not constitute the practice of law, medicine, psychiatry, clinical psychology, clinical social work, or any other mental health profession. If you are having trouble urinating, you should always contact a physician since difficulty with voiding can be a symptom of a serious medical condition.

Q: I'm facing a urine drug test in prison, for probation, or related to a criminal/civil judgment. What can I do?

A: You should provide your attorney with a heads-up on this situation so there is someone who can defend you at the probation hearing, and further advise you about legal issues and your rights after conviction.

You need three things to make your case: (1) Medical documentation of your condition, (2) a lawyer willing to work hard for you, and (3) the information and assistance that we can provide which could include expert testimony about paruresis in general and arguments to help establish your rights to alternative testing to prove your drug-free status.

Show your lawyer this document. If your lawyer has any questions, please contact IPA at our 800 number for further clarification. IPA will work to connect you to a lawyer with a history of successful legal challenges so yours can establish precedent in court. The key vulnerability in current drug testing policy where your lawyer can make a persuasive argument is that a policy of calling an inability to provide a sample a refusal to test and presuming drug use based on the inability to provide a sample is a discriminatory practice, especially for a person with paruresis. A person with shy bladder or paruresis wants to give a sample, but is unable to do it.

The United States justice system is based on the fundamental concept of innocent until proven guilty, but drug-testing policy turns this concept on its head. The person who is unable to produce a urine sample is presumed guilty in the absence of any evidence. Drug use must be established by testing, and without a test or a witness testifying you were under the influence of drugs at the time of the test there is no evidence of drug use, nor is there reasonable suspicion of it. You can offer to provide the evidence by any other means that's convenient for you, such as a hair test, using a catheter to obtain the urine sample, a saliva test, or a sweat patch. You or your lawyer will need to prevail upon the judge to use common sense in your case, not a policy based on invalid assumptions that people can urinate in front of someone watching them.

Equating a refusal to test with guilt is erroneously based on laws for driving under the influence of alcohol, where a person's refusal to submit to a breathalyzer test given at the police station is legal evidence of guilt in most states. However, there are key differences. In the case of drunk driving, there is an arresting officer who gives a field sobriety test to the driver and observes through the driver's behavior suspicion of intoxication. There is also an implied consent law where a licensed driver agrees to submit to testing for intoxication in order to be granted the privilege to drive. There is no such implied consent governing you in this situation. Staying off of drugs may be a condition of probation or a requirement if you are serving a jail sentence, but proving you are drug free can be accomplished through a variety of means other than urine testing.

From a medical point of view, the alcohol breath test is quite different from a urine test. We all must breathe; there is no such thing as an inability to breathe for a living person. Urination, however, is quite different. A person with paruresis won't be able to urinate with others present. Contrary to widespread public belief, the muscles that control urination are not under the person's voluntary control.[iii] Someone with paruresis won't be able to urinate until their anxiety disappears, which will not happen in a drug testing facility. The person may experience bodily harm in terms of bladder or kidney damage before being able to urinate. A doctor serving as an expert witness can explain to the court that once a person's bladder fills beyond a certain point, it may be impossible to drain it without medical intervention. There will be

horrific pain, and only insertion of a catheter will empty the urine from the person's bladder. This amounts to cruel and unusual punishment without any evidence of guilt. It's the legal equivalent of torture.

If these arguments are made successfully, your lawyer should be able to prove that there is no solid legal basis for presuming drug use if a person with paruresis is unable to provide a urine sample. If you have an alternative test showing you are drug free, the court should find in your favor. IPA wants to hear from anyone with either a positive or negative court decision regarding drug testing so we can continue to strengthen our arguments.

We suggest to your PO or correctional health administrator that they use a hair test, sweat patch, or oral fluid test on you. These are inexpensive, and the hair test is especially good for detecting use of drugs during the past 90 days. In other words, if you have been staying off the stuff for 3 months, the hair test will prove it. Another option is to see a doctor or urologist and learn to use a catheter to provide the urine sample.

Tell your probation officer or other authority involved in the drug testing program about these options and try to work with them to find one that is acceptable to both of you and involves the minimum cost.

Alternative tests are less expensive for the government than a hearing to revoke probation, and far less expensive than putting you in jail. These are important and practical arguments to make with the authorities. Depending on how the negotiations go, you may need to pay all or part of the extra cost for an alternative test. If you need to use a catheter you'll likely need to bear the cost of a doctor's visit and buying the catheter, which typically costs under \$12. IPA hopes someday to change the law so that the government will pay for these tests, but until that point the responsibility may be yours. Please support the IPA, as we can't achieve these things without the help of your donations.

If you need to pay for a hair test, and it might not be a bad idea to have one done so the evidence that you are clean is available to your attorney and the court, they cost around \$70-100. It takes about a week to get the results back.

[\[iii\]](#) Allen, T.D. Psychogenic Urinary Retention. Southern Medical Journal 65.3(1972): 302-304.

WARNING AND DISCLAIMER: These materials are NOT a substitute for medical or legal advice and does not constitute the practice of law, medicine, psychiatry, clinical psychology, clinical social work, or any other mental health profession. If you are having trouble urinating, you should always contact a physician since difficulty with voiding can be a symptom of a serious medical condition.

Coping techniques that are not "recovery techniques"

Lightweight coping techniques:

Distraction - Doing various mental calculations in your head seems to distract your brain from keeping the urinary sphincters shut, and they will open. Things like adding up a column of numbers, multiplying double digit numbers, counting backwards from 200 by 7's, figuring out how to solve some problem that's been bothering you.

Major Coping Techniques for moderate to severe sufferers of paruresis:

a. Breath-Hold: This is a neat trick if you can get it to work. For some men, if they breathe out about 2/3 of their air, and then hold their breath for 30, 45 seconds or longer, their urinary sphincters will open involuntarily and they will pee. No relaxation necessary. We have 30 to 50 men who swear by this technique and find it easier to use each time they try it. The physiological phenomenon is attributed to "hypoxia" which means low oxygen level in the blood. When the brain senses hypoxia, it relaxes unnecessary muscles groups to reduce oxygen consumption. Thus on some people, the two sphincters are released and urine flows. Unfortunately, this control limit varies with individuals. We've had reports from two men that went unconscious and found themselves on the floor after waking up from trying this technique. Other men, it hasn't worked for them. Not one woman has reported this technique working for them.

b. Self Intermittent Catheter (SIC) also referred to as Clean Intermittent Catheter (CIC): This involves one using a small rubber or plastic tube (manufactured for this specific use), inserted into the urethra to drain the bladder. There are many patient groups out there that are using this method to drain their bladder 4 or 5 times a day and it also works for moderate to severe paruresis. The patient groups are paralysis patients, some multiple sclerosis, some diabetes, paruresis, and misc. others. The paruresis folks often only need to use the catheters in some high stress or troublesome situations like plane restrooms, maybe a few times a year, or maybe more depending on the person. They can easily be used in a restroom stall in a standing position or sitting position in 2 to 4 minutes. (One man who uses a catheter out in open at a urinal - if he gets asked, he just says "broken plumbing".) Most people think caths would be painful, but it is necessary to take the time to find a catheter that is the right size and design for them. (The clean catheter technique was pioneered and written up in urology journals by Urology Professor Jack Lapides at the University of Michigan in 1971 and allowed many otherwise functional patients to leave hospitals and live at home) I would estimate that we've heard reports of over 200 members, both men and women, who have used SIC in treating their paruresis symptoms.

Recovery Techniques

Cognitive Behavior Therapy (There is no alternative to it, not hypnosis, biofeedback, psychoanalysis, EMDR, TFT, NLP, etc.): Work gradually to exposure yourself through a hierarchy of increasingly difficult scenarios.

Learn more at <https://www.paruresis.org/faq>

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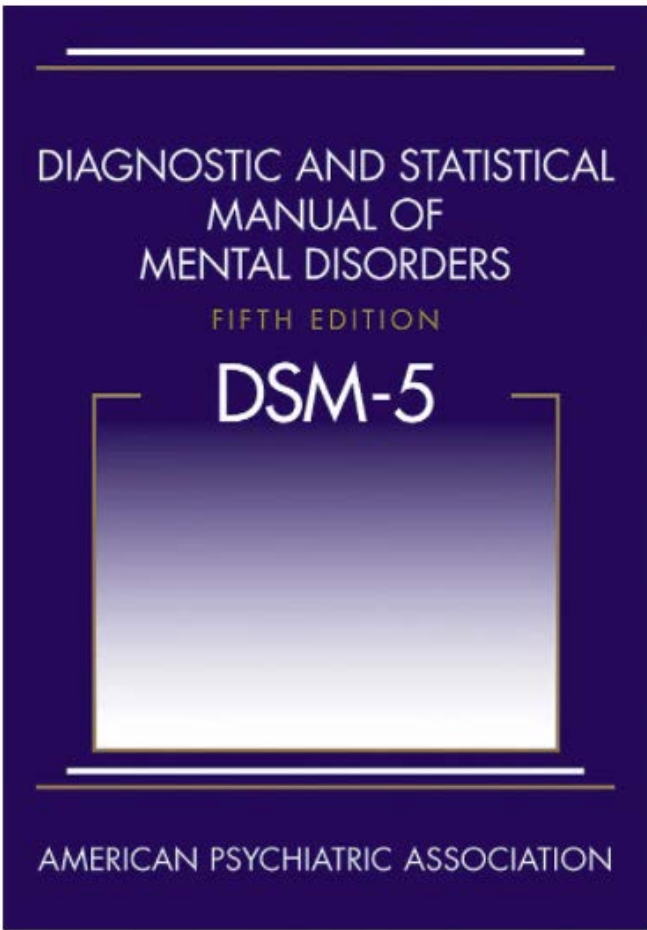
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related disorders, somatic symptom and related disorders, and personality disorders (par-
ticularly dependent personality disorder).

Social Anxiety Disorder (Social Phobia)

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

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

Specify if:

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

Specifiers

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

Diagnostic Features

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

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

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

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

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

Associated Features Supporting Diagnosis

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

Prevalence

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

Development and Course

Median age at onset of social anxiety disorder in the United States is 13 years, and 75% of individuals have an age at onset between 8 and 15 years. The disorder sometimes emerges out of a childhood history of social inhibition or shyness in U.S. and European studies. Onset can also occur in early childhood. Onset of social anxiety disorder may follow a stressful or humiliating experience (e.g., being bullied, vomiting during a public speech), or it may be insidious, developing slowly. First onset in adulthood is relatively rare and is more likely to occur after a stressful or humiliating event or after life changes that require new social roles (e.g., marrying someone from a different social class, receiving a job promotion). Social anxiety disorder may diminish after an individual with fear of dating marries and may reemerge after divorce. Among individuals presenting to clinical care, the disorder tends to be particularly persistent.

Adolescents endorse a broader pattern of fear and avoidance, including of dating, compared with younger children. Older adults express social anxiety at lower levels but across a broader range of situations, whereas younger adults express higher levels of social anxiety for specific situations. In older adults, social anxiety may concern disability due to declining sensory functioning (hearing, vision) or embarrassment about one's appearance (e.g., tremor as a symptom of Parkinson's disease) or functioning due to medical conditions, incontinence, or cognitive impairment (e.g., forgetting people's names). In the community approximately 30% of individuals with social anxiety disorder experience remission of symptoms within 1 year, and about 50% experience remission within a few years. For approximately 60% of individuals without a specific treatment for social anxiety disorder, the course takes several years or longer.

Detection of social anxiety disorder in older adults may be challenging because of several factors, including a focus on somatic symptoms, comorbid medical illness, limited insight, changes to social environment or roles that may obscure impairment in social functioning, or reticence about describing psychological distress.

Risk and Prognostic Factors

Temperamental. Underlying traits that predispose individuals to social anxiety disorder include behavioral inhibition and fear of negative evaluation.

Environmental. There is no causative role of increased rates of childhood maltreatment or other early-onset psychosocial adversity in the development of social anxiety disorder. However, childhood maltreatment and adversity are risk factors for social anxiety disorder.

Genetic and physiological. Traits predisposing individuals to social anxiety disorder, such as behavioral inhibition, are strongly genetically influenced. The genetic influence is subject to gene-environment interaction; that is, children with high behavioral inhibition are more susceptible to environmental influences, such as socially anxious modeling by parents. Also, social anxiety disorder is heritable (but performance-only anxiety less so). First-degree relatives have a two to six times greater chance of having social anxiety disorder, and liability to the disorder involves the interplay of disorder-specific (e.g., fear of negative evaluation) and nonspecific (e.g., neuroticism) genetic factors.

Culture-Related Diagnostic Issues

The syndrome of *taijin kyofusho* (e.g., in Japan and Korea) is often characterized by social-evaluative concerns, fulfilling criteria for social anxiety disorder, that are associated with the fear that the individual makes *other* people uncomfortable (e.g., "My gaze upsets people so they look away and avoid me"), a fear that is at times experienced with delusional intensity. This symptom may also be found in non-Asian settings. Other presentations of *taijin kyofusho* may fulfill criteria for body dysmorphic disorder or delusional disorder.

Immigrant status is associated with significantly lower rates of social anxiety disorder in both Latino and non-Latino white groups. Prevalence rates of social anxiety disorder may not be in line with self-reported social anxiety levels in the same culture—that is, societies with strong collectivistic orientations may report high levels of social anxiety but low prevalence of social anxiety disorder.

Gender-Related Diagnostic Issues

Females with social anxiety disorder report a greater number of social fears and comorbid depressive, bipolar, and anxiety disorders, whereas males are more likely to fear dating, have oppositional defiant disorder or conduct disorder, and use alcohol and illicit drugs to relieve symptoms of the disorder. **Paruresis is more common in males.**

Functional Consequences of Social Anxiety Disorder

Social anxiety disorder is associated with elevated rates of school dropout and with decreased well-being, employment, workplace productivity, socioeconomic status, and quality of life. Social anxiety disorder is also associated with being single, unmarried, or divorced and with not having children, particularly among men. In older adults, there may be impairment in caregiving duties and volunteer activities. Social anxiety disorder also impedes leisure activities. Despite the extent of distress and social impairment associated with social anxiety disorder, only about half of individuals with the disorder in Western societies ever seek treatment, and they tend to do so only after 15–20 years of experiencing symptoms. Not being employed is a strong predictor for the persistence of social anxiety disorder.

Differential Diagnosis

Normative shyness. Shyness (i.e., social reticence) is a common personality trait and is not by itself pathological. In some societies, shyness is even evaluated positively. However, when there is a significant adverse impact on social, occupational, and other important areas of functioning, a diagnosis of social anxiety disorder should be considered, and when full diagnostic criteria for social anxiety disorder are met, the disorder should be diagnosed. Only a minority (12%) of self-identified shy individuals in the United States have symptoms that meet diagnostic criteria for social anxiety disorder.

Agoraphobia. Individuals with agoraphobia may fear and avoid social situations (e.g., going to a movie) because escape might be difficult or help might not be available in the event of incapacitation or panic-like symptoms, whereas individuals with social anxiety disorder are most fearful of scrutiny by others. Moreover, individuals with social anxiety disorder are likely to be calm when left entirely alone, which is often not the case in agoraphobia.

Panic disorder. Individuals with social anxiety disorder may have panic attacks, but the concern is about fear of negative evaluation, whereas in panic disorder the concern is about the panic attacks themselves.

Generalized anxiety disorder. Social worries are common in generalized anxiety disorder, but the focus is more on the nature of ongoing relationships rather than on fear of negative evaluation. Individuals with generalized anxiety disorder, particularly children, may have excessive worries about the quality of their social performance, but these worries also pertain to nonsocial performance and when the individual is not being evaluated by others. In social anxiety disorder, the worries focus on social performance and others' evaluation.

Separation anxiety disorder. Individuals with separation anxiety disorder may avoid social settings (including school refusal) because of concerns about being separated from attachment figures or, in children, about requiring the presence of a parent when it is not developmentally appropriate. Individuals with separation anxiety disorder are usually comfortable in social settings when their attachment figure is present or when they are at

home, whereas those with social anxiety disorder may be uncomfortable when social situations occur at home or in the presence of attachment figures.

Specific phobias. Individuals with specific phobias may fear embarrassment or humiliation (e.g., embarrassment about fainting when they have their blood drawn), but they do not generally fear negative evaluation in other social situations.

Selective mutism. Individuals with selective mutism may fail to speak because of fear of negative evaluation, but they do not fear negative evaluation in social situations where no speaking is required (e.g., nonverbal play).

Major depressive disorder. Individuals with major depressive disorder may be concerned about being negatively evaluated by others because they feel they are bad or not worthy of being liked. In contrast, individuals with social anxiety disorder are worried about being negatively evaluated because of certain social behaviors or physical symptoms.

Body dysmorphic disorder. Individuals with body dysmorphic disorder are preoccupied with one or more perceived defects or flaws in their physical appearance that are not observable or appear slight to others; this preoccupation often causes social anxiety and avoidance. If their social fears and avoidance are caused only by their beliefs about their appearance, a separate diagnosis of social anxiety disorder is not warranted.

Delusional disorder. Individuals with delusional disorder may have nonbizarre delusions and/or hallucinations related to the delusional theme that focus on being rejected by or offending others. Although extent of insight into beliefs about social situations may vary, many individuals with social anxiety disorder have good insight that their beliefs are out of proportion to the actual threat posed by the social situation.

Autism spectrum disorder. Social anxiety and social communication deficits are hallmarks of autism spectrum disorder. Individuals with social anxiety disorder typically have adequate age-appropriate social relationships and social communication capacity, although they may appear to have impairment in these areas when first interacting with unfamiliar peers or adults.

Personality disorders. Given its frequent onset in childhood and its persistence into and through adulthood, social anxiety disorder may resemble a personality disorder. The most apparent overlap is with avoidant personality disorder. Individuals with avoidant personality disorder have a broader avoidance pattern than those with social anxiety disorder. Nonetheless, social anxiety disorder is typically more comorbid with avoidant personality disorder than with other personality disorders, and avoidant personality disorder is more comorbid with social anxiety disorder than with other anxiety disorders.

Other mental disorders. Social fears and discomfort can occur as part of schizophrenia, but other evidence for psychotic symptoms is usually present. In individuals with an eating disorder, it is important to determine that fear of negative evaluation about eating disorder symptoms or behaviors (e.g., purging and vomiting) is not the sole source of social anxiety before applying a diagnosis of social anxiety disorder. Similarly, obsessive-compulsive disorder may be associated with social anxiety, but the additional diagnosis of social anxiety disorder is used only when social fears and avoidance are independent of the foci of the obsessions and compulsions.

Other medical conditions. Medical conditions may produce symptoms that may be embarrassing (e.g. trembling in Parkinson's disease). When the fear of negative evaluation due to other medical conditions is excessive, a diagnosis of social anxiety disorder should be considered.

Oppositional defiant disorder. Refusal to speak due to opposition to authority figures should be differentiated from failure to speak due to fear of negative evaluation.

Comorbidity

Social anxiety disorder is often comorbid with other anxiety disorders, major depressive disorder, and substance use disorders, and the onset of social anxiety disorder generally precedes that of the other disorders, except for specific phobia and separation anxiety disorder. Chronic social isolation in the course of a social anxiety disorder may result in major depressive disorder. Comorbidity with depression is high also in older adults. Substances may be used as self-medication for social fears, but the symptoms of substance intoxication or withdrawal, such as trembling, may also be a source of (further) social fear. Social anxiety disorder is frequently comorbid with bipolar disorder or body dysmorphic disorder; for example, an individual has body dysmorphic disorder concerning a preoccupation with a slight irregularity of her nose, as well as social anxiety disorder because of a severe fear of sounding unintelligent. The more generalized form of social anxiety disorder, but not social anxiety disorder, performance only, is often comorbid with avoidant personality disorder. In children, comorbidities with high-functioning autism and selective mutism are common.

Panic Disorder

Diagnostic Criteria

300.01 (F41.0)

- A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:

Note: The abrupt surge can occur from a calm state or an anxious state.

1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort.
7. Nausea or abdominal distress.
8. Feeling dizzy, unsteady, light-headed, or faint.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or “going crazy.”
13. Fear of dying.

Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.

- B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:
1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, “going crazy”).
 2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).