ANXIETY DISORDERS IN THE DSM-5

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Poll Question

• Who are you?
• Clinical counselor in Private Practice
• Clinical Counselor in Agency/Hospital/Education/Community Setting
• Counselor Educator
• Student
• School Counselor
• Rehabilitation Counselor
• Psychologist
Anxiety Disorders Defined

- Anxiety is defined as “a state of intense apprehension, uncertainty, and fear resulting from the anticipation of a threatening event or situation, often to a degree that normal physical and psychological functioning is disrupted” (American Heritage Medical, 2007, p. 38).

- The American Psychiatric Association (APA) purports that each of the Anxiety Disorders share features of fear and anxiety.

- “Fear is the emotional response to real or perceived threat, whereas anxiety is anticipation of future threat” (APA, 2013, p. 189).

Characteristics

- Physiological symptoms include: muscle tension, heart palpitations, sweating, dizziness, or shortness of breath.

- Emotional symptoms include: restlessness, a sense of impending doom, fear of dying, fear of embarrassment or humiliation, or fear of something terrible happening.
Prevalence

- Each year, Anxiety Disorders impact approximately 18%, or 40 million, adults in the United States (NIMH, 2013b; NIMH, 2013c).

- Anxiety disorders have a lifetime prevalence of approximately 30% (Kessler et al., 2005).

- Close to 50% of individuals diagnosed with an Anxiety Disorder also meet the criteria for a Depressive Disorder (Batelaan, De Graaf, Van Balkom, Vollebergh, & Beekman, 2012).

Major Changes from *DSM-IV-TR* to *DSM-5*

- Specific changes to the Anxiety Disorders chapter:

  1. Including Selective Mutism and Separation Anxiety Disorder.

  2. Changing the name of Social Phobia to Social Anxiety Disorder.

  3. Removing Panic Attack as a specifier for Agoraphobia.

  4. Assigning Panic Attack as a specifier that may be applied to a wide array of *DSM-5* diagnoses.
### Differential Diagnosis of Anxiety Disorders & Depressive Disorders

- Challenging due to the high comorbidity (up to 50%) of Anxiety Disorders with Depressive Disorders.

- Depressive Disorders are sometimes viewed as “anxious-misery” with high incidences of sadness and anhedonia.

- Anxiety Disorders often include “anxious anticipation”, uncertainty, and fear (Craske et al., 2009).

- Sleep disturbance, overall fatigue, and difficulty with concentration can be symptoms of both (APA, 2013).

### Separation Anxiety Disorder

- Separation Anxiety Disorder was moved from *Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence (DSM-IV-TR)* to the Anxiety Disorders chapter.

- The age-of-onset requirement (“before age 18 years”) was been dropped; thus allowing for diagnosis of Separation Anxiety Disorder in adults (Mohr & Schneider, 2013).
Separation Anxiety Disorder

- Duration of at least six months in adults; at least one month in children.

- Prevalence rates are as follows: children (4%); adolescents, (1.6%); and adults, (0.9% to 1.9%).

- Separation Anxiety Disorder is the most prevalent Anxiety Disorder in children, with girls more susceptible than boys.

- Functionality in school, work, or social settings is often impaired (APA, 2013).

Selective Mutism

- Selective Mutism—the voluntary refusal to speak (typically occurring outside of the home or immediate family).

- This is a new diagnosis in the Anxiety Disorders chapter of the *DSM-5*, due to the restructuring of the chapters and the removal of the *Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence* (APA, 2013).
Selective Mutism

- **Essential Features**

  - Selective Mutism is a refusal to verbally communicate outside of the home or with people other than immediate family/caregivers.

  - Children with Selective Mutism will sometimes communicate with nonverbals such as nodding or grunting, and these children do not usually possess language deficits.

  - Selective Mutism typically has an age of onset of under 5 years and is often first noticed in school settings (APA, 2013).

Specific Phobia

- Specific Phobias represent the existence of fear or anxiety in the presence of a specific situation or object. This is called the “phobic stimulus” (APA, 2013).

- This fear or anxiety must be markedly stronger than the actual threat of the object or situation (i.e., likelihood of being stuck on a well-maintained elevator).

- Specific Phobias were first identified as such in the *DSM-III-R* and carry a lifetime prevalence rate of 9.4% to 12.5% (Marques et al., 2011).
Specific Phobia

- Specific Phobias can develop after a traumatic event or from witnessing traumatic events.

- Individuals with Specific Phobia will avoid situations of exposure to the stimulus.

- The fear or anxiety happens every time the person is exposed to the stimulus and may include symptoms of panic attack.

- The median age of onset for a diagnosis of Specific Phobia is 13 years (APA, 2013).

Specific Phobia Coding

- Approximately 75% of individuals diagnosed with Specific Phobia fear more than one object. When this occurs, more than one diagnosis is given.

- 300.29 (F40.228) Animal
- 300.29 (F40.228) Natural Environment
- 300.29 (F40.23x) Blood-injection injury
  - F40.230 Fear of blood
  - F40.231 Fear of injections and transfusions
  - F40.232 Fear of other medical care
  - F40.233 Fear of injury
- 300.29 (F40.248) Situational (e.g. airplanes, elevators, enclosed spaces)
- 300.29 (F40.298) Other (situations that may lead to choking or vomiting; in children, e.g., loud sounds or costumed characters).

- In cases where individuals experience panic attacks in response to their phobia, clinicians should add with panic attacks to the diagnosis.
Social Anxiety Disorder (SAD)

- Social phobia was originally classified as a mental disorder in the *DSM-III* and has been renamed Social Anxiety Disorder (SAD) in the *DSM-5*.

- The main feature of SAD is ongoing fear and worry surrounding myriad social situations (Kerns, Corner, Pincus, & Hofmann, 2013).

- It is one of the most common mental disorders with a lifetime prevalence rate of slightly greater than 10%.

- The majority of diagnoses are made during childhood or early adolescence (Kerns et al., 2013; Marques et al., 2011).

- SAD is often seen in conjunction with Major Depressive Disorders, other Anxiety Disorders, and Substance Use Disorders (APA, 2013).

SAD

- Individuals with SAD often fear negative evaluation (e.g., being humiliated, embarrassed, or rejected) by others (either unfamiliar or familiar) in performance, interaction, or observation situations.

- A *Performance only* specifier has been added for SAD in the *DSM-5* and includes a minimum duration of 6 months.

- Children, adolescents, and adults now share the same criteria for duration, and the criterion for adult insight has been dropped (Mohr & Schneider, 2013).
SAD

- The *Performance only* specifier is given if anxiety is specific to speaking or performing in public.

- Individuals diagnosed with the *Performance only* specifier are mainly impaired in regard to their occupational environments. They may also display difficulty in school situations where public speaking is a requirement.

Panic Disorder

- Panic Disorder is defined as recurrent, unexpected panic attacks and was initially classified in the *DSM-III*.

- There is a median age of onset ranging from 20 to 24 years with a small percentage of individuals first diagnosed in childhood.

- Panic Disorder is not usually first seen in individuals over the age of 45.

- There is an annual U.S. prevalence rate of *2.1% to 2.8%*; this is one of the highest prevalence rates worldwide (Marques et al., 2011).
Panic Disorder

- The essential features of Panic Disorder are:
  - persistent fear or concern of inappropriate fear responses with recurrent and unexpected panic attacks
  - including physiological changes such as accelerated heart rate, sweating, dizziness, trembling, and chest pain.

- Panic Disorder has physical and cognitive symptoms and involves numerous, unexpected panic attacks (although it is important to note that individuals with Panic Disorder can have expected panic attacks too).

Panic Disorder

- Common differential diagnoses for Panic Disorder are:
  - Other specified or Unspecified Anxiety Disorder,
  - Anxiety Disorder Due to Another Medical Condition,
  - Substance/Medication-Induced Anxiety Disorder,
  - And other mental disorders with panic attacks as an associated feature.

- Illness Anxiety Disorder, formerly known as hypochondriasis, often shares features with and/or is comorbid with Panic Disorder (Starcevic, 2013).
Panic Attack Specifier

- Panic attack is not classified as a mental disorder and does not have a diagnostic code.

- Panic attacks are abrupt surges of intense fear; they can occur with other mental disorders such as Depressive and Anxiety Disorders and also be extant with physical disorders.

- *Panic attack* is a specifier for both mental and physical disorders; however, the elements of panic attack are contained within the criteria for Panic Disorder so it is not a specifier for that diagnosis.

- An example of panic attack used as a specifier is Social Anxiety Disorder, with Panic Attack (APA, 2013).

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**Panic Attack Specifier**

- **Essential Features**

  - Panic attacks represent intense fear or discomfort that occurs abruptly and peaks rapidly.

  - Physical symptoms are predominate and must include a minimum of four out of the thirteen identified symptoms, listed on page 214 of the *DSM-5*.

  ![Stress Meter](image)

- Panic attacks have an **11.2%** annual prevalence rate in the general U.S. population (APA, 2013).
Agoraphobia

- Agoraphobia is a newly codeable disorder in the *DSM-5* and represents an intense fear resultant from real or imagined exposure to a wide range of situations.

- There is a 1.7% prevalence rate for the diagnosis of Agoraphobia for adolescents through middle-aged adults.

- Agoraphobia lends to moderate to severe impairment in functioning with over 33% of individuals diagnosed with Agoraphobia restricted to home environments (APA, 2013).

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**Agoraphobia**

- **Essential Features**

  - Agoraphobia represents fear of situations where escape from bad things is difficult. This response happens almost every time an individual is exposed to the situation or event (it is not Agoraphobia if the response occurs only some of the time). Avoidance of the event or situation must also be present and can include cognitive or behavioral aspects (APA, 2013).

  - Acute stress disorder and Posttraumatic Stress Disorder can be distinguished from Agoraphobia in that the avoidance occurs only from situations that trigger a memory of the traumatic event—such as a driving or riding in a car after a motor vehicle accident (APA, 2013).
Generalized Anxiety Disorder (GAD)

- Generalized Anxiety Disorder (GAD), in existence since the DSM-III.

- GAD is one of the most common of all mental disorders with an annual prevalence rate of 2.9% among adults in the U.S.

- Excessive worry or anxiety about a number of events is the key feature of GAD with the experience of the anxiety or worry in discord with the actual or expected event.

- Although the DSM-5 Task Force proposed changes to GAD that would have resulted in a lowered diagnostic threshold, this disorder remains largely unchanged from the DSM-IV-TR.

GAD

- Essential features include anxiety or worry that takes place across a number of settings and more days than not for at least six months.

- The individual experiences at least three characteristic symptoms including:
  - restlessness or feeling keyed up or on edge
  - being easily fatigued
  - difficulty concentrating or mind going blank
  - irritability
  - muscle tension
  - and sleep disturbance (APA, 2013).

- Many of the Anxiety Disorders outlined in this chapter along with Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, Adjustment Disorders, Depressive Disorders, and psychotic disorders possess similar features to GAD.
Substance-Induced Anxiety Disorder

- Anxiety caused by substance utilization is the primary criterion for the diagnosis of substance/medication induced Anxiety Disorder.

- Panic or anxiety must have developed during or soon after substance/medication usage and be in excess of what would be expected to be associated with intoxication or withdrawal from that specific substance.

- Prevalence rates for this disorder are low (.002%).

- It is important for clinicians to tease out substances used to self-medicate anxious symptoms with anxiety resultant from substance usage or withdrawal.

Anxiety Disorder Due to Another Medical Condition

- Medical conditions can cause the development of an Anxiety Disorder, but they must cause clinically significant distress.

- APA reports “unclear” prevalence rates of Anxiety Disorder Due to Another Medical Condition resultant from the extreme difficulty with differential diagnosis for this category (APA, 2013).

- It is especially important for clinicians to carefully rule out differential diagnoses and consult with a physician before using the diagnosis of Anxiety Disorder Due to Another Medical Condition.
Anxiety Disorder Due to Another Medical Condition

- **Essential Features**

- Marked anxiety attacks occur and can be directly attributed to an existing medical condition. The development of the anxiety can parallel the course of the illness.

- Examples of medical conditions that cause Anxiety Disorder Due to Another Medical Condition include endocrine disease, cardiovascular disorders, respiratory illness, metabolic disturbance, and neurological illness (APA, 2013).

- The key to discernment regarding Anxiety Disorder Due to Another Medical Condition is that the anxiety symptoms must be attributed to the physiological effects of the medical condition.

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Treatment

- Although tending towards chronicity, Anxiety Disorders are responsive to psychotherapeutic treatment modalities.

- It is important for counselors to note that severe anxiety is a risk factor for suicide (Fawcett, 2013).

- Additionally, Anxiety Disorders are the most common disorders in youth (Sood, Mendez, & Kendall, 2012) and have a median age of onset of 11 years.
Implications for Counselors

- Due to the prevalence of Anxiety Disorders in the general population, these diagnoses are frequently the focus of clinical attention for counselors and are often diagnosed within counseling settings (ADAA, 2013).

- Individuals with Anxiety Disorders generally respond well to clinical intervention with effective treatments including Cognitive-Behavior Therapy (CBT), Behavior Therapy (BT), and relaxation training (AADA, 2013).

- Numerous research studies reveal that positive treatment outcomes for Anxiety Disorders are maintained longer for individuals, including children and adolescents, who have participated in CBT and BT (Hausmann et al., 2007; Hofmann & Smits, 2008; Silverman, Pina, & Viswesvaran, 2008)

References


## References


## Q & A

For additional questions, please contact: [Rburke@counseling.org](mailto:Rburke@counseling.org)

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July 24
Gary Gintner, PhD, LPC- Depositive Disorders

July 31
Paul Peluso, PhD, LMHC, LMFT- Personality Disorders and Wrap-Up