Anxiety Disorders in the DSM-5: New Rules on Diagnosis and Treatment

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Anxiety disorders are among the most common mental disorders, with a lifetime prevalence of 16%–29%.2 In addition to provoking substantial disability, anxiety disorders are highly comorbid with other mental and physical disorders, thus complicating the treatment of both types of disorders. This issue of Mood and Anxiety Disorders Rounds highlights changes to the diagnostic category of anxiety disorders reflected in the recently published fifth edition of the Diagnostic and Statistical Manual of Mental Disorders and outlines evidence-based treatments for individuals with anxiety disorders.

Anxiety disorders are common in clinical practice and are highly comorbid and disabling.3 Among the anxiety disorders, specific phobia and social anxiety disorder are the most common, with lifetime prevalence rates of 18.4% and 13.0%, respectively.4 Panic disorder, generalized anxiety disorder (GAD), agoraphobia, and separation anxiety disorder each have lifetime prevalence rates of 2%–7%.

While all anxiety disorders share the core features of excessive fear, anxiety, and avoidance, they differ in the specific object or situation of concern.5 They also differ from normal fear or anxiety in terms of duration; symptoms related to an anxiety disorder typically persist for >6 months. Anxiety disorders can only be diagnosed when the physiological effects of substances, other medications, or other medical diagnoses have been ruled out or when the symptoms cannot be better explained by the diagnosis of another mental disorder.5 Thus, thorough patient assessment should include a review of systems, medication history (including over-the-counter medications), substance use, a complete evaluation of anxiety symptoms, a focused physical examination of symptomatic areas, and a functional assessment. Inquiries about substance use should include questions about illicit drugs (particularly stimulants), alcohol, and caffeine. Further investigations should follow based on the results of the initial assessment (Table 1).6

What’s New in the DSM-5 for Anxiety Disorders?

Several important changes were made to the diagnostic category of Anxiety Disorders in the fifth edition of the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-5), including “cleaving” certain disorders into multiple new chapters, regrouping, adding new conditions, and refining criteria for some disorders. For example, obsessive compulsive disorder (OCD) has moved into its own chapter that includes the new entity of “hoarding disorder,” while posttraumatic stress disorder (PTSD) has shifted into a new chapter that includes acute stress and adjustment disorders. Anxiety disorders in childhood are no longer in a separate chapter. Within Anxiety Disorders, panic disorder and agoraphobia have been declared separate disorders since each can occur alone. In order to distinguish the diagnosis of agoraphobia from that of specific phobia, the criteria for the former require the endorsement of fears from ≥2 agoraphobic situations. Additionally, a panic attack specifier has been added to the DSM-5 that can be applied across all mental disorders. Panic attacks outside of panic disorder – but associated with other disorders – are frequently noted and may have value in predicting psychopathology, severity, and outcome.7

Regarding agoraphobia, specific phobia, and social anxiety disorder, the criteria no longer include age >18 years in order to recognize that patients’ anxiety is excessive or unreasonable; the rationale is that individuals typically overestimate their risk in “phobic” situations. In addition,
Complete blood count  
Prolactin  
Urinalysis  
Urine toxicology for substance use  
Liver enzymes  
Serum bilirubin  
Serum creatinine  
Electrolytes  
Electrocardiogram (if age >40 years or if indicated)  
Thyroid-stimulating hormone  
Fasting glucose  
Serum bilirubin  
24-hour creatinine clearance (if history of renal disease)  
Serum creatinine

study by Kearns et al10 called this new criterion into question, this remains controversial, may have onset in adulthood.11 Childhood into adulthood, and in some instances (although this remains controversial), may have onset in adulthood.11 Another controversial change in the diagnosis of social anxiety disorder is that the “generalized” specifier has been removed and replaced with a “performance only” specifier, noting that this group tends to be distinct in etiology, age of onset, and physiological and treatment response.6 However, a study by Kearn et al10 called this new criterion into question, as none of a sample of 204 anxious youth exhibited a discrete “performance” fear without fear in other social circumstances. Clinical and research experience with this new DSM-5 specifier will, in the coming year, determine whether this change was well founded.

Separation anxiety disorder, previously considered in the Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence section, is now listed under Anxiety Disorders, consistent with evidence that the disorder may persist from childhood into adulthood and, in some instances (although this remains controversial), may have onset in adulthood.11 Selective mutism has likewise been added to the Anxiety Disorders category. A summary of these changes by disorder can be found in Table 2.

OCD, PTSD, and acute stress disorder are no longer included in the Anxiety Disorders chapter, but are now included in the OCD and Related Disorders and Trauma- and Stressor-related Disorders chapters, respectively.5 These category changes are controversial in that they emphasize how these disorders differ from one another in terms of biological mechanism and treatment approach. On the other hand, these changes may underemphasize the similarities in these conditions.12 Furthermore, it is unclear if these individuals require a separate or different treatment than what was previously provided.

The decision to create a distinct category for OCD is based on research showing that OCD is related to both anxiety and other disorders, including Cluster C, tic, somatoform, grooming, and mood disorders.13 Additionally, hoarding – previously categorized within the diagnosis of OCD – has become its own disorder. Similarly, evidence suggests that PTSD and acute stress disorder be classified as a distinct category, recognizing their common etiology of trauma.14

A new “anxious distressed” specifier has also been added to the Depressive Disorders and Bipolar and Related Disorders categories in the DSM-5. The anxious-distressed feature has been noted to be a major feature of bipolar and major depressive disorder, and high levels of anxiety are associated with increased suicidality and burden of illness. Therefore, identifying this specifier can help with treatment and management. This specifier is applied to individuals with ≥2 anxious symptoms as specified in the DSM-5.5 This new criterion, however, does not come with a clause indicating not to diagnose if there is a comorbid anxiety disorder. This has the potential for individuals with a comorbid mood and anxiety disorder to be labeled with the “anxious-distressed” specifier, rather than a separate (comorbid) anxiety disorder, which may lead to undertreatment of the anxiety disorder.

One of the major implications of the DSM-5 may be its impact on research, particularly in terms of childhood anxiety disorders. For example, these changes have encouraged the development of child-specific assessment tools (eg, Picture Anxiety Tests)15 and disorder-specific treatment (eg, the TAFF program for Separation Anxiety Disorder).16 Currently, the DSM-5 changes to the Anxiety Disorders category can be considered a necessary step towards increased evidence-based diagnosis, assessment, and treatment of childhood anxiety disorders that, to this date, has been lacking.17 However, in the authors’ opinion, these changes will have a less immediate impact on clinical practice.

**CASE STUDY**18

A 35-year-old Asian-Canadian woman was referred to a psychiatrist for assessment of anxiety and avoidance. Two years earlier, she was awakened one night by chest pain that she believed was due to a heart attack. Accompanying symptoms were shortness of breath, rapid pulse, sweating, and dizziness. Her family took her to the Emergency Department, where a thorough medical work-up ruled out any cardiac problems. After this event, however, she stopped driving and was unable to attend her children’s sports events, go on buses, or to her church for fear of recurrence of the chest pain. Although she could not define a specific stressor prior to the onset, a number of stressful life events had occurred, including the death of a close friend from cancer and her husband losing his job. There was no prior history of emotional problems; however, she had a history of asthma. As well, when the patient was 12 years old, her father had suddenly died of a heart attack.

When considering treatment for the patient in this case, an algorithm (Figure 1) can be helpful. She presented with physiological symptoms of panic attacks and subsequent avoidance of situations that she believed were the cause of her
In keeping with the algorithm, medical causes were ruled out in the Emergency Room. After a complete assessment, this patient would likely be diagnosed with panic disorder. General treatment options for anxiety disorders are presented in the following section and an update to this case report is presented later in this issue.18

**Evidence-based Treatment of Anxiety Disorders**

Treatments are derived from studies using DSM-IV criteria and so may need adjustment in view of DSM-5 changes.

**General approach**

The treatment of anxiety disorders can be extremely gratifying for clinicians because patients tend to respond well to psychological and pharmacological therapies. Several practice guidelines can be referenced for the treatment of anxiety disorders, specifically, panic disorder and social anxiety disorder.6,19-21 A careful, comprehensive assessment of anxiety symptoms, disabilities, the presence of comorbid mental and physical conditions, patient preferences for treatment, and access to evidence-based psychotherapies is important. Measuring symptoms using panic or “worry” diaries or the use of self-reported standardized scales (eg, the Overall Anxiety Severity and Interference Scale [OASIS])22 can help both patients and therapists track the course and severity of anxiety problems and are indisputable aids to treatment.

**The impact of comorbidity**

The presence of a current comorbidity with a mental disorder (ie, mood, substance use, or a personality disorder) significantly affects management. If an individual is severely depressed, treatment of the depression—usually with a combination of medication(s) and therapy—and attention to anxiety symptoms is a priority. If a bipolar disorder is comorbid with an anxiety disorder(s), it may affect the type of medications used (eg, choice of a mood stabilizer or gabapentin). Self-medication with alcohol and drugs to reduce tension and anxiety is common and is associated with an increased risk of substance-use disorders.23 It is important for both patients and clinicians to understand that a vicious cycle can develop when anxiety symptoms lead to self-
medication with alcohol and drugs resulting in rebound anxiety. Past recommendations insisted on abstinence before treating comorbid anxiety and substance use disorders; however, current thinking favours concurrent treatment of both disorders whenever feasible.

Most patients prefer treating anxiety with psychotherapy alone or in combination with medication. However, evidence-based psychotherapy may not be readily accessible to all patients. Thus, medication often becomes the de facto treatment of anxiety disorders. Even in such circumstances, it should be possible to optimize patient care with appropriate educational, motivational, and behavioural instructions and resources.

Psychotherapy

Among the interventions for anxiety disorders, cognitive behavioural therapy (CBT) has the most robust evidence for efficacy. It can be delivered via a variety of formats, including individual, group, bibliotherapy, telephone, and the computer. Although there have been few changes in the treatment of anxiety disorders since the Canadian Psychiatric Association’s 2006 clinical practice guidelines, Internet-based CBT (iCBT) has become a well-established treatment for depression, panic disorder, and social anxiety disorder, with the potential to reduce comorbidity. Mobile CBT applications are increasingly available but have not been evaluated. CBT for the various anxiety disorders differ somewhat in focus and content, but are similar in underlying principles and approaches. Core components include psychoeducation, relaxation training, cognitive restructuring, and exposure therapy. Over the course of CBT, patients slowly face their anxiety-provoking situations and learn that if they stay in the situation long enough, their anxiety resolves.
While other psychotherapies - eg, psychodynamic psychotherapy, acceptance and commitment therapy, mindfulness-based stress reduction, or other therapies that target emotion regulation - are promising, further research is necessary to establish both efficacy and linkage to patient preferences. Acceptability and response to CBT for anxiety disorders is high; however, there is ample room for new treatments to meet the needs of patients who fail standard therapies.

Pharmacotherapy

Pharmacotherapy is an important option for many patients with anxiety disorders, either in combination with CBT or as standalone treatment. Pharmacotherapy should never be prescribed without additional educational materials. These can be provided at low or no cost online by accessing unbiased sources of high-quality information, including the National Institutes of Health, the Anxiety and Depression Association of America (ADAA), UpToDate® (written expressly for consumers), or anxieties.com.

Several classes of medications are indicated by Health Canada and similar regulatory agencies in other countries for the treatment of specific anxiety disorders. Although adherence to approved medications guarantees that a certain level of evidence has been attained in granting their approval, any licensed practitioner can choose to prescribe off-label, provided the marketed medication has a base of solid, peer-reviewed, published evidence for efficacy and safety in the particular clinical condition and specific to patient circumstances. The classes of medications with the best evidence of safety (when used appropriately) and efficacy for the treatment of anxiety disorders (with the exception of specific phobias) are the antidepressants, including selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOIs), and the benzodiazepine anxiolytics.

TCAs and MAOIs have been rarely used since the advent of the SSRIs because they are less well-tolerated. Some experts, however, believe that MAOIs may be efficacious for patients whose symptoms do not respond to other treatments, particularly in the treatment of social anxiety disorder. There is also evidence that several non-benzodiazepine anxiolytics (eg, buspirone and pregabalin) can play a role and, for refractory anxiety, possibly the atypical antipsychotics can help.

SSRIs and SNRIs. There are currently 6 SSRIs (fluoxetine, sertraline, paroxetine, fluvoxamine, citalopram, and escitalopram) and 3 SNRIs (extended-release venlafaxine, desvenlafaxine, and duloxetine) available in Canada. Although the SSRIs have different indications for particular anxiety disorders, clinicians tend to treat them as having equal efficacy since there is no evidence to the contrary. As a class, the SSRIs are considered first-line agents for each of the anxiety disorders (with the notable exception of specific phobia) due to their overall levels of efficacy, safety, and tolerability.

It is recommended to begin a treatment trial with the lowest available dose of an SSRI. Follow-up should occur after the first week to assess medication tolerability and patient compliance. The dose is then gradually increased until a therapeutic dose is reached. An initial response is typically seen in 4-6 weeks and an optimal response achieved in 12-16 weeks. Follow-up should occur biweekly for the first 6 weeks and then monthly thereafter. There is a misconception that patients with anxiety disorders respond to lower doses of antidepressants than patients with depression. In fact, average doses for treating anxiety disorders are as high or higher than for depression. In addition, many patients presenting with anxiety also have major depression, necessitating the use of a full antidepressant dose. Clinicians may take an extra 1-2 weeks to reach these doses in patients with anxiety disorders, comorbid or otherwise. Progress can be measured at each appointment with clinician-rated tools (eg, the Clinical Global Impression scale) or self-report scales (eg, the Depression Anxiety Stress Scale).

In patients who fail to respond to an SSRI, the next step is to try a different SSRI or to switch to an SNRI. Patients who experience a partial response to an SNRI or SNRI may be considered for adjunctive treatment with a benzodiazepine or another anti-anxiety agent. Pharmacotherapy may be needed for 1-2 years, or longer.

Benzodiazepines are among the best tolerated and most efficacious of all the anti-anxiety agents, with broad-spectrum efficacy across the anxiety disorders, including specific phobia. They can be used as first-line agents for treating anxiety and are the best-established pharmacotherapy for treating anxiety that is predictable and limited to particular situations (eg, a specific phobia such as flying or social phobia such as public speaking) as they can be prescribed on an as-needed (prn) basis. However, benzodiazepines need to be prescribed with caution due to the potential for abuse. They should only be prescribed with great care and strict supervision to patients with a history of alcohol or other substance abuse.

Prescription of prn benzodiazepines for unpredictable anxieties (eg, panic disorder) or chronic anxiety (eg, GAD) is not recommended. Benzodiazepines should generally be prescribed for anxiety on a regular schedule (ie, 1-4 times daily depending on the pharmacokinetic and pharmacodynamic properties of the particular benzodiazepine), with prn use for occasionally recurring, predictable specific phobias.

Non-benzodiazepine anxiolytics. Buspirone is a non-benzodiazepine anxiolytic with efficacy limited to the treatment of GAD. Gabapentin and pregabalin have limited evidence for efficacy in treating anxiety disorders, although they are sometimes used as an alternative to the benzodiazepines, often as an adjunct to antidepressants.

Atypical antipsychotics. There is very limited evidence that atypical antipsychotics may be efficacious as monotherapy or as an adjunct to antidepressants for treatment-resistant anxiety disorders.

Combining psychotherapy and pharmacotherapy

Several studies suggest, albeit with few data, that combining CBT and pharmacotherapy for anxiety disorders is superior to either one alone, particularly in children. However, the efficacy of either treatment...
CASE STUDY (cont.)

Our patient, after being diagnosed with panic disorder, was taught about the panic model. The therapist asked her to keep a diary of her panic attacks, including details such as where the attack occurred, her symptoms during the attack, and what she did to manage her anxiety. During treatment sessions, she learned how to identify the “hot” thoughts that increased her anxiety and ways to challenge this thinking by considering the evidence for and against her fear of having a heart attack. Along with CBT, she was offered a trial of an SSRI. She started on 50 mg/day of sertraline that was titrated up until an optimal therapeutic dose was achieved. After 6 weeks, the patient did not demonstrate a meaningful clinical response and the panic attacks continued. The treating physician then decided to switch her to paroxetine, another SSRI. After 6 weeks, the patient continued benefit with the paroxetine, and was maintained on this medication.

Conclusion

Anxiety disorders are highly prevalent and frequently disabling conditions that often begin in childhood and persist into adulthood. They are generally very responsive to CBT and/or pharmacotherapy. All patients should receive education regarding their anxiety disorder, options for treatment, prognosis, triggering factors, and signs of relapse.

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