Deconstructing the DSM-5

By Jason H. King

Assessment and diagnosis of anxiety, somatic symptom and related disorders

The chapter on anxiety disorders in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) includes important refinements and new conceptualizations, while also attending to the cultural needs of our clients.

The anxiety disorders chapter no longer includes obsessive-compulsive disorder (now in the obsessive-compulsive and related disorders chapter) or posttraumatic stress disorder and acute stress disorder (now included with the trauma- and stressor-related disorders chapter). The sequential order of these chapters in the DSM-5 reflects the close relationships among them, however.

I want to emphasize that because obsessive-compulsive disorder, posttraumatic stress disorder and acute stress disorder are not technically referred to as anxiety disorders, anxiety is still pronounced in their presentation (see DSM-5 pages 235-236). Even so, fear and phobia, which are cardinal signs of anxiety disorders, are not manifest in these disorders.

The reason for their new diagnostic home is because "the disorders included in DSM-5 were reordered into a revised organizational structure meant to stimulate new clinical perspectives" (page xli). Furthermore, the revised chapter structure was informed by recent research in neuroscience (common neurocircuitry) and by emerging genetic linkages (genetic vulnerability and environmental exposure) between diagnostic groups. The anxiety disorders chapter is arranged developmentally, with disorders sequenced according to the typical age of onset.

The new landscape

I want to first discuss several across-the-board changes to all seven of the anxiety disorders before I address each independently. The DSM-5 requires a minimum symptom duration of six months for each anxiety disorder before a diagnosis can be assigned. The only exception is with separation anxiety disorder and selective mutism, which require symptom duration of at least one month in children and adolescents.

Second, for all anxiety disorders, the client's subjective and manifest anxiety must be out of proportion to the situation and represent clinically significant distress. Anxiety disorders differ from transient fear or anxiety and "also differ from developmentally normative fear or anxiety by being excessive or persisting beyond developmentally appropriate periods" (page 189).

Third, to provide greater accuracy and flexibility in the clinical description of individual symptomatic presentations, there are severity measures that are specific to each anxiety disorder for children and adults (located at psychiatry.org/dsm5 under "Online

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Assessment Measures" and then "Disorder-Specific Severity Measures"). The severity measures correspond closely to the criteria that constitute each disorder's definition. Counselors can administer these measures at both an initial interview and over time to track the severity of the client's disorder and response to treatment.

Fourth, the DSM-5 removed all of the DSM-IV-TR's age requirements. For example, the criteria for agoraphobia, specific phobia and social anxiety disorder (social phobia) no longer include the requirement that individuals older than 18 recognize that their anxiety is excessive or unreasonable. This change is based on evidence that individuals with such disorders often overestimate the danger in phobic situations, while older individuals often misattribute phobic fears to aging.

In addition, the six-month duration, previously limited to individuals younger than 18 in the DSM-IV-TR, is now extended to all ages. This change is intended to minimize overdiagnosis of transient fears. Also in contrast to the DSM-IV-TR, the diagnostic criteria for separation anxiety disorder no longer specify that onset must be before age 18 because a substantial number of adults report onset after that age.

Finally, the DSM-5 emphasizes cultural sensitivity among all anxiety disorders, but especially social anxiety disorder and panic disorder (see "Culture-Related Diagnostic Issues" on pages 205-206, 211-212 and 216). "Since individuals with anxiety disorders typically overestimate the danger in situations they fear or avoid, the primary determination of whether the fear or anxiety is excessive or out of proportion is made by the clinician, taking cultural contextual factors into account" (page 189).

This means culture-specific symptoms such as tinnitus, neck soreness, headaches and uncontrollable screaming or crying that manifest in Japanese, Korean, Latino, Vietnamese, Latin American, Cambodian, African American or Caribbean populations should not count as required symptoms when formulating a diagnosis. For additional discussion on expanded cultural sensitivity for DSM-5 anxiety disorders, I recommend reading "Cultural Issues" on page 14 and the "Glossary of Cultural Concepts of Distress" on pages 833-837.

Separation anxiety disorder

According to a 2013 article written by Susan Bögels and colleagues for Clinical Psychology Review (dx.doi.org/10.1016/j.cpr.2013.03.006), separation anxiety disorder in adults has been underdiagnosed despite high adulthood prevalence that is often comorbid and debilitating, and notwithstanding a substantial portion of individuals reporting first onset of the disorder in adulthood.

Causal factors for underdiagnosis include previous classification of the disorder in the DSM-IV-TR under a chapter titled "Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence," giving the impression that the disorder was restricted to pediatric populations.

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This trend concerned the DSM-5 anxiety disorders work group, resulting in separation anxiety disorder being moved to the anxiety disorders chapter and the addition of the following language to its diagnostic criterion:
A.1. "… or experiencing …"
A.2. "… such as illness, injury, disasters or death."
A.3. "… having an accident, becoming ill …"
A.4. "… to go out, away from home …"

Characteristic of this disorder, adults typically become overly concerned about the Criterion A events happening to their offspring and spouse, resulting in personal marked discomfort. Adults with separation anxiety disorder may also be uncomfortable when traveling independently. Counselors can determine the severity level of this disorder for children or adults by using the Severity Measure for Separation Anxiety Disorder.

Selective mutism

In the DSM-IV-TR, selective mutism was classified in the chapter titled "Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence." It is now classified as an anxiety disorder, given that a large majority of children with selective mutism are anxious. The diagnostic criteria are largely unchanged from the DSM-IV-TR.

Specific phobia

The DSM-5 removed the DSM-IV-TR criterion B phrase "… which may take the form of a situationally bound or situationally predisposed Panic Attack" because a panic attack is not indicative of specific phobia. Counselors can determine the severity level of this disorder for children or adults by using the Severity Measure for Specific Phobia.

Social anxiety disorder (social phobia)

Social phobia (as it was called in the DSM-IV-TR) receives a name enhancement with "social anxiety disorder" being added to its formal diagnostic title.

Similar to what happened with specific phobia, the DSM-5 removed the DSM-IV-TR criterion B phrase: "Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack." To more accurately convey the definitive feature of this disorder, the phrase was replaced with the following language: "The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated."

In addition, the DSM-IV-TR "generalized" specifier was removed from the DSM-5 and replaced with a "performance only" specifier (first introduced on page 455 of the DSM-IV-TR). Counselors can use this specifier for clients whose fear is restricted to speaking or performing in public (for example, dancers, speakers, musicians or athletes). Counselors can determine the severity level of this disorder for children or adults by using the Severity Measure for Social Anxiety Disorder (Social Phobia).

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Panic disorder

The DSM-5 collapses the DSM-IV-TR characteristic types "cued, uncued, situational and situationally predisposed" to "expected and unexpected." The DSM-IV-TR diagnosis "panic disorder without agoraphobia" is also collapsed into the DSM-5 conceptualization.

Removed from the DSM-5 is "panic disorder with agoraphobia" because if agoraphobia is present, a separate diagnosis of agoraphobia is given. Counselors can determine the severity level of this disorder for children or adults by using the Severity Measure for Panic Disorder.

Panic attack specifier

In the DSM-5, the 13 symptoms characteristic of panic attack become usable as a new specifier. Panic attack "symptoms are presented for the purpose of identifying a panic attack; however, panic attack is not a mental disorder and cannot be coded. Panic attacks can occur in the context of any anxiety disorders as well as other mental disorders (e.g., depressive disorder, posttraumatic stress disorder, substance use disorders) and some medical conditions (e.g., cardiac, respiratory, vestibular, gastrointestinal).

When the presence of panic attack is identified, it should be noted as a specifier (e.g., 'posttraumatic stress disorder with panic attack'). For panic disorder, the presence of panic attacks is contained within the criteria for the disorder and panic attack is not used as a specifier" (page 214). For clients who display fewer than four of the required panic attack specifier symptoms, counselors may use the designation "with limited symptom attacks" in the diagnostic formulation.

Agoraphobia

In the DSM-IV-TR, agoraphobia was not a codable disorder. In the DSM-5, agoraphobia represents an "upgrade" of the DSM-IV-TR "agoraphobia without history of panic disorder" discussed on pages 441-443. Essentially, agoraphobia is diagnosed irrespective of the presence of panic disorder because a substantial number of individuals with agoraphobia do not experience panic symptoms. It is diagnosed only if the fear, anxiety or avoidance persists.

Endorsement of fears from two or more of five agoraphobia situations is now required because this is a robust means for distinguishing agoraphobia from specific phobias. Counselors can determine the severity level of this disorder for children or adults by using the Severity Measure for Agoraphobia.

Generalized anxiety disorder

The DSM-5 retains the DSM-IV-TR diagnostic symptoms for generalized anxiety disorder. Because of its high comorbidity with depressive disorders and its potential for being overdiagnosed in children, the DSM-5 encourages counselors to restrict diagnosing by properly assessing manifest symptom "intensity, duration or frequency" to ensure that symptoms are "pervasive, pronounced and distressing" and that client "worries are excessive and typically interfere significantly with psychosocial functioning" (pages 222-

223). Counselors can determine the severity level of this disorder for children or adults by using the Severity Measure for Generalized Anxiety Disorder.

Somatic symptom and related disorders

In an interview with Psychiatric News, Joel Dimsdale, chair of the DSM-5 somatic symptoms disorders work group, commented, "The heart of these disorders is a disproportionate and excessive response to somatic symptoms. We are talking about persistent symptoms lasting six months, including thoughts, feelings and behaviors that are disproportionate to somatic symptoms. Patients may catastrophize about fairly minor somatic symptoms, become very anxious and constantly scan for information about an illness, or avoid situations and behaviors they believe are related to illness." Let's examine the somatic symptom and related disorders in more detail.

Somatic symptom disorder

According to research published in 2011 by J. G. M. Rosmalen and colleagues in *Psychological Medicine* (doi.org/10.1017/S0033291710001625), data failed to provide empirical support for the designated DSM-IV-TR somatoform-related disorders symptom cluster. Yet their data underlined the validity of the emerging DSM-5 dimensional approach of diagnosing these disorders.

In the DSM-IV-TR, there was a great deal of overlap across the somatoform disorders and a lack of clarity about the boundaries of diagnoses. Hence, the DSM-5 collapses the DSM-IV-TR's somatization disorder, undifferentiated somatoform disorder and pain disorder into a new diagnosis: somatic symptom disorder. According to the new manual, this diagnosis encompasses about 75 percent of the DSM-IV-TR hypochondriasis diagnoses. Clinical profiles of this disorder include client symptoms marked by "significant disruption [and] marked impairment" and "disproportionate, persistently excessive" client reactions (page 311).

To avoid pejorative and demeaning client attributions, the DSM-5 indicates that "it is not appropriate to give an individual a mental disorder diagnosis solely because a medical cause cannot be demonstrated. Somatic symptoms without an evident medical explanation are not sufficient to make this diagnosis. The individual's suffering is authentic, whether or not it is medically explained" (page 311).

Counselors may use the specifier "with predominant pain" to indicate this presence in clients. Counselors can also communicate symptom duration of longer than six months with the specifier "persistent." Severity of the disorder is indicated by mild (one symptom), moderate (two-plus symptoms) or severe (multiple symptoms) designations. When developing a clinical formulation of somatic symptom disorder, counselors would do well to consider the DSM-5's discussion on culture-related diagnostic issues mentioned earlier in this article.

Illness anxiety disorder

The former hypochondriasis disorder is renamed illness anxiety disorder in the DSM-5 to capture individuals who exhibit high health anxiety without also having somatic symptoms in a manner that is not pejorative (for example, by referring to them "hypochondriacs").

Clients receiving this diagnosis display incessant worry and preoccupation related to illness. Counselors can use two new specifiers: care seeking type (excessive health-related behaviors) or care avoidant type (maladaptive avoidance).

Conversion disorder (functional neurological symptom disorder)

Criteria for this disorder were modified to strongly recommend neurological examination to ensure clear evidence of incompatibility with neurological disease. In addition to the expansion of the diagnostic name (functional neurological symptom disorder communicates motor and sensory symptoms indicative of central nervous system functioning), conversion disorder has 12 new descriptive and course specifiers for diagnostic precision.

Psychological factors affecting other medical conditions

This disorder, previously located in the DSM-IV-TR's "Other Conditions That May Be a Focus of Clinical Attention," receives an upgrade in the DSM-5. Criterion B.4. from the DSM-IV-TR (which read "stress-related physiological responses precipitate or exacerbate …") was changed to "the factors influence the underlying pathophysiology, precipitating or exacerbating symptoms …" New specifiers include mild, moderate, severe (requiring hospitalization/emergency department visitation) and extreme (life-threatening risk).

Factitious disorder

This independent chapter from the DSM-IV-TR merges into the DSM-5 chapter on somatic symptom and related disorders. Also known as Munchausen syndrome, or Munchausen by proxy, this disorder may be imposed on one's self or on another. The new manual replaces three DSM-IV-TR types with two specifiers: single episode and recurrent episode.

Counselors should be diagnostically skilled in differentiating this disorder from the non-mental health condition of malingering by reading DSM-5 pages 726-727. Counselors can determine the severity of these somatic symptom and related disorders for children or adults by using the Clinician-Rated Severity of Somatic Symptom Disorder.
Until next month, be well!

Bio

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