Anxiety and *DSM-5*

David J. Kupfer, MD

Abstract

The DSM-5 *process, and the publication of* DSM-5 *in 2013, have had a considerable impact on the classification of anxiety disorders. Major changes included the reorganization of the chapter structure, individual groupings of disorders within each chapter from a life span viewpoint, and the use of specifiers. The* DSM-5 *chapter on anxiety disorders does not include obsessive-compulsive disorder or post-traumatic stress disorder. The chapter itself now reflects a developmental approach. The text of each disorder has been enhanced with short sections on development and course, risk and prognostic factors, etc. It is expected that the reformulation of anxiety disorders in* DSM-5 *will lead to greater precision in a variety of ways, as illustrated in the papers in this issue of* Dialogues in Clinical Neuroscience. *In summary, these changes in the way we classify anxiety disorders reflect our best view on the clinical empirical data and should prove useful in the assessment of specific anxiety disorders.*

Keywords: *anxiety disorder; DSM-5; classification; panic attack specifier; anxious distress*

Author affiliations: Department of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania, USA

Address for correspondence: David J. Kupfer, MD, University of Pittsburgh School of Medicine, Department of Psychiatry, 3811 O'Hara Street, Pittsburgh, PA 15213, USA
(e-mail: kupferdj@upmc.edu)

The publication of *DSM-5* in 2013 marked the culmination of an extensive review of all psychiatric disorders.[1] These disorder reviews typically included literature reviews, secondary data analyses when appropriate and, for selected disorders, international conferences focused on the disorder. In addition, field trials were conducted to evaluate suggested new diagnostic criteria.[2] Attention was also given to the ongoing evaluation of disorders for the *ICD* revision process. The expectation was that *DSM-5* and *ICD-11* would be more aligned than previous versions of the *DSM* and *ICD* diagnostic systems.

Anxiety disorders represent one of the major groups of disorders seen in psychiatry, and in the rest of medicine as well. Over several decades, the classification of these disorders had not changed dramatically, although advances in neuroscience and therapeutics have focused attention on how the anxiety disorders are grouped. When the *DSM-5* process began, attention was given to providing a more sophisticated scientific approach to possible etiology and pathogenesis of these disorders. Several international conferences were held between 2003 and 2008 to sharpen the natural separation points of diagnostic groups under the rubric of "anxiety disorders." Indeed, four separate international meetings were devoted to these potential groupings.

The *DSM-5* process and the resulting publication of *DSM-5* in 2013 has had a considerable impact on the classification of anxiety disorders. Major changes included the reorganization in the chapter structure, individual groupings of disorders within each chapter from a lifespan viewpoint, and the use of specifiers. Steps were taken so that the text could convey more information for a dimensional view of symptoms and capture more precisely psychiatric morbidity and the severity of conditions. In addition, the use of apps and the electronic version of *DSM-5* have provided greater flexibility in its use and more opportunity to use references and rating scales for assessment.

With respect to chapter changes, the *DSM-5* chapter on anxiety disorders does not include obsessive-compulsive disorder. Rather, it is placed in a new chapter entitled "Obsessive-Compulsive and Related Disorders." Nor does the anxiety disorders chapter include post-traumatic stress disorder (PTSD) or acute stress disorder, which now appear in a new chapter denoted as "Trauma- and Stressor-Related Disorders." The chapter itself now reflects a developmental approach, with disorders sequenced according to the usual age at onset. In addition, a 6-month duration is now extended to all ages for most of these disorders, including specific phobia and social anxiety disorder (social phobia). It is important to note that panic attacks can now be listed as a specifier that is applicable to all *DSM-5* disorders, not just anxiety disorders. Panic disorder and agoraphobia are now unlinked in *DSM-5*, each with separate criteria. Separation anxiety disorder and selective mutism are classified as anxiety disorders, unlike their previous

placement in the first chapter of *DSM-IV* among disorders that appear in childhood. The wording of the criteria for separation anxiety disorder has been modified to more adequately represent the expression of separation anxiety symptoms in adulthood. Thus, the diagnostic criteria no longer specify that onset must be before age 18 years. The text of each disorder has been enhanced with short sections on development and course, risk and prognostic factors, and associated biologic information when indicated.

Disorder-specific rating scales are available in the electronic version of *DSM-5* to enable clinicians to better characterize the severity of each anxiety disorder and to track changes in severity over time. These scales have been developed to have the same format (but different focus) across the various anxiety disorders, with ratings of specific behavioral symptoms, cognitive ideation symptoms, and physical symptoms relevant to each disorder.

The reformulation of anxiety disorders in *DSM-5* can lead to greater precision in a variety of ways, as illustrated in the papers in this issue of *Dialogues in Clinical Neuroscience*. For example, epidemiological studies can identify better separation of disorders, as well as the overlap across disorders. Translational research efforts and the discovery of biological markers in subgroup diagnoses and treatment predictors can be more easily mapped onto this updated formulation. The chapter structure and the individual disorders can be more easily associated with genetic and other biological factors. An example of this strategy is the placement of anxiety disorders between chapters on depression and obsessive-compulsive disorders. The new specifiers of anxiety disorders on *DSM-5* can assist in achieving a greater degree of precision in treatment interventions. As mentioned earlier, the panic attack specifier in the anxiety chapter can be used in conjunction with any disorder, since there is considerable evidence that the presence of panic attacks may affect treatment response. Interestingly, both bipolar disorders and depressive disorders can be accompanied by an anxious distress specifier. Anxious distress has been noted as a prominent feature of both bipolar and major depressive disorder in both primary care and specialty mental health settings. Perhaps most importantly, high levels of anxiety have been associated with higher suicide risk, longer duration of illness, and greater likelihood of treatment nonresponse. As a result, it is clinically useful to specify accurately the presence and severity level of anxious distress for treatment planning and monitoring of response to treatment.

One of the final recommendations made by the *DSM-5* Task Force was not to wait for 20 years for the next edition, but to consider updates in selected areas within 4 to 5 years in the form of a *DSM-5.1* edition. The data discussed in the papers in this quarterly publication point to areas needing possible alteration of diagnostic criteria, as well as the pursuit of meaningful ways to use biologic data in improving diagnostic criteria. Studies involving sensitivity and specificity will need to be conducted to assess the readiness for specific diagnostic criteria to be adjusted. In summary, the changes in anxiety disorders do reflect our best view on the clinical empirical data and provide useful guides in the assessment of specific anxiety disorders. ❑

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