

Anxiety as espoused in the DSM 5: The DSM 5 as Published in May 2013 a Clear perspective

<https://psychpoliticszw.wordpress.com/2023/10/08/anxiety-as-espoused-in-the-dsm-5/>

The purpose of my writing is on two fronts one is to enhance the understanding of anxiety amongst persons and in particular practitioners in mental health and on the second front it is to enhance careful and knowledgeable diagnosis of anxiety disorders which has an effect on reliability and validity of the DSM as a nosological system

The anxiety are as follows:

Separation Anxiety Disorder

Selective mutism

Social anxiety disorder (social phobia)

Panic disorder

Agoraphobia

Generalized anxiety disorder

Substance/medication-induced anxiety disorder

Anxiety disorders, Fear and Panic Attacks

Anxiety disorders include disorders that share features of excessive fear and anxiety and related behavioral disturbances.

Fear-is the emotional response to real or perceived imminent threat, whereas anxiety is anticipation of future threat. Obviously, these two states overlap, but they also differ, with fear more often associated with surges of autonomic arousal necessary for fight or flight, thoughts of immediate danger, and escape behaviors, and anxiety more often associated with muscle tension and vigilance in preparation for future danger and cautious or avoidant behaviors. Sometimes the level of fear or anxiety is reduced by pervasive avoidance behaviors. Panic attacks -feature prominently within the anxiety disorders as a particular type of fear response. Panic attacks are not limited to anxiety disorders but rather can be seen in other mental disorders as well.

Epidemiology of Anxiety disorders

Anxiety disorders differ from developmentally normative fear or anxiety by being excessive or persisting beyond developmentally appropriate periods.

They differ from transient fear or anxiety, often stress-induced, by being persistent (e.g., typically lasting 6 months or more), although the criterion for duration is intended as a general guide with allowance for some degree of flexibility and is sometimes of shorter duration in children (as in separation anxiety disorder and selective mutism). 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. Many of the anxiety disorders develop in childhood and tend to persist if not treated. Most occur more frequently in females than in males (approximately 2:1 ratio). Each anxiety disorder is diagnosed only when the symptoms are not attributable to the physiological effects of a substance/medication or to another medical condition or are not better explained by another mental disorder.

Separation Anxiety Disorder

Is fearful or anxious about separation from attachment figures to a degree that is developmentally inappropriate. There is persistent fear or anxiety about harm coming to attachment figures and events that could lead to loss of or separation from attachment figures and reluctance to go away from attachment figures, as well as nightmares and physical symptoms of distress. Although the symptoms often develop in childhood, they can be expressed throughout adult hood as well.

Diagnosis of Separation Anxiety Disorder

A. Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:

1. Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.
2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.
3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.
4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.
5. Persistent and excessive fear of or reluctance a¹bout being alone or without major attachment figures at home or in other settings.

6. Repeated nightmares involving the theme of separation. 8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated.
- B. The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in adults.
- C. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.
- D. The disturbance is not better explained by another mental disorder, such as refusing to leave home because of excessive resistance to change in autism spectrum disorder; delusions or hallucinations concerning separation in psychotic disorders; refusal to go outside without a trusted companion in agoraphobia; worries about ill health or other harm befalling significant others in generalized anxiety disorder; or concerns about having an illness in illness anxiety disorder.

Prevalence

The 12-month prevalence of separation anxiety disorder among adults in the United States is 0.9%-1.9%. In children, 6- to 12-month prevalence is estimated to be approximately 4%. In adolescents in the United States, the 12-month prevalence is 1.6%. Separation anxiety disorder decreases in prevalence from childhood through adolescence and adulthood and is the most prevalent anxiety disorder in children younger than 12 years. In clinical samples of children, the disorder is equally common in males and females. In the community, the disorder is more frequent in females.

Development and Course

Periods of heightened separation anxiety from attachment figures are part of normal early development and may indicate the development of secure attachment relationships (e.g., around 1 year of age, when infants may suffer from stranger anxiety). Onset of separation anxiety disorder may be as early as preschool age and may occur at any time during childhood and more rarely in adolescence. Typically there are periods of exacerbation and remission. In some cases, both the anxiety about possible separation and the avoidance of situations involving separation from the home or nuclear family (e.g., going away to college, moving away from attachment figures) may persist through adulthood.

However, the majority of children with separation anxiety disorder are free of impairing anxiety disorders over their lifetimes. Many adults with separation anxiety disorder do not recall a childhood onset of separation anxiety disorder, although they may recall symptoms.

The manifestations of separation anxiety disorder vary with age. Younger children are more reluctant to go to school or may avoid school altogether. Younger children may not express worries or specific fears of definite threats to parents, home, or themselves, and the anxiety is manifested only when separation is experienced. As children age, worries emerge; these are often worries about specific dangers (e.g., accidents,

kidnapping, mugging, death) or vague concerns about not being reunited with attachment figures. In adults, separation anxiety disorder may limit their ability to cope with changes in circumstances (e.g., moving, getting married). Adults with the disorder are typically overconcerned about their offspring and spouses and experience marked discomfort when separated from them. They may also experience significant disruption in work or social experiences because of needing to continuously check on the whereabouts of a significant other.

Risk and Prognostic Factors

Environmental. Separation anxiety disorder often develops after life stress, especially a loss (e.g., the death of a relative or pet; an illness of the individual or a relative; a change of schools; parental divorce; a move to a new neighborhood; immigration; a disaster that involved periods of separation from attachment figures). In young adults, other examples of life stress include leaving the parental home, entering into a romantic relationship, and becoming a parent. Parental overprotection and intrusiveness may be associated with separation anxiety disorder. **Genetic and physiological.** Separation anxiety disorder in children may be heritable. Heritability was estimated at 73% in a community sample of 6-year-old twins, with higher rates in girls. Children with separation anxiety disorder display particularly enhanced sensitivity to respiratory stimulation using CO₂-enriched air.

Gender-Related Diagnostic issues

Girls manifest greater reluctance to attend or avoidance of school than boys. Indirect expression of fear of separation may be more common in males than in females, for example, by limited independent activity, reluctance to be away from home alone, or distress when spouse or offspring do things independently or when contact with spouse or offspring is not possible.

Suicide Risk

Separation anxiety disorder in children may be associated with an increased risk for suicide. In a community sample, the presence of mood disorders, anxiety disorders, or substance use has been associated with suicidal ideation and attempts. However, this association is not specific to separation anxiety disorder and is found in several anxiety disorders

Selective Mutism

Is characterized by a consistent failure to speak in social situations in which there is an expectation to speak (e.g., school) even though the individual speaks in other situations. The failure to speak has significant consequences on achievement in academic or occupational settings or otherwise interferes with normal social communication. Individuals with specific phobia are fearful or anxious about or avoidant of

circumscribed objects or situations. A specific cognitive ideation is not featured in this disorder, as it is in other anxiety disorders. The fear, anxiety, or avoidance is almost always immediately induced by the phobic situation, to a degree that is persistent and out of proportion to the actual risk posed. There are various types of specific phobias: animal; natural environment; blood-injection-injury; situational; and other situations.

A. Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations.
B. The disturbance interferes with educational or occupational achievement or with social communication.

C. The duration of the disturbance is at least 1 month (not limited to the first month of school).

D. The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.

E. The disturbance is not better explained by a communication disorder (e.g., childhood-onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.

Prevalence

Selective mutism is a relatively rare disorder and has not been included as a diagnostic category in epidemiological studies of prevalence of childhood disorders. Point prevalence using various clinic or school samples ranges between 0.03% and 1% depending on the setting (e.g., clinic vs. school vs. general population) and ages of the individuals in the sample. The prevalence of the disorder does not seem to vary by sex or race/ethnicity. The disorder is more likely to manifest in young children than in adolescents and adults.

Development and Course

The onset of selective mutism is usually before age 5 years, but the disturbance may not come to clinical attention until entry into school, where there is an increase in social interaction and performance tasks, such as reading aloud. The persistence of the disorder is variable. Although clinical reports suggest that many individuals “outgrow” selective mutism, the longitudinal course of the disorder is unknown. In some cases, particularly in individuals with social anxiety disorder, selective mutism may disappear, but symptoms of social anxiety disorder remain.

Risk and Prognostic Factors

Temperamental. Temperamental risk factors for selective mutism are not well identified. Negative affectivity (neuroticism) or behavioral inhibition may play a role, as may parental history of shyness, social isolation, and social anxiety. Children with

selective mutism may have subtle receptive language difficulties compared with their peers, although receptive language is still within the normal range. Environmental. Social inhibition on the part of parents may serve as a model for social reticence and selective mutism in children. Furthermore, parents of children with selective mutism have been described as overprotective or more controlling than parents of children with other anxiety disorders or no disorder. Genetic and physiological factors. Because of the significant overlap between selective mutism and social anxiety disorder, there may be shared genetic factors between these conditions.

Differential Diagnosis

Communication disorders. Neurodevelopmental disorders and schizophrenia and other psychotic disorders. Social anxiety disorder (social phobia).

Comorbidity

The most common comorbid conditions are other anxiety disorders, most commonly social anxiety disorder, followed by separation anxiety disorder and specific phobia. Oppositional behaviors have been noted to occur in children with selective mutism, although oppositional behavior may be limited to situations requiring speech. Communication delays or disorders also may appear in some children with selective mutism.

Diagnostic Criteria

A. Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging.

B. The phobic object or situation almost always provokes immediate fear or anxiety.

C. The phobic object or situation is actively avoided or endured with intense fear or anxiety.

D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.

E. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

G. The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like

symptoms or other incapacitating symptoms (as in agoraphobia): objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in posttraumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder). Specify if: Code based on the phobic stimulus:
300.29 (F40.218) Animal (e.g., spiders, insects, dogs).

300.29 (F40.228) Natural environment (e.g., heights, storms, water).

300.29 (F40.23X) Blood-injection-injury (e.g., needles, invasive medical procedures)
Specifiers It is common for individuals to have multiple specific phobias. The average individual with specific phobia fears three objects or situations, and approximately 75% of individuals with specific phobia fear more than one situation or object. In such cases, multiple specific phobia diagnoses, each with its own diagnostic code reflecting the phobic stimulus, would need to be given. For example, if an individual fears thunderstorms and flying, then two diagnoses would be given: specific phobia, natural environment, and specific phobia, situational.

Prevalence

In the United States, the 12-month community prevalence estimate for specific phobia is approximately 7%-9%. Prevalence rates in European countries are largely similar to those in the United States (e.g., about 6%), but rates are generally lower in Asian, African, and Latin American countries (2%-4%). Prevalence rates are approximately 5% in children and are approximately 16% in 13- to 17-year-olds. Prevalence rates are lower in older individuals (about 3%-5%), possibly reflecting diminishing severity to subclinical levels. Females are more frequently affected than males, at a rate of approximately 2:1, although rates vary across different phobic stimuli. That is, animal, natural environment, and situational specific phobias are predominantly experienced by females, whereas blood-injection-injury phobia is experienced nearly equally by both genders.

Suicide Risk

Individuals with specific phobia are up to 60% more likely to make a suicide attempt than are individuals without the diagnosis. However, it is likely that these elevated rates are primarily due to comorbidity with personality disorders and other anxiety disorders.

7. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.

Wonder Makasi

Intern Counseling Psychologist