

Deconstructing the DSM-5

By Jason H. King

Assessment and diagnosis of PTSD and skin-picking disorder

I am enjoying the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in my clinical practice. I started working with an adult female client (I will call her “Mary”) who presented with an extensive trauma history and skin-picking behaviors. She reported having prior treatment that used eye movement desensitization and reprocessing (EMDR), yet informed me that she intermittently experiences “relapses” (her word for trauma flashbacks and intrusive images of her various trauma episodes).

Background

To verify the presence and severity of her trauma, I used the new DSM-5 criteria set and its associated level one and level two cross-cutting symptom measures. According to the American Psychiatric Association, these “emerging measures” in Section III of the DSM-5 are to be administered at the initial interview and used to monitor treatment progress, thus serving to advance the use of initial symptomatic status and reported outcome information.

Cross-cutting symptom measures may aid in a comprehensive mental status assessment by drawing attention to symptoms that are important across diagnoses. They are intended to help identify additional areas of inquiry that may guide treatment and prognosis.

The cross-cutting measures have two levels. Level one questions offer a brief survey of 13 domains (depression, anger, mania, anxiety, somatic symptoms, suicidal ideation, psychosis, sleep problems, memory, repetitive thoughts and behaviors, dissociation, personality functioning and substance use) for adults and 12 domains (depression, anger, irritability, mania, anxiety, somatic symptoms, inattention, suicidal ideation/attempt, psychosis, sleep disturbance, repetitive thoughts and behaviors, and substance use), for children and adolescents.

Level two assessment measures, such as the National Stressful Events Survey PTSD Short Scale, provide a more in-depth assessment of certain domains. You can access these, and many other free assessment measures used in the DSM-5 clinical field trials, at psychiatry.org/practice/dsm/dsm5/online-assessment-measures.

The new landscape

The DSM-5 no longer lists posttraumatic stress disorder (PTSD) under the category of “anxiety disorders” but rather in a new category called “trauma- and stressor-related disorders” (along with reactive attachment disorder, disinhibited social engagement disorder, acute stress disorder and adjustment disorders).

The DSM-5 now contains more than 25 potential trauma-causing events, including sexual abuse, natural disasters, vehicle accidents and medical incidents. This expanded list of trauma-inducing events correlates nicely with the 2009 and 2016 CACREP standards that

require knowledge in the “effects of crises, disasters and other trauma-causing events on persons of all ages/across the life span.” An exception to the new DSM-5 diagnostic criteria is trauma caused by non-life-threatening illnesses or debilitating conditions.

In the DSM-5, there are now three new exposure sources:

1) Directly experiencing the traumatic event, such as a first responder collecting human remains or a child protective worker repeatedly being exposed to details of sexual abuse. Exposure to the traumatic event through media such as pictures, television or movies are not considered to be directly experiencing the traumatic event unless that exposure is related to a person’s work.

Personally, I find this exclusion concerning. In a mixed methods study in 2005, Mary Pulido found that indirect exposure to a terrorist attack was particularly relevant and related to PTSD symptoms, while Naomi Breslau and colleagues found that 0.7 percent of 9/11 PTSD cases resulted from indirect media exposure.

2) Witnessing the traumatic event in person

3) Learning that the traumatic event occurred to a close family member or close friend, with natural death not qualifying as a trauma trigger

The DSM-5 also contains new language discussing cultural syndromes and idioms of distress and how these influence PTSD expression. Temperamental, environmental and physiological factors are also discussed. Suicide risk factors, functional consequences of PTSD, development and course (children, adolescents, younger adults, older adults) and gender-related diagnostic issues are also new to the DSM-5.

What I find most helpful are the new risk and prognostic factors that discuss pretraumatic (before), peritraumatic (during) and posttraumatic (after) factors. These factors help to guide the diagnostic process and promote clinical utility for effective treatment planning.

The DSM-5 also eliminated the “subjective fear-based distress” criterion because research indicates that not all individuals with PTSD respond with a fear-based reaction. Some individuals instead respond with anhedonic, dysphoric, aggressive, phobic or dissociative reactions to the trauma-causing event. This change in the diagnostic criteria helps us to be more sensitive to the diverse PTSD presentations that we may see in our clients.

According to Dr. Matthew J. Friedman, a member of the DSM-5 Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic and Dissociative Disorders Work Group: “When PTSD was first proposed in 1980 for DSM-III, the major scientific model was that it was a fear-based anxiety disorder. So, the A2 criteria in DSM-IV called for a fear-based reaction of fear, helplessness or horror. But a lot of research now indicates that for many people who have intense emotional reactions to a traumatic event and go on to develop PTSD, their reaction is not fear based, but more likely to be dysphoria or anhedonia.”

The DSM-5 now requires four symptom categories to diagnose PTSD (the DSM-IV required only three categories). Those four categories are:

1) Intrusion symptoms: Covers spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress.

2) Persistent avoidance of stimuli: Refers to distressing memories, thoughts, feelings or external reminders of the event.

3) Negative alterations in cognitions and mood: Represents myriad feelings, from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities. It also includes an inability to remember key aspects of the event or reconceptualized symptoms and persistent negative emotional states, such as numbing.

4) Marked alterations in arousal and reactivity: Includes aggressive, reckless or self-destructive behavior, sleep disturbances, hypervigilance or related problems. This criterion emphasizes the “flight” aspect associated with PTSD and also accounts for the “fight” reaction often seen in PTSD.

New descriptive and course specifiers for PTSD include “with dissociative symptoms” (depersonalization, feeling disconnection from one’s body/derealization, feeling disconnected from the surrounding environment) and “with delayed expression” (in the DSM-IV, this was referred to as “delayed onset”).

The most clinically significant addition to PTSD in the DSM-5 is creation of independent diagnostic criteria for pediatric PTSD for children age 6 and younger. These criteria merge the adult criterion “C” and criterion “D” and lower the symptom threshold from 3 to 1 to be developmentally sensitive.

Some of the specific pediatric language includes “reenactment of events related to trauma, directly or symbolically,” “may appear in play or dissociative states,” “developmental regression,” “frightening dreams without recognizable content,” “may become preoccupied with reminders of the trauma” and “tend to experience primary mood changes.”

Differentiation between PTSD and acute stress disorder (ASD) is critical in the diagnostic process. In the DSM-5, ASD features the same PTSD criterion but also includes a strong anger response, irritable reactivity, aggressive responses and chaotic or impulsive behaviors. ASD further requires that individuals exhibit any nine of the 14 listed symptoms in five categories: intrusion, negative mood, dissociative, avoidance and arousal. Notice that “dissociative” is the additional symptom category that is not required for PTSD.

This inclusion is consistent with Paula Panasetis’ 2003 research that found that persistent dissociation is more strongly associated with ASD severity and intrusive symptoms than with peritraumatic dissociation. In addition, persistent dissociation, rather than peritraumatic dissociation, is associated with posttraumatic psychopathology. To learn

more about dissociation in ASD and PTSD, I encourage you to read an article in PTSD Research Quarterly that can be accessed at tsd.va.gov/professional/newsletters/research-quarterly/V17N1.pdf.

Latest research

This past year, Erin Koffel and colleagues utilized pre- and post-deployment data collected from a sample of 213 National Guard brigade combat team soldiers deployed to Iraq. Koffel and colleagues found that the DSM-5 symptom of anger showed the most increase from pre- to post-deployment in participants diagnosed with PTSD. In addition, anger had the strongest relation to PTSD and showed some evidence of specificity. They concluded that several of the other new and revised DSM-5 PTSD symptoms appear to be nonspecific and that their inclusion in the diagnostic criteria for PTSD is unlikely to improve differential diagnosis.

Also this past year, Jon Elhai and colleagues surveyed 585 college students on the web using the Stressful Life Events Screening Questionnaire to assess for trauma exposure, but with additions to account for the proposed traumatic stressor changes in the DSM-5 PTSD criteria. Although 67 percent of participants reported at least one traumatic event on the basis of the DSM-IV PTSD trauma classification, 59 percent of participants would meet the DSM-5's proposed trauma classification for PTSD. They concluded that estimates of PTSD prevalence would be 0.4-1.8 percent higher for the DSM-5 versus the DSM-IV.

Excoriation (skin-picking) disorder

This diagnosis, new to the DSM-5, is listed in the chapter on obsessive-compulsive and related disorders, which also contains obsessive-compulsive disorder (OCD), body dysmorphic disorder, hoarding disorder and trichotillomania (hair-pulling disorder).

Diagnostic features for excoriation include compulsive skin picking at multiple body sites, including the face, arms and hands, and using objects such as tweezers, pins, scissors and fingernails. Individuals may be triggered by feelings of anxiety, boredom, distress or tension and will spend several hours per day for months or even years picking at skin.

To meet the diagnostic criteria for excoriation disorder, individuals must spend a minimum of one hour per day picking, thinking about picking and resisting urges to pick their skin. Some of these individuals may engage in rituals with skin and scabs that cause damage, scarring and infection. Ironically, pain is not routinely reported in these individuals.

According to the DSM-5, excoriation disorder has a high correlation with OCD. The dermatopathological diagnosis is rarely required because skin lesions are clearly identifiable, and most individuals who engage in it admit to skin picking. Excoriation disorder is not to be diagnosed if it occurs in response to a psychotic disorder, is not tic-like as displayed in Tourette's disorder and is not to be confused with nonsuicidal self-injury, which typically has an intentional, noncompulsive, psychopathological expectation resulting from interpersonal difficulties (see the DSM-5, pages 803-806).

Latest research

Last year, Christine Lochner and colleagues found that in individuals with excoriation disorder, their skin picking persisted despite repeated attempts to decrease or stop, and their recurrent skin picking resulted in skin lesions. “Urges” or “the need” to pick were not endorsed by all study subjects, but this behavior did correlate with severity of skin picking; “resistance” to picking was not universally endorsed either.

The researchers found that although most study participants had urges to pick or a sense of relief when picking, such phenomena were not universal and should not be included in the DSM-5 diagnostic criteria set. They suggested that an additional criterion of repeated attempts to decrease or stop skin picking seemed warranted.

Mary

OK, back to my client. The most important thing I want to emphasize is how I used the new DSM-5 assessment measures and textual description to detect Mary’s PTSD and skin-picking diagnoses. I found the new diagnostic system very comprehensive and friendly to clinicians.

With the DSM-5’s new dimensional framework, I conceptualized Mary’s excoriation as an extension, or manifestation, of her PTSD. What I mean by this is that during my clinical interview and use of differential procedures, I determined that her skin picking was directly related to her unresolved trauma. It was a coping mechanism that she began using shortly after her first (of many) trauma triggers at age 6.

Using the DSM-IV multi-axial system, Mary’s diagnoses would have been conceptualized and communicated as the following:

- Axis I: Posttraumatic stress disorder, chronic
Excoriation (skin-picking) disorder

The limitation to this coding and reporting system is that it gives the impression that excoriation disorder is independent of PTSD, essentially fragmenting her treatment plan.

With the DSM-5’s new dimensional classification and coding system, however, Mary’s diagnoses is reported as the following:

- Posttraumatic stress disorder, with excoriation (skin picking) disorder presentation
- This method of classification indicates that excoriation disorder is connected to Mary’s PTSD, thus promoting clinical utility by informing her treatment plan and assisting with prognostic and outcome factors.

Thanks for reading my experiences with use of the DSM-5. Until next month, be well.

Bio

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