Deconstructing the DSM-5

By Jason H. King

Assessment and diagnosis of obsessive-compulsive and related disorders

In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the obsessive-compulsive and related disorders chapter is a new addition containing obsessive-compulsive disorder (moved from the DSM-IV-TR *anxiety disorders* chapter), body dysmorphic disorder (moved from the DSM-IV-TR *somatoform disorders* chapter), hoarding disorder (new for DSM-5), trichotillomania (hair-pulling) disorder (moved from the DSM-IV-TR *other impulse control disorders* chapter), and excoriation (skin-picking) disorder (new for DSM-5).

This reorganization of previous DSM-IV-TR disorders and integration with new DSM-5 disorders represents a grouping of similar clinical profiles characterized by repetitive or ritualistic behaviors, uncontrollable urges, intrusive mental images, and preoccupation with distressing thoughts.

Anxiety is prominent in the obsessive-compulsive and related disorders. However, the anxiety presentation in these disorders differs from the anxiety presentation in the fear and phobic-based disorders listed in the DSM-5 *anxiety disorders* chapter. The anxiety manifest from the obsessive-compulsive and related disorders is usually tension building, behavioral activation focused, non-phobic stimulus driven, and non-physiologically arousing; whereas the anxiety disorders are usually more restlessness in nature, behavioral avoidance focused, phobic stimulus driven, and physiologically arousing.

Finally, obsessive-compulsive and related disorders differ neurobiologically from anxiety disorders in that the basal ganglia tends to be dysregulated. This collection of subcortical nuclei located in the limbic system of the brain controls voluntary motor movements, routine behaviors, cognition, and emotion.

Obsessive-compulsive disorder (OCD)

This disorder received some moderate changes in DSM-5. First, DSM-IV-TR Criterion A1 language "…thoughts, *impulses*, or images…" and "intrusive and *inappropriate*" is changed in DSM-5 to read "thoughts, *urges*, or images…" and "intrusive and *unwanted*."

The rationale for these two word changes is that individuals with OCD do not act impulsively, such as manifest by individuals with ADHD or bipolar disorder, but rather they act to get relief from a progressive urge; and the clinical focus needs to address what is subjectively distressing for the individual, rather than what is judgmentally determined inappropriate by the counselor.

Second, DSM-5 removed DSM-IV-TR Criterion A2 and A4 for obsessions, and Criterion B:

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2. The thoughts, impulses, or images are not simply excessive worries about real-life problems. This was removed because it is assumed in making a diagnosis of a psychopathological condition, hence it was redundant.

4. The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion). This was assumed into an expansion of the DSM-IV-TR insight specifier.

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable (Note: This does not apply to children). This was assumed into an expansion of the DSM-IV-TR insight specifier.

Third, DSM-5 expanded the DSM-IV-TR *insight* specifier for OCD. Counselors can now indicate *with good or fair insight* in which the individual can entertain that their mental intrusion or catastrophic belief is definitely or probably not true. For example, the individual believes that the house definitely will not, probably will not, or may or may not burn down if the stove is not checked 30 times.

The DSM-IV-TR *with poor insight* specifier, in which the individual believes their mental intrusion or catastrophic belief is probably true, is retained in DSM-5. For example, the individual believes that the house will probably burn down if the stove is not checked 30 times.

Finally, counselors can now indicate *with absent insight/delusional beliefs* in which the individual is completely convinced their mental intrusion or catastrophic belief is true. For example, the individual is convinced that the house will burn down if the stove is not checked 30 times. Research estimates that 4% or less of individuals with OCD will qualify for *with absent insight/delusional beliefs* specifier.

Katharine Phillips, M.D., former chair of the DSM-5 Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group, provided helpful context as to why *with absent insight/delusional beliefs* specifier was added. In a February 15, 2013 interview with *Psychiatric News* (doi: 10.1176/appi.pn.2013.2b39), she said "clinical experience suggests that patients with delusional beliefs as a symptom of one of these [obsessive-compulsive related] disorders are sometimes diagnosed with a psychotic disorder, which may lead to inappropriate treatment with antipsychotic medication only.

The specifier will emphasize that patients with delusional beliefs that may occur as a symptom of these disorders do have OCD or body dysmorphic disorder or hoarding disorder. Those with OCD and body dysmorphic disorder should be treated with an SSRI rather than antipsychotic monotherapy."

Fourth, DSM-5 added a *tic-related* specifier to identify individuals with a current or past comorbid tic disorder, because this comorbidity may have important clinical implications related to themes of OCD symptoms, comorbidity, course, and pattern of familial

transmission. Research estimates that about 30% of individuals diagnosed with OCD will qualify for this specifier at some point during their lifespan.

Counselors are reminded to use the DSM-5 Level 2—Repetitive Thoughts and Behaviors Cross-Cutting Symptom Measure located at www.psychiatry.org/dsm5. This measure is an adaptation of the Florida Obsessive Compulsive Inventory Severity Scale and is available for children ages 11-17 and adults ages 18+.

Because body dysmorphic disorder, hoarding disorder, trichotillomania (hair-pulling) disorder, and excoriation (skin-picking) disorder are "related" to OCD, this measure can be used for symptom severity determination. Counselors are reminded to review the other specified obsessive-compulsive and related disorders in this chapter that present similar OCD syndromes, such as obsessional jealousy.

Body dysmorphic disorder

In DSM-5, Criterion A now includes language to address "*flaws…that are not observable or appear slight to others*." Criterion B is new for DSM-5 and anchors this disorder as OCD related: "*At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns*." Criterion D is changed in DSM-5 to exclude any eating disorder as opposed to excluding only anorexia nervosa as found in DSM-IV-TR. Body dysmorphic disorder now has two available specifiers: (1) the same OCD insight specified discussed previously and (2) with muscle dysmorphia to indicate the individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular. Counselors are reminded to review the other specified obsessive-compulsive and related disorders in this chapter that present similar body-focused syndromes, such as body dysmorphic–like disorder with actual flaws, body dysmorphic–like disorder without repetitive behaviors, body-focused repetitive behavior disorder, shubo-kyofu, koro, and jikoshu-kyofu.

Hoarding disorder

In DSM-IV-TR, hoarding is listed as one of the diagnostic criteria for obsessive-compulsive personality disorder (OCPD), and when hoarding is extreme, the manual encourages counselors to consider a diagnosis of OCD that may be comorbid with OCPD. Now in DSM-5, hoarding is a genetically discrete, strongly heritable disorder that includes difficulty discarding, urges to save, clutter, excessive acquisition, indecisiveness, perfectionism, procrastination, disorganization, and avoidance. Neuroimaging and neuropsychological studies from Dr. Sanjaya Saxena, lead author and director of the Neuropsychiatric Institute's OCD Program at the University of California, San Diego, indicate that hoarding is neurobiologically distinct from OCD and implicate dysfunction of the anterior cingulate cortex and other ventral and medial prefrontal cortical areas that mediate decision-making, attention, spatialorientation, memory, and emotional regulation (Neurobiology and Treatment of Compulsive Hoarding, *CNS Spectrums*, 2008, pages 29-36).

DSM-5 hoarding disorder is characterized by persistent difficulty discarding or parting with possessions, including animals. The intentional clutter or congest of objects or animals must be clinically significant, excessive, cause long standing difficulty, and result in substantially compromising the intended purpose of active living areas (more peripheral areas, such as garages, attics, or basements are not included). Individuals with hoarding disorder typically experience distress if they are unable to or are prevented from acquiring items. Deleterious consequences of hoarding include emotional, physical, social, financial, legal, or unsanitary conditions. Hoarding disorder contrasts with normative collecting behavior, which is organized and systematic, and normative collecting does not produce the clutter, distress, or impairment typical of hoarding disorder.
Hoarding disorder has two available specifiers: (1) the same OCD insight specified discussed previously and (2) *with excessive acquisition* to classify individuals who engage in disproportionate buying, followed by acquisition of free items (e.g., leaflets, items discarded by others). Research estimates that about 80%-90% of individuals with hoarding disorder will qualify for this specifier.

Trichotillomania (hair-pulling) disorder
For DSM-5, Criterion A is retained as presented in DSM-IV-TR. Criterion B from DSM-IV-TR is changed from "*An increasing sense of tension immediately before pulling out the hair or when attempting to resist the behavior*" to "*Repeated attempts to decrease or stop hair pulling*" in DSM-5. DSM-IV-TR Criterion C "*Pleasure, gratification, or relief when pulling out the hair*" is removed and additional exclusionary criteria distinguishing trichotillomania from other mental disorders (e.g., body dysmorphic disorder) is added.

Excoriation (skin-picking) disorder
See my October 2013 *Counseling Today* article titled "Assessment and diagnosis of PTSD and skin-picking disorder" for discussion of this new DSM-5 disorder.

Case study: JoAnn
JoAnn, a 43-year-old woman who lived alone in her house, presented for counseling after being referred by her daughter. She described her current hoarding behavior as "difficulty throwing things away" and "going on frequent shopping sprees." JoAnn's difficulties with organization and discarding of her possessions had resulted in a clutter-filled environment in her home (see DSM-5 page 248 for a clinical definition of *clutter*). As a result, her main disability was complete social isolation due to embarrassment about others seeing her home in this state. JoAnn's symptoms of hoarding had waxed and waned since childhood. Her problems with severe hoarding began to worsen since moving into her home 14 years ago, and continued to worsen in the last 6 years. Her family history was significant for hoarding behaviors in her mother and maternal grandmother.
JoAnn's house consisted of four bedrooms, two and one-half baths, and a den. The volume of cluttered possessions took up the majority of the living space with clutter as high as four feet in some areas. No rooms in the house could be used for their intended purpose, especially the kitchen. Getting around the house was only partially possible by using trails, as tables, chairs, couches, and floors were almost completely covered with items. JoAnn's hoarded possessions included newspapers, magazines, bills, videos, pictures, clothing

items, and musical instruments, books, leaflets, and notes. She had not allowed people to visit her home in many years, causing her to lose touch with many friends and relatives. On the DSM-5 Level 2—Repetitive Thoughts and Behaviors Cross-Cutting Symptom Measure, JoAnn's responses produced an average total score of 3.2, indicating a *severe* rating of symptom intensity. On the WHODAS 2.0 (World Health Organization Disability Assessment Schedule 2.0) 36-item version, self-administered, JoAnn's average domain score was 4.8, indicating a *severe-extreme* disability rating. Putting it all together, JoAnn's DSM-5 diagnostic formulation was written in this manner:

- Severe-extreme disability per WHODAS
- V60.3 Problem Related to Living Alone (chronic feelings of loneliness, isolation, and lack of structure in carrying out activities of daily living)
- 300.3 Severe Hoarding Disorder, With Excessive Acquisition, With Absent Insight/Delusional Beliefs

Until next month, be well!

Bio

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