

# Deconstructing the DSM-5

By Jason H. King

## Assessment and diagnosis of dissociative and trauma- and stressor-related disorders

According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), “Dissociative disorders are frequently found in the aftermath of trauma, and many of the symptoms, including embarrassment and confusion about the symptoms or a desire to hide them, are influenced by the proximity to trauma” (page 291).

For this reason, the dissociative disorders are a “neighboring” diagnostic category with the trauma and stressor-related disorders in the new manual chapter sequencing. The DSM-5 dissociative disorders chapter contains dissociative identity disorder, dissociative amnesia, depersonalization/derealization disorder and other specified dissociative disorder.

## The new landscape

Significant modifications were made to dissociative identity disorder in the DSM-5. The Criterion A focus on two or more distinct personality states being manifest in the client is retained from the DSM-IV-TR. However, the DSM-5 replaces the phrase “each with its own relatively enduring pattern of perceiving, relating to and thinking about the environment and self” with the phrase “which may be described in some cultures as an experience of possession.”

Also new to the diagnostic criteria is identity disruption in the individual, which is evidenced by discontinuity in sense of agency and alterations in sensory-motor functioning, affect, behavior, consciousness, memory, perception or cognition. This new Criterion A contains elements from the DSM-IV-TR’s Criterion B and Criterion C descriptions. Symptoms of identity disruption may be reported by the client or observed by the counselor.

The new Criterion B addresses recurrent memory gaps in everyday events, important personal information and trauma events that are independent of common forgetfulness. Criterion D provides an exclusion that the individual’s identity disturbance is not part of a cultural or religious normative practice.

The DSM-5 retains the diagnostic note stating that childhood imaginary or fantasy play is not indicative of the disorder. The DSM-5 also contains text modifications that clarify the nature and course of trauma-induced identity disruptions as displayed in children, adolescents, older individuals, females and males.

Finally, the DSM-5 includes an important suicide risk note for this disorder: “Over 70% of outpatients with dissociative identity disorder have attempted suicide; multiple attempts are common, and other self-injurious behavior is frequent” (page 295). Although the DSM-5 proposes suicidal behavior disorder and nonsuicidal self-injury as conditions for further

study in Section III (pages 801-806), I advise counselors to consider suicidal and nonsuicidal self-injurious behaviors as symptoms related to major depressive disorder, posttraumatic stress disorder, dissociative identity disorder or borderline personality rather than independent clinical syndromes.

For dissociative amnesia, the disorder description is very similar to that found in the DSM-IV-TR. What is new in the DSM-5 is the following diagnostic note: “Dissociative amnesia most often consists of localized or selective amnesia for a specific event or events; or generalized amnesia for identity and life history” (page 298).

The disorder’s descriptive text was updated to include helpful conceptualization and treatment planning components that include trauma, child abuse and victimization history, as well as self-mutilation, suicide attempts and other high-risk behaviors.

Dissociative fugue disorder, included in the DSM-IV-TR, is “downgraded” to become a specifier for dissociative amnesia in the DSM-5. The independent diagnosis was redundant because dissociative amnesia already accounts for an individual’s inability to recall some or all information from his or her past, along with accompanying confusion about personality identity.

In the DSM-5, depersonalization disorder now includes the word “derealization” in its title. This addition took place to improve clinical conceptualization and to promote recognition that individuals with trauma backgrounds may experience either or both syndromes. The DSM-5 replaces the DSM-IV-TR phrase “mental processes” by using “with respect to one’s thoughts, feelings, sensations, body or actions” in Criterion A1

For Criterion A2, derealization diagnostic criteria requires the following: “Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless or visually distorted).”

Regarding differential diagnosis, counselors are reminded that even though borderline personality disorder may present with transient, stress-related paranoid ideation or severe dissociative symptoms, depersonalization symptoms are generally of insufficient severity or duration to warrant an additional diagnosis.

## Assessment

Counselors can use “An office mental status examination for complex chronic dissociative symptoms and multiple personality disorder” by Richard J. Loewenstein (published in the September 1991 edition of *Psychiatric Clinics of North America*). His psychopathological symptoms and assessment questions include the following:

### Blackouts/time loss

- Do you ever have blackouts, blank spells or memory lapses?
- Do you lose time?

### Disremembered behavior

- Do you find evidence that you have said and done things that you do not recall?
- Do people tell you of behavior you have engaged in that you do not recall?

### Fugues

- Do you ever find yourself in a place and not know how you got there?

### Unexplained possessions

- Do you find objects in your possession (clothes, groceries, books) that you do not remember acquiring? Out-of-character items? Items a child might have?
- Do you find that objects disappear from you in ways for which you cannot account?
- Do you find writings, drawings or artistic productions in your possession that you must have created but do not recall creating?

### Inexplicable changes in relationships

- Do you find that your relationships with people frequently change in ways that you cannot explain?

### Fluctuations in skills/habits/knowledge

- Do you find that sometimes you can do things with amazing ease that seem much more difficult or impossible at other times?
- Does your taste in food, music or personal habits seem to fluctuate?
- Does your handwriting change frequently? A little? A lot? Is it childlike?
- Are you right-handed or left-handed? Does it fluctuate?

### Fragmentary recall of life history

- Do you have gaps in your memory of your life?
- Do you remember your childhood? When do those memories start? What is your first memory? What is your next memory? Next?

### Intrusion/overlap/interference (passive influence)

- Do you have thoughts or feelings that come from inside or outside you that don't feel like yours? Are they outside your control?
- Do you have impulses or engage in behaviors that don't seem to be coming from you?
- Do you hear voices, sounds or conversations in your mind?

### Negative hallucinations

- Do you ever not see/hear what's going on around you? Can you block out people or things altogether?

### Analgesia

- Are you able to block out physical pain? Wholly? Partly? Always? Sometimes?

### Depersonalization/derealization

- Do you frequently have the experience of feeling as if you are outside yourself or watching yourself as if you were another person?
- Do you ever feel disconnected from yourself or as if you were unreal?
- Do you experience the world as unreal? As if you are in a fog or daze?
- Do you ever look in the mirror and not recognize yourself?

### Trauma

- Who made the rules in your family and how were they enforced?
- Did you witness violence between family members?
- Have you ever had unwanted sexual contact with anyone? As a child? Teenager? Adult?
- As a child, what made you feel safe? Was anyone kind to or supportive of you?
- Flashbacks; intrusive symptoms; sight, sound, taste, smell, touch: Do you ever experience events that happened to you before as if they are happening now?
- Nightmares: how often, since when? Do you awaken disoriented? Find yourself somewhere else?
- Are there specific people, situations or objects that trigger you? Are these associated with time loss?
- Are you a jumpy person? Easily startled?
- Do you avoid people, situations or things that remind you of traumatic or overwhelming events? Can you block out feelings?

### Somatoform symptoms

- Do you ever get physical symptoms/pain that your doctors can't medically explain?

I recommend reading Bethany L. Brand and Richard J. Loewenstein's 2010 article "Dissociative disorders: An overview of assessment, phenomenology and treatment." For a phenomenal discussion about theoretical models and clinical utility of dissociation in trauma (with associated experience, reexperiencing and avoidance symptoms), I endorse Constance Dalenberg and Eve Carlson's 2012 article "Dissociation in posttraumatic stress disorder part II: How theoretical models fit the empirical evidence and recommendations for modifying the diagnostic criteria for PTSD," published in the journal *Psychological Trauma: Theory, Research, Practice and Policy*.

I also encourage counselors to review the International Society for the Study of Trauma and Dissociation website at [isst-d.org](http://isst-d.org) for helpful resources on this topic.

### Trauma and stressor-related disorders

This chapter in the DSM-5 contains reactive attachment disorder (RAD), disinhibited social engagement disorder, posttraumatic stress disorder (PTSD), acute stress disorder and adjustment disorders. I do not discuss PTSD this month because I wrote about that disorder in the October 2013 edition of *Counseling Today*.

RAD received a complete reconceptualization and expansion in the DSM-5. The DSM-IV-TR subtype "inhibited" was removed and assumed into the new disorder conceptualization. In

addition, the DSM-IV-TR subtype “disinhibited” was “upgraded” into an independent clinical syndrome: disinhibited social engagement disorder.

Evidence-derived criteria that defines two statistically and clinically distinct syndromes justified the change. Counselors who work with children presenting with these disorders may want to read Charles Zeanah and Mary Margaret Gleason’s 2010 article, “Reactive attachment disorder: Review for DSM-V.”

RAD differs from disinhibited social engagement disorder in that “the former is expressed as an internalizing disorder with depressive symptoms and withdrawn behavior, while the latter is marked by disinhibition and externalizing behavior” (page 265 of the DSM-5).

RAD is characterized by avoidant and disturbed attachment behaviors and a marked absence of seeking comfort from primary caretakers. Disinhibited social engagement disorder is characterized by indiscriminant behaviors that violate social boundaries of the child’s culture, yet it can be common for the child not to have any signs of disturbed attachment.

RAD requires that a minimum of five out of eight symptoms manifest prior to age 5 but no sooner than 9 months of age (the DSM-IV-TR required only two of five symptoms and did not include the restriction of being at least 9 months old). Disinhibited social engagement disorder requires that at least five of seven symptoms manifest after age 9 months (unlike with RAD, there is no requirement that symptoms manifest before age 5).

Developmental psychology research indicates that selective attachments become evident around 9 months of age; presence of this condition becomes important to distinguish normative from pathological symptoms. RAD and disinhibited social engagement disorder share the common trauma-stressor origin of repeated insufficient care during early childhood development.

Counselors may use the DSM-5 Early Development and Home Background Form—Parent/Guardian (located at [psychiatry.org/practice/dsm/dsm5/online-assessment-measures](http://psychiatry.org/practice/dsm/dsm5/online-assessment-measures)) to screen for early developmental trauma and current trauma-inducing home experiences. If children display symptoms of either disorder for more than 12 months, counselors use the specifier “persistent,” and they use the specifier “severe” when all possible symptoms are endorsed.

Acute stress disorder in the DSM-5 is conceptually intact from the DSM-IV-TR. The only changes include the following:

- Criterion C says “duration of the disturbance is three days to one month after trauma exposure” (previously required two days after trauma exposure). There is a new note for this criterion indicating that “symptoms typically begin immediately after the trauma, but persistence for at least three days and up to a month is needed to meet disorder criteria” (page 281).

- Criteria B, C, D and E are reorganized into five symptom clusters instead of descriptive paragraphs and require that nine of 14 symptoms are manifest to satisfy diagnostic criteria.

The DSM-IV-TR adjustment disorders, with their associated specifiers, are also conceptually intact in the DSM-5, but they find a new home in the trauma and stressor-related disorders chapter. Added to Criterion B1 is the phrase “taking into account the external context and the cultural factors that might influence symptom severity and presentation.”

Until next month, be well!

### Bio

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