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# Examining potential overlap of *DSM-5* PTSD criteria D and E

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ABSTRACT

The *Diagnostic and Statistical Manual, Fifth Edition-5* (*DSM-5*) has adopted a four-factor symptom model for Posttraumatic Stress Disorder (PTSD) that includes new symptom additions in criterion D (D2, D3, D4), negative alterations in cognition and mood. This article examines potential overlapping endorsement of these symptoms amongst one another and with the behavioral symptoms within PTSD criterion E (E1 and E3; alterations in arousal and reactivity), through the lenses of cognitive-behavioral theory. Responses of veteran participants (*N*=320) completing the PTSD Checklist-5 were used to determine overlap in symptom reporting. We conducted a series of direct logistic regressions to determine the predictive ability of meeting the criterion D or E symptoms based on endorsement of the target D symptoms (D2, D3, D4). Results suggest that the new cognitive and emotional symptoms of criterion D have significant overlapping content, and that thought-related symptoms are often endorsed in conjunction with their behavioral counterpoint (D2/E3; D4/E1). Our results suggest that *DSM-5* criterion D symptoms may not be central to the diagnostic structure of PTSD. These symptoms add complexity and difficulty to diagnosing PTSD without adding much unique content.

## 1. Introduction

The release of the *Diagnostic and Statistical Manual, Fifth Edition* (*DSM-5;* American Psychiatric Association, 2013) has garnered much attention, as it includes significant changes across various psychiatric disorders at both the nosology and symptom levels. Major modifications in *DSM-5* include but are not limited to re-clustering of chapters, changes in terminology, and the movement to a non-axil system (Regier et al., 2013).

At the disorder level, probably one of the most notable changes occurred within the anxiety disorders module with the removal of Posttraumatic Stress Disorder (PTSD) from the anxiety chapter. While controversial (Zoellner et al., 2011), this move was based on research (Friedman et al., 2011) in which it was concluded that PTSD no longer fit within the anxiety disorder spectrum, nor was it best captured as an internalizing disorder. Thus, a new chapter was created and titled “Trauma-and Stress-Related Disorders” to capture diagnoses that emerge following exposure to traumatic sequela.

Changes also were made to the PTSD symptom structure. Based on converging factor analytic research which supported a four, rather than three-factor structure (Yufik and Simms, 2010), negative alterations in cognition and mood were added as a new criterion D cluster. This factor comprises the *Diagnostic and Statistical Manual, Fourth Edition* (*DSM-IV*; American Psychiatric Association, 2000) criterion C symptoms, other than effortful avoidance (now *DSM-5* C1 and C2), and several new symptoms characteristic of general distress and dysphoria. These new *DSM-5* criterion D symptoms, specifically D2, D3, and D4 (see Table 1 for definitions), were added because they are characteristic of the cognitive errors, negative thinking, and negative emotions often seen in individuals with a PTSD diagnosis (Resick and Miller, 2009).

From both a practical and theoretical perspective, concerns about potential symptom overlap and how to avoid it arose with initial readings of the new PTSD criteria (Brewin et al., 2009). Unlike the *DSM-IV*, which utilized extensive field trials to examine the validity and reliability of proposed diagnostic criteria, the *DSM-5* field trials focused almost exclusively on test-retest reliability among diagnosticians, who are trained in differential diagnosis (Clarke et al., 2013; Friedman, 2013). Thus, these proposed symptom changes might pose complications for the line clinician assessing PTSD. In particular, the new criteria appear to provide many places where the double counting of symptoms can occur. This is especially true for clinicians trained in

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**Table 1**
PCL-5 items for target DSM-5 PTSD criterion D and E symptoms.

| PTSD criteria | PCL-5 item | Item wording | CBT- category |
|---|---|---|---|
| D2 | 9 | Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous) | Thought |
| D3 | 10 | Blaming yourself or someone else for the stressful experience or what happened after it | Thought |
| D4 | 11 | Having strong negative feelings such as fear, horror, anger, guilt or shame | Feeling |
| E1 | 15 | Irritable behavior, angry outbursts, or acting aggressively | Behavior |
| E3 | 17 | Being “superalert” or watchful or on guard | Behavior |

Note. PCL-5=PTSD checklist-5; PTSD=Posttraumatic Stress Disorder.

cognitive behavioral therapy (CBT; the basis of evidence based psychotherapy for PTSD), who hold that thoughts result in emotional and behavioral consequences. For example, in CBT an aggressive behavior cannot be devoid of angry thoughts and emotions.

The *DSM-5* attempts to differentiate criterion D and E symptoms when possible. For example, criterion E1 (irritable, angry, or aggressive behavior) is behavioral whereas D4 is emotional (pervasive negative emotional state, including anger). In spite of this, from a CBT theoretical perspective, overlap exists because having an aggressive E1 behavior necessitates having an angry D4 emotion. CBT would also suggest that treating any one of these components (e.g., D4 angry thought) would result in a decrease in the other related symptom (e.g., E1 aggressive behavior) because of this relationship (Persons et al., 2001). Well trained clinicians may prove successful at separating out these symptoms on their own accord or by using diagnostic instruments like the Clinician Administered PTSD Scale for *DSM-5* (CAPS-5; Weathers et al., 2013a). However, it currently is unclear whether clinicians who are not trained in diagnostic interviewing regularly use such instruments to achieve the highest level of symptom assessment. Moreover, this level of differentiation is likely impossible for a patient who is being asked to complete a self-report symptom checklist.

Despite research to suggest relatively comparable prevalence rates of PTSD from *DSM-IV* to *DSM-5* (Elhai et al., 2012; Calhoun et al., 2012; Kilpatrick et al., 2013), no studies to date have examined symptom overlap within the PTSD criterion D, overlap between D and E criteria, or how criterion symptom counts are affected by symptom overlap. Thus, the current study sought to examine three questions. First, how often are PTSD D2, D3, and D4 endorsed in conjunction with one another? Second, how does the coding of target criterion D symptoms impact the overall calculation of who meets the threshold of criterion D and is above diagnostic cut-score on the PCL-5? Third, how often are criterion D symptoms coded in conjunction with criterion E symptoms of similar content (i.e., D2/E3 and D4/E1)? We hypothesized that individuals given a self-report measure of PTSD symptoms would have higher levels of symptom overlap for criterion D, and that this would increase the odds of meeting both that criterion and a PTSD diagnosis. We also hypothesized that a majority of patients would endorse criterion D symptoms in conjunction with criterion E counterparts. Table 1 displays PCL-5 items for the target criteria D and E symptoms examined in this study.

## 2. Methods

Veterans (*N*=489) presenting to two Veterans Health Administration clinics were administered the CAPS-5 and PTSD Checklist for *DSM-5* (PCL-5; Weathers, et al., 2013b) as part of their treatment intake assessment upon presenting to a PTSD specialty clinic. The CAPS-5 was administered by doctoral-level psychologists who were extensively trained on the previous version, but did not have formal training on the CAPS-5. Regardless, the CAPS-5 was used to confirm a clinician-rated diagnosis of PTSD, resulting in a sample size of 320 veteran participants. Since the measures were administered as part of routine clinical assessment, no inter-rater reliability data were collected. The IRB approved use of these data for research purposes. To test whether the conceptual concerns noted about the *DSM-5* PTSD criteria actually occurred, we employed the PCL-5. The PCL-5 is a self-report measure that includes 20 questions that mirror each *DSM-5* PTSD symptom. A total-symptom score of zero to 80 can be obtained by summing the items (PTSD Checklist for DSM-5, 2015). Recent reports suggest that a cut-score of 33 is used to determine probable PTSD (PTSD Checklist for DSM-5, 2015). In addition to using the PCL-5 total-score, we dichotomized the items to result in presence or absence of symptom reporting. Reporting a two or more (moderately, quite a bit, or extremely) on the PCL-5 items resulted in presence, and reporting a zero or one (not at all, a little bit, respectively) resulted in absence. Of note, reliability statistics for the PCL-5 indicated adequate-to-excellent internal consistency for the PCL-5 total score (α=0.90) and subscale scores (intrusion α=0.83; avoidance α=0.80; negative alterations in cognitions/mood α=0.80; arousal α=0.77).

### 2.1. Data analytic plan

PCL-5 items corresponding to target PTSD criteria D (D2, D3, D4) and E (E1 and E3; Table 1) were used in our analyses. Crosstab analyses were used to determine how often PTSD criteria D2, D3, and D4 are endorsed in conjunction with one another. A series of direct logistic regressions were then used to determine the predictive ability of meeting the target criterion D symptoms, based on the endorsement of other target D symptoms. A second series of direct logistic regressions were conducted to determine the predictive ability of meeting the target criterion E symptom, based on endorsement of the target criterion D symptom counterpart. Finally, we calculated the proportion of veterans who would have met criterion D (two or more D symptoms endorsed) and were above the PCL-5 cut-score of 33, without endorsing one of the three target criterion D symptoms.

## 3. Results

### 3.1. Preliminary analyses

The mean age of the sample was 47.3 years (*SD*=16.5). Table 2 depicts all other demographic information. The mean PCL-5 total score was 54.13 (*SD*=13.0), with 296 (92.5%) of our sample having a total score above 33, the clinical cut-score suggested by the National Center for PTSD indicative of clinically significant levels of posttraumatic distress (PTSD Checklist for DSM-5, 2015). All but eight individuals (2.5%) from our sample met criterion D for PTSD on the PCL-5.

### 3.2. Primary analyses

In order to examine how often the new target criterion D symptoms were endorsed in conjunction with one another, a crosstab analysis was first computed. As expected, most individuals (e.g., between 62–76%) endorsed criteria D2, D3, and D4 in conjunction with one another (Table 3). Next, a series of three direct logistic regression equations were computed to determine the likelihood of endorsing one of the target criterion D symptoms, based on the endorsement of another new criterion D symptom. The first was performed to assess D3 and D2. The

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