# Deconstructing the DSM-5

By Jason H. King

## Assessment and diagnosis of depressive disorders and bereavement reactions

In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), depressive disorders are listed independently from the bipolar-related disorders because of the absence of manic or hypomanic symptoms and "the presence of sad, empty or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function" (page 155).

However, the depressive disorders are a neighboring chapter to bipolar-related disorders because "of symptomatology, family history and genetics" (page 123). For example, major depressive episodes commonly precede manic episodes in bipolar I disorder, and a current or past major depressive episode is required for a diagnosis of bipolar II disorder. Cyclothymic disorder contains numerous depressive symptoms that do not meet the criteria for a major depressive episode.

Included in the depressive disorders chapter in the DSM-5 are disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder (dysthymia) and premenstrual dysphoric disorder. This month's article will discuss each of the depressive disorders, with the exception of disruptive mood dysregulation disorder, which was reviewed in the November 2013 edition of Counseling Today.

## Major depressive disorder

The DSM-5 retains this classic psychiatric syndrome with virtually no changes from the DSM-IV-TR description. The only modification is addition of the word hopeless to Criterion A: "… (e.g., feels sad, empty, hopeless) …"

However, counselors are encouraged to carefully read the revised descriptive text for this disorder, especially as it relates to the culture-related diagnostic issues, gender-related diagnostic issues and suicide risk. Remember to use the online assessment measures for the depressive disorders to determine the symptom intensity levels of mild, moderate or severe.

These cross-cutting symptom severity measures, accessible at psychiatry.org/practice/dsm/dsm5/online-assessment-measures, include:

- Level 2—Depression—Adult (PROMIS Emotional Distress—Depression—Short Form)
- Level 2—Depression—Parent/Guardian of Child Age 6-17 (PROMIS Emotional Distress—Depression—Parent Item Bank)
- Level 2—Depression—Child Age 11-17 (PROMIS Emotional Distress—Depression—Pediatric Item Bank)
- Severity Measure for Depression—Adult (Patient Health Questionnaire [PHQ-9])
- Severity Measure for Depression—Child Age 11-17 (PHQ-9 modified for Adolescents [PHQ-A]—Adapted)

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An important change to major depressive disorder in the DSM-5 is removal of the former Criterion E that read: "The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms or psychomotor retardation."

The rationale for removing that criterion was threefold:
1) Many individuals who clearly met criteria for a major depressive episode were deprived of treatment because the diagnosis was restricted.

2) The DSM-IV-TR bereavement exclusion suggested that grief somehow protected someone from major depression.

3) The International Classification of Diseases (ICD) does not contain a bereavement exclusion, and the DSM-5 was revised with the overarching goal of harmonizing the two classifications as much as possible.

Essentially, this means counselors should default to the standard major depressive episode criteria when individuals present with clinical symptoms resulting from significant loss, including bereavement, financial ruin, losses from a natural disaster and a serious medical illness or disability.

Although the grieving process is natural and unique to each individual and shares some of the same features of depression, including intense sadness and withdrawal from customary activities, grief and depression are also different in important aspects.

With grief, painful feelings come in waves and are often intermixed with positive memories of the deceased; with depression, mood and ideation are almost constantly negative. In addition, with grief, self-esteem is typically preserved. With major depressive disorder, corrosive feelings of worthlessness and self-loathing are common.

I encourage counselors to read the DSM-5 footnote on page 161 to help them distinguish grief from a major depressive episode. In addition, page 289 provides an option for counselors to diagnose severe and persistent grief and mourning reactions lasting longer than 12 months as persistent complex bereavement disorder as an other specified trauma- and stressor-related disorder (see also pages 789-792).

Finally, counselors can reference uncomplicated bereavement, described on pages 716-717 in the DSM-5 chapter on "Other Conditions That May Be a Focus of Clinical Attention."

For enhanced diagnostic precision and targeted treatment planning, counselors can use six descriptive specifiers retained from the DSM-IV-TR and two new descriptive specifiers (see DSM-5 pages 184-188):

- With anxious distress (new)

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- With mixed features (new for the DSM-5; a "downgrade" from the DSM-IV-TR diagnosis)
- With melancholic features (retained from the DSM-IV-TR)
- With atypical features (retained)
- With psychotic features (retained)
- With catatonia (retained)
- With peripartum onset (formerly postpartum onset in the DSM-IV-TR)
- With seasonal pattern (retained)

Counselors may also use the retained DSM-IV-TR course specifiers, in partial remission and in full remission, as well as the severity specifiers, mild, moderate and severe.

## Persistent depressive disorder (dysthymia)

This disorder encompasses the DSM-IV-TR's former chronic specifier for a major depressive episode, which required the full criteria for a major depressive episode being met continuously for at least the past two years. Core diagnostic symptoms, with associated intensity, frequency and duration, are unchanged in the DSM-5.

I would remind counselors that major depression may precede persistent depressive disorder, major depressive episodes may occur during persistent depressive disorder, and early-onset (prior to age 21) persistent depressive disorder is strongly associated with personality disorders.

New to the DSM-5 are the following course and descriptive specifiers available for use with this disorder (see page 169 for the complete description):
• With pure dysthymic syndrome
• With persistent major depressive episode
• With intermittent major depressive episodes, with current episode
• With intermittent major depressive episodes, without current episode

## Premenstrual dysphoric disorder

This disorder was listed in DSM-IV-TR Appendix B: Criteria Sets and Axes Provided for Further Study. Almost 20 years of additional research on this condition has confirmed a specific and treatment-responsive form of depressive disorder with a marked impact on functioning that begins sometime following ovulation and remits within a few days of menses.

Premenstrual syndrome is defined as recurrent moderate psychological and physical symptoms that occur during the luteal phase of menses and resolve with menstruation. It affects 20 to 32 percent of premenopausal women. Women with premenstrual dysphoric disorder experience affective or somatic symptoms that cause severe dysfunction in social or occupational realms. The disorder affects 3 to 8 percent of premenopausal women.

According to C. Neill Epperson and colleagues' article "Premenstrual dysphoric disorder: Evidence for a new category for DSM-5," published in the May 2012 edition of The

American Journal of Psychiatry, the DSM-5 Mood Disorders Work Group charged a panel of experts in women's mental health to 1) evaluate the previous criteria for premenstrual dysphoric disorder, 2) assess whether there was sufficient empirical evidence to support its inclusion as a diagnostic category and 3) comment on whether the previous diagnostic criteria were consistent with the additional data that had become available.

The work group included eight individuals from various countries, six of whom possessed specialty expertise in premenstrual dysphoric disorder or reproductive mood disorders. The panel thoroughly vetted the literature, leading to its recommendation that premenstrual dysphoric disorder be moved from the appendix and classified as a diagnosis in the depressive disorders section of the DSM-5.

To be a diagnosable condition, an individual must have a minimum of five of the 11 available symptoms for a duration of one year. To help properly diagnose this condition, I encourage counselors to carefully read the descriptive text in the DSM-5 to understand the antecedent validators (familial aggregation), concurrent validators (biological markers) and predictive validators (response to treatment and course of illness).

I further recommend review of M. Kathleen Lustyk and W.G. Gerrish's "Premenstrual syndrome and premenstrual dysphoric disorder: Issues of quality of life, stress and exercise" (spu.edu/depts/spfc/happenings/documents/chap115.pdf).

Regarding valid and reliable psychometric assessment procedures, counselors can use a number of scales, including Jean Endicott and Wilma Harrison's Daily Record of Severity of Problems (DRSP). The DRSP provides sensitive, reliable and valid measures of the symptoms and impairment criteria for premenstrual dysphoric disorder.

The DRSP aligns with the 11 diagnostic criteria listed in the DSM-5. It also aligns with Criterion F, which requires confirmation of Criterion A by prospective daily ratings during at least two symptomatic cycles. Counselors can download the DRSP at lindnercenterofhope.org/Portals/0/drsp_month.pdf.

In addition, Meir Steiner and David Streiner's Visual Analogue Scales for Premenstrual Mood Symptoms is commonly used in clinical trials for premenstrual dysphoric disorder. Finally, Steiner and colleagues' Premenstrual Tension Syndrome Rating Scale, which features a self-report and an observer version, is widely used to measure illness severity in women who have premenstrual dysphoric disorder.

## Case study: Andrew

Andrew is a 14-year-old male who presented with long-term depression and anxiety symptoms, resulting in family relationship disruption, school challenges and impaired social/peer interactions. What follows is a letter I drafted for his physician in support of psychotropic medication treatment.

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Per a clinical interview and testing using a variety of psychological instruments (Youth Outcome Questionnaire, Millon Adolescent Clinical Inventory, the SNAP-IV Rating Scale and the DSM-5 Level 2—Depression—Child Age 11–17 and Parent), I have diagnosed Andrew with the following DSM-5 disorder:

• 300.4 Persistent depressive disorder (dysthymia), early onset, with atypical features (mood reactivity, hypersomnia and a long-standing pattern of extreme sensitivity at perceived interpersonal rejection), with anxious distress (feeling unusually restless, difficulty concentrating because of worry), with pure dysthymic syndrome, severe

Andrew has engaged with me in psychotherapy off and on for the past 18 months and remains committed to future treatment. My recommendation is that he be prescribed Wellbutrin to target his co-occurring depressive and anxiety symptoms, and to assist with attention abilities.

I have tested Andrew for ADHD (using the Conners Continuous Performance Test), and he presents with some mild symptoms in the inattentive domain, but not enough to warrant a diagnosis. Andrew also presents with mood fluctuations, some of which are characteristic of hypomanic features, but not sufficient for a bipolar diagnosis.

If Andrew is nonresponsive to Wellbutrin, I am supportive he try a selective serotonin reuptake inhibitor (e.g., Celexa) and second-generation antipsychotic (e.g., Abilify) combination to augment his chronic depressive mood treatment. Please note that Andrew does not present with suicide intent/self-injurious behaviors, psychotic symptoms and substance abuse.

Until next month, be well!

## Bio

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