

## DECONSTRUCTING THE DSM-5

By Jason H. King

### ASSESSMENT AND DIAGNOSIS OF SCHIZOPHRENIA SPECTRUM DISORDERS

Happy New Year as you engage in your counseling, research, supervision or educational endeavors. I want to kick off 2014 by talking about schizophrenia spectrum and other psychotic disorders in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The new manual presents a fundamental shift in conceptualization and diagnostic classification of these disorders.

### THE NEW LANDSCAPE

You may notice the word “spectrum” has been added to the general classification title. This change was intended to capture the widespread sharing of symptoms and risk factors across the psychotic disorders and to highlight clinical reality and symptom heterogeneity between psychotic disorders.

This past year, Stephen Heckers and colleagues discussed this in their Schizophrenia Research article “Structure of the psychotic disorders classification in DSM-5” (see [ccpweb.wustl.edu/pdfs/2013dsm2\\_DB.pdf](http://ccpweb.wustl.edu/pdfs/2013dsm2_DB.pdf)). They noted that psychotic disorders are heterogeneous and that no single symptom (such as hallucinations or delusions) is pathognomonic, or distinctively characteristic.

Hence, in the DSM-5, categorical assessment, especially of schizoaffective bipolar type and bipolar with psychotic features, is complemented with a dimensional assessment of psychosis that allows for more specific and individualized client evaluation. This is because the level, the number and the duration of psychotic signs and symptoms are used to demarcate psychotic disorders. The severity of mood symptoms in psychosis has prognostic value and guides treatment.

Despite the new dimensional conceptualization of psychotic disorders, they are retained as categorical disorders because, as described in the DSM-5, “the DSM-5 taskforce recognized that it is premature scientifically to propose alternative definitions for most disorders. The organizational structure is meant to serve as a bridge to new diagnostic approaches without disrupting current clinical practice or research.”

This is especially relevant with schizoaffective disorder. In their article “Schizoaffective disorder in the DSM-5” found in Schizophrenia Research (see [ccpweb.wustl.edu/pdfs/2013dsm\\_SR.pdf](http://ccpweb.wustl.edu/pdfs/2013dsm_SR.pdf)), Dolores Malaspina and colleagues explained that schizoaffective disorder is controversial because of poor reliability, low stability, weak validity and excessive application in practice. Even the DSM-5 acknowledges “there is growing evidence that schizoaffective disorder is not a distinct nosological category.”

King, J. H. (January 2014). Deconstructing the DSM-5: Assessment and diagnosis of schizophrenia spectrum disorders. *Counseling Today*, 56(7), 12-14.

However, the new manual recognizes the clinical utility in maintaining a diagnosis that is important to counselors who are addressing the middle ground between fully psychotic disorders with no affective symptoms during the psychotic episode (i.e., schizophrenia disorder) and fully affective disorders with no psychotic symptoms during the mood episode (i.e., bipolar II disorder).

In 2013, Victoria Cosgrove and Trisha Suppes published “Informing DSM-5: Biological boundaries between bipolar I disorder, schizoaffective disorder and schizophrenia” in *BMC Medicine* (see [biomedcentral.com/1741-7015/11/127](http://biomedcentral.com/1741-7015/11/127)). For the DSM-5, existing nosological boundaries between bipolar disorder and schizophrenia were retained. In addition, schizoaffective disorder was preserved as an independent diagnosis because the biological data are not yet compelling enough to justify a move to a more neurodevelopmentally continuous model of psychosis.

The authors also noted that family studies suggest a clear genetic link between all three disorders. Most important, hallucinations and delusions are typically considered the hallmark of schizophrenia, but mood fluctuations are central to bipolar disorder. Although bipolar mood episodes may have an inherent episodic rhythm, all three disorders can all be chronic, lifelong conditions that cause significant functional impairment.

Yet, the symptoms of bipolar disorder, but not schizophrenia, are often responsive to mood stabilizing medications such as lithium and other anticonvulsants. Because of this “top-down” effect in which antipsychotic medications are used to treat both schizophrenia and bipolar disorders, the DSM-5 lists bipolar-related disorders in sequence after schizophrenia disorders.

In addition, schizoaffective disorder is listed as the final psychotic disorder in the schizophrenia spectrum disorders chapter because it serves as a bridge to the bipolar-related disorders chapter in the DSM-5.

#### ASSESSMENT MEASURES

If you work with clients presenting with psychotic disorders or teach counselor education students, I strongly encourage you to read the “Key Features That Define the Psychotic Disorders” on pages 87-88 of the DSM-5. Also critical to read is discussion of the new Clinician-Rated Assessment of Symptoms and Related Clinical Phenomena in Psychosis (pages 89-90). This section describes the heterogeneity of psychotic disorders and the dimensional framework for the assessment of primary symptom severity within the psychotic disorders.

You will then want to read pages 742-744 to learn about proper use of the new Clinician-Rated Dimensions of Psychosis Symptom Severity (CRDPSS) to help with treatment planning and prognostic decision-making. The CRDPSS is an eight-item measure that

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assesses the severity of mental health symptoms that are important across psychotic disorders. These symptoms include delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, negative symptoms (i.e., restricted emotional expression or avolition), impaired cognition, depression and mania.

Psychosis symptoms are rated on a five-point scale: not present, equivocal (severity or duration not sufficient to be considered psychosis), mild (little pressure to act, not very bothered by symptoms), moderate (some pressure to respond or somewhat bothered by symptoms) and severe (severe pressure to respond to voices or very bothered by voices).

To track changes in your client's symptom severity over time, the CRDPSS may be completed at regular intervals as clinically indicated, depending on the stability of your client's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for your client that might warrant further assessment, treatment and follow-up. Of course, clinical judgment should guide decision-making procedures, and counselors must adhere to the following:

- The 2009 Council for Accreditation of Counseling and Related Educational Programs Standards related to social and cultural factors when assessing clients
- The 2011 American Mental Health Counselors Association (AMHCA) Standards for the Practice of Clinical Mental Health Counseling, particularly knowledge and skills related to specialized clinical assessment (see B.1.d., B.5.-B.7.)
- The ACA Code of Ethics or AMHCA's code of ethics specific to assessment and diagnostic practices

According to the DSM-5, proper use of the CRDPSS may include clinical neuropsychological assessment (especially of client cognitive functioning) to help guide diagnosis and treatment. Counselor assessment of client cognition, depression and mania symptom domains can further assist with making critically important distinctions between the various schizophrenia spectrum and other psychotic disorders.

#### CLINICAL DIAGNOSTIC CHANGES

With the DSM-5, the traditional five schizophrenia subtypes (catatonic, disorganized, paranoid, residual and undifferentiated) are no longer used to specify psychotic presentations. This is because the DSM-5 represents a shift from categorical or dichotomous-oriented classification to dimensional or spectrum-oriented classification, such as previously discussed with use of the CRDPSS.

Other reasons for removing the subtypes:

- They lack significant clinical utility (see the 2009 article “Are There Valid Subtypes of Schizophrenia? A Grade of Membership Analysis” in *Psychopathology*).
- The majority of clients with schizophrenia received the paranoid subtype (diluting the need for other subtypes).
- These subtypes have not exhibited distinctive patterns of treatment response or longitudinal course.
- Catatonia (marked psychomotor disturbance such as unresponsiveness to agitation) is now a specifier that can be used outside of schizophrenia spectrum and other psychotic disorders, such as with neurodevelopmental disorders, bipolar disorders, depressive disorders, neurocognitive disorders, medical disorders and as a side effect of some psychotropic medications. For clients to receive this specifier, three of 12 symptoms must be present (without a specific time duration or frequency).

Also new to the DSM-5 are descriptive and course specifiers applicable after 12 months to all schizophrenia spectrum and other psychotic disorders except for brief psychotic disorder (subsides after one month) and schizophreniform disorder (replaced with schizophrenia disorder after a duration of six months). These specifiers include the following:

- First episode, currently in acute episode (symptom criteria are fulfilled)
- First episode, currently in partial remission (symptom criteria are not fully fulfilled)
- First episode, currently in full remission (symptom criteria are not present)
- Multiple episodes, currently in acute episode
- Multiple episodes, currently in partial remission
- Multiple episodes, currently in full remission
- Continuous (subthreshold symptom periods being very brief relative to the overall course)
- Unspecified

Schizotypal (personality) disorder is now cross-listed in the schizophrenia spectrum and other psychotic disorders chapter.

Criterion A for delusional disorder no longer requires delusions to be nonbizarre. A specifier for bizarre-type delusions provides continuity with the DSM-IV-TR. The demarcation of delusional disorder from psychotic variants of obsessive-compulsive

disorder and body dysmorphic disorder is explicitly noted in the DSM-5 with a new exclusion criterion stating that the symptoms must not be better explained by these conditions.

The DSM-5 no longer separates delusional disorder from shared delusional disorder. If criteria are met for delusional disorder, then that diagnosis is made. If the diagnosis cannot be made but shared beliefs are present, then the diagnosis “other specified schizophrenia spectrum and other psychotic disorder” is used.

The DSM-5 now requires brief psychotic disorder, schizophreniform disorder and schizophrenia disorder to include at least one positive symptom (for example, delusions, hallucinations or disorganized speech) in addition to disorganized or catatonic behavior. The DSM-5 also eliminates the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations (for example, two or more voices conversing) due to the nonspecificity of these symptoms and the poor reliability in distinguishing bizarre from nonbizarre delusions.

According to the American Psychiatric Association, the primary change to schizoaffective disorder is the requirement that a major mood episode be present for a majority of the disorder’s total duration after Criterion A is met. This change was made on both conceptual and psychometric grounds, making schizoaffective disorder a longitudinal instead of cross-sectional diagnosis (more comparable with schizophrenia, bipolar disorder and major depressive disorder, which are bridged by this condition).

The change was also made to improve the reliability, diagnostic stability and validity of the disorder, while recognizing that the characterization of clients with both psychotic and mood symptoms, either concurrently or at different points in their illness, is a clinical challenge.

The other specified schizophrenia spectrum and other psychotic disorder diagnosis includes the following:

- Persistent auditory hallucinations
- Delusions with significant overlapping mood episodes
- Attenuated psychosis syndrome (also see DSM-5 pages 783-786)
- Delusional symptoms in partner of individual with delusional disorder

Cultural and socioeconomic factors must be considered during your client’s assessment and diagnostic process, including sensitivity to emotional expression, eye contact, body language, and visual or auditory hallucinations with a religious content. The DSM-5’s life

span developmental focus informs counselors that in children, delusions and hallucinations may be less elaborate than in adults, while visual hallucinations are more common and should be distinguished from normal fantasy play.

Overall, these changes should improve diagnosis and characterization of your clients with psychotic disorders, while facilitating measurement-based treatment and permitting a more precise future delineation of the schizophrenia spectrum and other psychotic disorders (for more information, see the Schizophrenia Research article “Definition and description of schizophrenia in the DSM-5” at [ccpweb.wustl.edu/pdfs/2013\\_defdes.pdf](http://ccpweb.wustl.edu/pdfs/2013_defdes.pdf)).

#### SAMPLE DSM-5 DIAGNOSIS

When formulating clinical impressions, be sure to conduct a thorough mental status examination and rule out substance intoxication, traumatic brain injury, neurocognitive disorder and any associated general medical condition (for example, temporal lobe epilepsy). Psychotic syndromes may also temporarily be experienced when taking anticholinergic, cardiovascular and steroid drugs, depressant-like prescriptions and over-the-counter drugs.

Putting it all together produces the following potential diagnosis:

- Schizophrenia spectrum disorder, severe hallucinations, moderate delusions (erotomantic and persecutory), equivocal disorganized speech, moderate abnormal psychomotor behavior, moderate negative symptoms, continuous episode, currently in partial remission, without catatonia

A common misconception is that diagnosis of mental disorders classifies your clients, when in actuality what are being classified are disorders that your clients have. For this reason, the diagnostic manual avoids the use of “schizophrenic” and instead uses the more accurate designation “an individual with schizophrenia.” My best to you as 2014 begins.

#### BIO

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