

# Deconstructing the DSM-5

By Jason H. King

## Assessment and diagnosis of psychotic and bipolar-related disorders

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) retains the fourth edition's bipolar I, bipolar II and cyclothymic disorders. New language for the DSM-5 indicates that adults with bipolar I disorder have high rates of serious and/or untreated co-occurring medical conditions" (page 132).

In addition, bipolar II disorder "is no longer thought to be a 'milder' condition than bipolar I disorder, largely because of the amount of time individuals with this condition spend in depression and because the instability of mood experienced by individuals with bipolar II disorder is typically accompanied by serious impairment in work and social functioning" (page 123). Cyclothymic disorder is still considered to be a milder or subthreshold form of bipolar disorder in the DSM-5.

In the January issue of *Counseling Today*, I wrote about the nosological boundaries between bipolar-related disorders and schizophrenia spectrum disorder. This month, I want to expand that discussion and go deeper into the psychotic and bipolar-related disorders.

## The new landscape

The cardinal symptoms evident in manic and hypomanic episodes remain unchanged in the DSM-5. However, some important linguistic clarifications are added to curtail the trend of diagnosing children and adolescents with a bipolar-related disorder for manifesting impairing irritability, marked anger and physical aggression (read my November 2013 *Counseling Today* article on disruptive mood dysregulation disorder for a discussion on properly diagnosing these symptoms in pediatric populations).

According to the fourth edition of the DSM, children and adolescents manifest depression, not mania or hypomania, through an irritable and cranky mood expressed by "persistent anger, a tendency to respond to events with angry outbursts or blaming others, or an exaggerated sense of frustration of minor matters."

This description aligns with research from Ronald Kessler indicating that irritability in major depressive disorder is associated with early age of onset, lifetime persistence, comorbidity with anxiety and impulse-control disorders, fatigue and self-reproach during episodes, and disability (see the 2010 article "The importance of irritability as a symptom of major depressive disorder: Results from the National Comorbidity Survey Replication" published in *Molecular Psychiatry*).

In the opinion of Ellen Leibenluft, a National Institute of Mental Health senior investigator who conducts research on whether children with impairing irritability (severe mood dysregulation) should be diagnosed with bipolar disorder, the vast majority of irritability

in children is not bipolar disorder. Her longitudinal data in both clinical and community samples indicate that nonepisodic irritability in children and adolescents is common.

According to Leibenluft, who served on the DSM-5 Childhood and Adolescent Disorders Work Group, nonepisodic irritability is associated with an elevated risk for anxiety and unipolar depressive disorders in adulthood, but not bipolar disorder. Her data also suggest that children and adolescents with impairing irritability have lower familial rates of bipolar disorder than do those with bipolar disorder, as well as differing brain mechanisms mediating pathophysiologic abnormalities.

Because of these factors, she advocates for thorough assessment and differential diagnosis in this population by spending ample time with the child and parents, obtaining abundant information and carefully considering all relevant clinical material (see her 2011 article, "Severe mood dysregulation, irritability and the diagnostic boundaries of bipolar disorder in youths," published in *The American Journal of Psychiatry*).

To further distinguish irritability as a nonpsychiatric marker for mania and hypomania in bipolar I and bipolar II disorders, the DSM-5 added the following verbiage to the symptom descriptions.

- Criterion A: "... and abnormally and persistently increased goal-directed activity or energy ..."
- Criterion B: "... and represent a noticeable change from usual behavior."

For cyclothymic disorder, the following verbiage was added to the symptom descriptions in the DSM-5.

- Criterion A: "... that do not meet criteria for a hypomanic episode ..."
- Criterion B: "... the hypomanic and depressive periods have been present for at least half the time ..."
- Criterion C: "Criteria for a major depressive, manic or hypomanic episode have never been met." (The DSM-5 removed the DSM-IV-TR "note" that allowed manifestation of these episodes after the initial two years).

### Mania versus hypomania

The DSM-5 retains the dichotomous distinction between bipolar I and bipolar II disorders. To recap, bipolar I is characterized by manic episodes, while bipolar II is characterized by hypomanic episodes. By definition, hypomanic episodes manifest with a shorter symptom duration requirement of four days as compared with manic episodes that manifest with a longer symptom duration requirement of seven days.

But what really differentiates mania from hypomania is the severity, duration and, from a psychological point of view, experience of each client. According to the DSM-5, a hypomanic episode has to be "clearly different from the usual nondepressed mood."

The three most important criterion that refer to functional impairment essentially summarize the major differences between manic and hypomanic episodes:

- Criterion C: “The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.”
- Criterion D: “The disturbance in mood and the change in functioning are observable by others” (italicized to indicate new language for the DSM-5).
- Criterion E. “The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic” (italicized to indicate new language for the DSM-5).

Mania, or affective psychosis as described by German psychiatrist Emil Kraepelin in the 19th century, may manifest as acute, delusional or delirious. The transition from hypomania to acute mania (rapid onset and/or a short course) is marked by a severe exacerbation of the symptoms seen in hypomania and the appearance of delusional symptoms (fixed beliefs that are not amenable to change in light of conflicting evidence).

Prominent delusions in this state may include the following:

- Persecutory: The belief that one is going to be harmed, harassed or otherwise mistreated by an individual, organization or other group.
- Referential: The belief that certain gestures, comments, environmental cues and so forth are directed at oneself.
- Grandiose: The belief that one has exceptional abilities, wealth or fame.
- Erotomanic: When an individual believes falsely that another person is in love with him or her.
- Nihilistic: The conviction that a major catastrophe will occur.
- Somatic: Preoccupations regarding health and organ function.
- Bizarre: Clearly implausible beliefs that are not understandable to same-culture peers and that do not derive from ordinary life experiences.

Counselors should keep in mind that it is difficult to make the distinction between a delusion and a strongly held idea. The distinction depends, in part, on the degree of conviction with which the belief is held despite clear or reasonable contradictory evidence regarding its veracity.

The transition to delirious mania is marked by restlessness, confusion, incoherence of thought and speech, and intensification of the symptoms seen in acute mania, especially hallucinations (perception-like experiences that occur without an external — such as auditory, visual, tactile, gustatory or olfactory — stimulus).

The depressive episodes seen in bipolar disorder, in contrast to those typically seen in a major depression, tend to come on fairly acutely, over perhaps a few weeks, and often occur without any significant precipitating factors.

The DSM-5 provides further distinctions between manic episodes and hypomanic episodes induced by antidepressant treatment:

- “A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I

diagnosis” (see DSM-5, page 124). This condition is considered an indicator or true bipolar disorder, not substance/medication-induced bipolar and related disorder (see pages 142-145).

- “However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis” (page 125).

### Assessment measures

Section III of the DSM-5 provides emerging measures to facilitate client assessment and development of a comprehensive case formulation. In turn, this will contribute to a diagnosis and treatment plan that is tailored to the individual presentation and clinical context (see pages 733-737).

As noted on page 24 of the DSM-5, “Cross-cutting symptom and diagnosis-specific severity measures provide quantitative ratings of important clinical areas that are designed to be used at the initial evaluation to establish a baseline for comparison with ratings on subsequent encounters to monitor changes and inform treatment planning.”

With this in mind, I recommend using the Altman Self-Rating Mania Scale (Level 2—Mania—Adult and Level 2—Mania—Child Age 11-17) to facilitate diagnosis of bipolar-related disorders. This cross-cutting symptom measure is a five-item self-rating mania scale designed to assess the presence and/or severity of manic symptoms. It can be accessed at [psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Disorder](http://psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Disorder).

This instrument contains the following instructions for clients:

“On the DSM-5 Level 1 cross-cutting questionnaire you just completed, you indicated that during the past 2 weeks you (the individual receiving care) have been bothered by ‘sleeping less than usual, but still having a lot of energy’ and/or ‘starting lots more projects than usual or doing more risky things than usual’ at a mild or greater level of severity.

The five statement groups or questions below ask about these feelings in more detail in the following areas:

- feeling happier or more cheerful
- self-confidence
- sleep patterns
- talking
- activity levels — socially, sexually, at work, home or school”

Traditional psychometrically sound instruments, such as the Minnesota Multiphasic Personality Inventory for adults and adolescents and the Millon Clinical Multiaxial Inventory for adults and adolescents, can further detect the presence of mania or hypomania and anchor your bipolar and related disorder diagnosis. Regarding differential diagnostic procedures — especially to avoid “double counting” of symptoms toward

borderline personality disorder — the DSM-5 requires counselors to suspend diagnosing a personality disorder during an untreated mood episode (see page 132).

To assist with this important and sometimes complicated process, I recommend Gregory Hatchett's 2010 article, "Differential diagnosis of borderline personality disorder from bipolar disorder," published in the *Journal of Mental Health Counseling*.

### Descriptive and course specifiers

The DSM-5 retains the following descriptive specifiers from the DSM-IV-TR for bipolar-related disorders: with melancholic features, with atypical features, with psychotic features and with catatonia. The DSM-5 also adds two new descriptive specifiers: with anxious distress and with mixed features.

The specifier "with anxious distress" is intended to identify clients with anxiety symptoms that are not part of the bipolar diagnostic criteria. Important differences exist between bipolar disorder with and without comorbid anxiety.

Lifetime comorbid bipolar disorders and anxiety are associated with decreased likelihood of recovery, poorer role functioning and quality of life, less time experiencing euthymia and greater likelihood of suicide attempts.

The presence of higher levels of anxiety during manic or hypomanic episodes appears to mark an illness of substantially greater long-term depressive morbidity. Overall, the outcome in bipolar-related disorders is worse in the presence of comorbid anxiety.

The coexistence of anxiety presents a particularly difficult challenge in the treatment of bipolar-related disorder illness because antidepressants, the mainstay of pharmacologic treatments for anxiety, may adversely alter the course of the illness.

In the DSM-IV-TR, a diagnosis of "mixed episode" required a client to simultaneously meet all criteria for an episode of major depression and an episode of mania. During its review of the latest research, the DSM-5 Mood Disorders Work Group recognized that individuals rarely meet full criteria for both episode types at the same time.

To be diagnosed with the new mixed features specifier in the case of major depression, the DSM-5 requires the presence of at least three manic or hypomanic symptoms that do not overlap with symptoms of major depression. In the case of mania or hypomania, the specifier requires the presence of at least three symptoms of depression in concert with the episode of mania or hypomania.

According to the American Psychiatric Association, this specifier will allow counselors to more accurately diagnose clients who may be suffering from concurrent symptoms of depression and mania or hypomania, as well as better tailor treatment to their behaviors. This is especially important because many clients with mixed features, depending on their

predominant symptoms, demonstrate poor response to lithium or become less stable when taking antidepressants.

Additionally, more accurately identifying these concurrent behaviors may allow counselors to recognize clients with a unipolar disorder who are at increased risk of progression to bipolar disorder.

The DSM-5 also retains the following course specifiers from the DSM-IV-TR: with rapid cycling, with seasonal pattern and with peripartum onset. However, the DSM-5 contains a new note regarding appropriate use of “with season pattern” because the pattern of onset and remission of episodes must have occurred during at least a two-year period, without any nonseasonal episodes occurring during that time.

Peripartum onset was formally referred to as “postpartum” in the DSM-IV-TR. The DSM-5 contains a new note indicating that 50 percent of “postpartum” major depressive episodes actually begin prior to delivery.

### Other specified bipolar and psychotic-related disorders

To enhance diagnostic specificity, the DSM-5 provides four example presentations in which symptoms characteristic of a bipolar or related disorder cause clinically significant distress or impairment but do not meet the full criteria for any of the bipolar-related disorders.

The other specified disorder category is provided to allow counselors to communicate the specific reason that the presentation does not meet the criteria for any specific category within a diagnostic class. This is done by recording the name of the category, followed by the specific reasons.

Other specified psychotic disorders include the following (listed on page 122 of the DSM-5):

- Persistent auditory hallucinations
- Delusions with significant overlapping mood episodes
- Attenuated psychosis syndrome (this condition is also proposed under “Conditions for Further Study” on pages 783-786 as a subthreshold psychotic symptom associated with a very significant increase in the risk of developing a full-fledged psychotic disorder)
- Delusional symptoms in partner of individual with delusional disorder

Other specified bipolar and related disorders include the following (listed on page 148):

- Short-duration hypomanic episodes (two to three days) and major depressive episodes
- Hypomanic episodes with insufficient symptoms and major depressive episodes
- Hypomanic episode without prior major depressive episode
- Short-duration cyclothymia (less than 24 months)

In conclusion, I recommend that counselors read Emanuel Severus and Michael Bauer’s article “Diagnosing bipolar disorders in DSM-5” (located at [journalbipolar disorders.com/content/1/1/14](http://journalbipolar disorders.com/content/1/1/14)) and *Treating Bipolar Disorder: A Clinician’s*

Guide to Interpersonal and Social Rhythm Therapy by Ellen Frank, a member of the DSM-5 Mood Disorders Work Group.

Until next month, be well!

### Bio

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