

## Bipolar and Depressive Disorders in Diagnostic and Statistical Manual of Mental Disorders-5: Clinical Implications of Revisions from Diagnostic and Statistical Manual of Mental Disorders-IV

### INTRODUCTION

Our modern system of classifying and diagnosing psychiatric disorders originated in Emil Kraepelin's dichotomization between dementia praecox (schizophrenia) and manic-depressive insanity (bipolar and unipolar disorders). Since that time, there have been separate sections on psychotic disorders and mood disorders in both the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual of mental disorders-5 (DSM-5) diagnostic manuals. This dichotomy has increasingly been called into question<sup>[1,2]</sup> and genetic, other neurobiological, and pharmacological data suggest that bipolar disorders may be on a continuum between schizophrenia and unipolar depression.<sup>[2,3]</sup> In addition, the definitions of these disorders in DSM-IV present a number of problems in clinical practice, including high use of not otherwise specified (NOS) diagnoses, high rates of spurious comorbidity, unclear boundaries with schizoaffective disorder, discrepant treatment of catatonia, and poor explanation of the significant heterogeneity within each diagnostic category. DSM-5<sup>[4]</sup> sought to address these limitations and incorporate new knowledge about these conditions generated over the past 20 years. Changes in the section on psychotic disorders were summarized in a prior issue of the Journal.<sup>[5]</sup> Some of those changes relevant to the clinical description of the mood disorders include a single set of criteria to diagnose catatonia and its treatment as a specifier across all disorders<sup>[6,7]</sup> and more stringent criteria for schizoaffective disorder.<sup>[8-10]</sup> In this article, we address the major changes made in the mood disorders section in DSM-5.

### SEPARATION OF BIPOLAR DISORDERS FROM DEPRESSIVE DISORDERS

One of the major changes made in DSM-5 is the division of the mood disorders section into two units, one on bipolar and related disorders and the other on depressive disorders.<sup>[11]</sup> The unit on bipolar and related disorders is placed in between the section on schizophrenia spectrum and other psychotic disorders on the one side and the section on depressive disorders on the other. A conglomerate of genetic and neurobiological findings supports this intermediate position of bipolar disorder between schizophrenia and unipolar depression. Whereas bipolar depression shares clinical features with unipolar depression (depressive symptoms, tendency toward an episodic course, family history, comorbidities), bipolar disorder also shares significant features with schizophrenia (symptomatology, genetic markers, family history, response of mania to antipsychotic agents).<sup>[2,3,12-14]</sup> This lends support to the change made in DSM-5 and is also consistent with observations that neurocognitive deficits and various neurobiological findings are seen across the spectrum of psychotic disorders, spanning schizophrenia through bipolar disorder to major depression.<sup>[15,16]</sup>

Although there is much empirical support and sound rationale for this separation between bipolar and depressive (unipolar) disorders, it has been criticized<sup>[17]</sup> because it conflicts with Kraepelinian orthodoxy.<sup>[18]</sup> Since DSM-5 has also been criticized for being too conservative in its approach,<sup>[19]</sup> this illustrates the challenges in updating our system of psychiatric classification.<sup>[20]</sup> Whereas the research implications of this change are evident, placement of bipolar and related disorders and unipolar and related disorders in separate chapters reinforces the clinical imperative of recognizing important differences between bipolar and unipolar depression with regard to comorbidities, treatment, and outcome.

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## BIPOLAR AND RELATED DISORDERS

Five relatively modest changes were made in an effort to improve clinical utility and specificity in the diagnosis of bipolar and related disorders. These include:

1. The elimination of the category of bipolar disorder, mixed, and its replacement by a new specifier “with mixed features”;
2. Addition of a requirement that abnormal and persistently increased goal-directed activity or energy accompany elevated or irritable mood as an essential criterion (criterion A) for diagnosing mania or hypomania;
3. Addition of “anxious distress” and other specifiers to improve the precision of characterizing these disorders in a clinically pertinent manner;
4. Provision of specific criteria for defining sub-threshold bipolar disorders; and
5. Elimination of antidepressant medication as an exclusion criterion for diagnosing mania or hypomania.

The diagnosis of mixed mood states as a distinct entity is being replaced by a “with mixed features” specifier for both mania and major depressive episodes. In DSM-IV, a mixed mood state could only be diagnosed if patients met the full criteria for both mania and major depression; since this was rarely the case, mixed mood states were rarely diagnosed. This led to bipolar depression being frequently diagnosed as unipolar depression and being inappropriately treated. In DSM-5, the “with mixed features” specifier can be applied to episodes of mania or hypomania when three or more depressive features are present as also to depressive episodes when three or more features of mania/hypomania are present. This should facilitate recognition and appropriate treatment of mixed mood states. While some have advocated for an even broader definition of “mixed features,”<sup>[21,22]</sup> this is clearly a change in the right direction for where there is much support<sup>[23-25]</sup> and that should help patients receive more specific treatment.

The requirement for abnormally and persistently increased goal-directed activity or energy in addition to elevated or irritable mood as an essential criterion for the diagnosing mania or hypomania should improve the specificity of the diagnosis.

Symptoms of anxiety are prominent in the majority of patients with bipolar and unipolar disorders and contribute significantly to suicidal behaviors and distress associated with these conditions.<sup>[26]</sup> The addition of the anxious distress to disorders in both the bipolar and depressive sections in DSM-5 should encourage much-needed attention to this important symptom domain and provision of measurement-based

care.<sup>[27,28]</sup> In addition to “mixed features” and “anxiety distress”, the inclusion of several other specifiers to better characterize the heterogeneous presentation of bipolar disorders in individual patients should help clinicians provide more precise treatment.

Diagnostic and statistical manual of mental disorders-5 introduces a new category of other specified bipolar and related disorders and provides explicit definitions for these conditions. This should improve characterization of different conditions included in the hitherto amorphous category of sub-threshold bipolar disorders. Such conditions are not uncommon and this change should facilitate their distinction from major depression.

Finally, the allowance of a diagnosis of bipolar disorder when mania or hypomania occurs in a patient receiving antidepressant medication is consistent with data indicating that such patients do not differ from other bipolar patients.

No other changes were made in the core criterion symptoms or duration criteria for mania, hypomania, or major depression.

## DEPRESSIVE AND RELATED DISORDERS

Diagnostic and statistical manual of mental disorders-5 contains three new disorders in this chapter, makes one change in the criteria for major depression, and adds several specifiers to better characterize the individual presentation of these otherwise heterogeneous disorders. Disruptive mood dysregulation disorder and persistent depressive disorder were added, and premenstrual dysphoric disorder was moved from the appendix in DSM-IV to the main body of the manual in DSM-5. The operationalized bereavement exclusion was replaced by a call for clinical judgment in the diagnosis of major depression in the context of bereavement. Several new specifiers were added similar to those in the chapter on bipolar and related disorders.

Since DSM-IV and ICD-10, there has been a 5-10-fold increase in the diagnosis of bipolar disorder among children and adolescents. Much of this increase has occurred among youth exhibiting significant irritability and behavioral dyscontrol. Studies of this group of patients have revealed that they are significantly different from those with bipolar disorder in terms of family history, comorbidities, treatment response, course, and outcome and that they may define a somewhat distinct population that is more closely related to those with unipolar depression.<sup>[29-32]</sup> Not all studies provide support for the introduction of this new category, however,<sup>[33]</sup> and its differentiation from oppositional defiant disorder is unclear. While

the precise implications of making this diagnosis are uncertain,<sup>[34]</sup> it would be prudent to treat diagnosed individuals with antidepressants and other modalities to treat depression rather than antipsychotics<sup>[35,36]</sup> or mood stabilizers.

Persistent depressive disorder is introduced as a new category in DSM-5, subsuming both DSM-IV dysthymic disorder and chronic major depression as also “double depression.” This change was made due to data, indicating that chronicity is a much better predictor of course and outcome than the number of symptoms<sup>[37]</sup> and because the reliability of discriminating chronic major depression from dysthymic disorder was found to be poor. Specifiers allow the description of the severity of depression and other precise characterization of the chronic depression in individual patients; the adequacy of this has been questioned.<sup>[34,38]</sup>

Premenstrual dysphoric disorder has been elevated from the appendix in DSM-IV to the main body (section 2) of the diagnostic manual in DSM-5 because data have confirmed the existence of a distinct treatment-responsive form of depression in women that occurs in the premenstrual phase of the menstrual cycle.<sup>[39]</sup>

While no other changes were made in the core criterion symptoms or duration criteria for major depression, one significant change in its definition was the elimination of the bereavement exclusion. In DSM-IV, major depressive episode could not be diagnosed within 2 months of death of a loved one. This exclusion was eliminated because the effects of bereavement are not limited to 2 months, and bereavement itself can precipitate a major depressive episode warranting clinical attention. An extensive footnote cautions the clinician about distinguishing features between the depression of bereavement and the depression of a major depressive episode. While the preponderance of data suggest that bereavement-related major depression does not differ from major depression occurring in other contexts,<sup>[40]</sup> the reliability of clinical judgment in making this distinction (as required in DSM-5) remains to be demonstrated.<sup>[41]</sup>

One concern with the definition of major depression is the continued poor clinical reliability of diagnosing this heterogeneous disorder.<sup>[42]</sup> As with the chapter on bipolar disorders, several specifiers to better characterize the heterogeneous presentation of depressive disorders in individual patients (mixed features, anxiety distress, melancholic features, atypical features, peripartum onset, mood-congruent, and mood-incongruent psychotic features [distinguish it from schizoaffective disorder and schizophrenia with depression]<sup>[43]</sup>) were added. This should help clinicians

both in more precisely describing the presentation of depression in individual patients and in providing specific treatment.

## CONCLUSIONS

Changes in the DSM-5 treatment of mood disorders incorporate new information about the nature of these conditions generated over the past 20 years and are principally designed to facilitate clinical assessment and treatment.

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