

Second in a series

Getting ready for DSM-5: Psychotic disorders

Modest changes intend to improve the clinical utility of psychotic disorder diagnoses

In DSM-IV,¹ the section on schizophrenia and other psychotic disorders includes schizophrenia (with 5 subtypes), schizophreniform disorder, schizoaffective disorder, delusional disorder, shared psychotic disorder, brief psychotic disorder, substance-induced psychotic disorder, psychotic disorder due to a general medical condition, and psychotic disorder not otherwise specified. As we consider proposed changes to DSM-5 (Table 1),² it is useful to consider limitations in our current construct of schizophrenia.

First, many etiological factors and pathophysiological processes appear relevant to what we consider schizophrenia and it is almost certain that our construct of schizophrenia encompasses not one but numerous diseases with a shared phenotype.³⁻⁵

Second, the boundary between schizophrenia and schizoaffective disorder is imprecisely defined, and a proportion of patients with schizophrenia with some mood symptoms may inappropriately receive a schizoaffective disorder diagnosis. This is compounded by the poor reliability and low diagnostic stability of a schizoaffective disorder diagnosis.⁶⁻⁸

Third, the current classic schizophrenia subtypes provide an inadequate description of the enormous heterogeneity of this condition. Additionally, subtype stability is low, and only the paranoid and undifferentiated subtypes are used frequently in clinical practice.

Fourth, the prominence given to Schneiderian first-rank symptoms (“bizarre” delusions or “special” hallucinations) appears misplaced.

Fifth, the current construct of schizophrenia inadequately describes the major psychopathological dimensions of the condition and stages of its evolution.^{8,9}



© IKON IMAGES/CORBIS



Rajiv Tandon, MD
Professor of Psychiatry
University of Florida
Gainesville, FL



Psychotic disorders in DSM-5

Clinical Point

Proposed changes to schizophrenia criteria include eliminating special treatment of bizarre delusions and other first-rank symptoms

Table 1

Psychotic disorders in DSM-5: Summary of proposed changes

Replace existing subtypes with dimensions
Include diagnosis of attenuated psychosis syndrome
Modify criteria for schizoaffective disorder
'Delink' catatonia from schizophrenia
Source: Reference 2

Finally, the current clinical construct of schizophrenia does not match neurobiological markers and genetic findings or specific pharmacological treatment provided.^{5,10} Proposed DSM-5 revisions² to the definition of schizophrenia to address these limitations are summarized below.

Schizophrenia syndrome

Proposed changes to the diagnostic criteria for schizophrenia are modest and continuity with DSM-IV is broadly maintained. Two modest changes to criterion A (active phase symptoms) are proposed:

- Eliminate special treatment of bizarre delusions and other Schneiderian first-rank symptoms. In DSM-IV, only 1 criterion A is required if it is a bizarre delusion or hallucination. Because Schneiderian first-rank symptoms do not have diagnostic specificity and diagnosing "bizarreness" of delusions and hallucinations has low reliability, it is proposed that these positive symptoms be treated like any other with regard to their diagnostic implications.
- Require that at least 1 of the 2 symptoms required to meet criterion A be delusions, hallucinations, or disorganized thinking. These are core positive symptoms diagnosed with high reliability and might reasonably be considered necessary for a reliable schizophrenia diagnosis.

Subtypes

The DSM-5 proposal for describing schizophrenia advocates eliminating DSM-IV schizophrenia subtypes. These subtypes have limited diagnostic stability, low reliability, and poor validity. Furthermore, ex-

cept for the paranoid and undifferentiated subtypes, other subtypes rarely are used in most mental health care systems.

Schizoaffective disorder

Characterizing patients with both psychotic and mood symptoms either concurrently or at different points during their illness always has been controversial. In DSM-I and DSM-II, a diagnosis of schizophrenia, schizoaffective subtype, generally was recommended for such patients. DSM-III reversed this recommendation and specified that schizophrenia was to be diagnosed only in the absence of prominent mood symptoms. Furthermore, in DSM-III, diagnosing schizoaffective disorder was strongly discouraged, and it was the only condition in DSM-III without operational criteria. Schizoaffective disorder saw a revival in DSM-III-R that has continued through DSM-IV. In fact, in many mental health care systems, almost one-third of patients with psychotic symptoms receive a schizoaffective disorder diagnosis. One of the insidious changes to the definition of schizoaffective disorder from DSM-III to DSM-IV is that it moved from being a lifetime diagnosis to a cross-sectional diagnosis—ie, in DSM-IV, only mood/psychotic symptoms in the current episode are considered, and the longitudinal course of these symptoms in the patient's life are ignored. The current DSM-5 proposal attempts to improve reliability of this diagnosis by providing more specific criteria and is reconceptualizing schizoaffective disorder as a longitudinal diagnosis. To this end, the most significant proposed change is to criterion C of schizoaffective disorder, which attempts to demarcate schizoaffective disorder from schizophrenia with prominent mood symptoms. Criterion C will be revised to state "symptoms that meet criteria for a mood episode are present for a majority (>50%) of the total duration of the active and residual periods of the illness."²

Psychopathological dimensions

Schizophrenic illness is characterized by several psychopathological domains, with a distinctive course, patterns of treatment-

response, and prognostic implications. The relative severity of symptom dimensions—positive, negative, mood, disorganization, motor, and cognitive—vary among patients and also within patients at different stages of their illness. Measuring the relative severity of these symptom dimensions throughout the illness course can provide clinicians with useful information about the nature of a patient’s schizophrenic illness and the specific impact of treatment on different aspects of his or her illness (Table 2). In addition to being clinically useful, dimensional measurement also should improve schizophrenia research because having dimensional information will permit studies on etiology and pathogenesis that cut across current diagnostic categories. Although field trials are evaluating 9 dimensions—delusions, hallucinations, disorganization, depression, mania, cognitive impairment, restricted emotional expression, avolition, and psychomotor—it is likely that fewer dimensions will be recommended for DSM-5, based on reliability results of these trials, clinical utility, and logistic feasibility in routine clinical settings.

Attenuated psychosis syndrome

Some clinicians and researchers believe that many patients with schizophrenia experience unsatisfactory outcomes because we identify the illness and initiate treatment after substantial brain tissue damage has occurred. Introducing attenuated psychosis syndrome will support clinicians’ efforts to recognize mild psychotic symptoms early in their evolution and to monitor—and if necessary, intervene—during these crucial early stages. Risks include possible stigma and inappropriate use of medications and other treatments. This controversial proposal is being field tested. It is unclear if this category will be included in DSM-5 and if it does, whether it will be in the main text or the appendix.

Catatonia

Catatonia will be used as a specifier for various psychotic disorders, major mood

Table 2

Goals of a dimensional approach to schizophrenia

Better understanding of schizophrenia
Distinct dimensions of illness
Distinct stages of illness
Elucidation of neurobiology
More precise delineation of etiology
More refined treatment development
Direction at specific dimension-endophenotype
Stage-specific treatment
Novel treatment targets

disorders, and associated with a general medical condition. Additionally, the same criteria will be used to diagnose catatonia across DSM-5. Catatonia Not Elsewhere Classified might be added as a residual category for other conditions in which a clear catatonic syndrome is present and the parent disorder has not yet been identified.²

Other psychotic disorders

Relatively minor changes are proposed in criteria for other disorders in this section. There are likely to be changes in the text, however, that incorporate new information about these conditions generated since publication of DSM-IV-TR in 2000. Some proposed changes include:

- deleting shared delusional disorder (folie à deux) as a separate diagnosis and instead characterizing it as a specifier for delusional disorder
- clarifying the distinction between substance-induced psychotic disorder and other psychotic disorders accompanied by comorbid substance use.

Current status of DSM-5

Field trials are being completed and their results remain to be analyzed. Major changes being evaluated in the field trials include:

- the impact of the change in concept and criteria for schizoaffective disorder
- the addition of a series of psychopathology dimensions

Clinical Point

The current DSM-5 proposal attempts to provide more specific criteria for schizoaffective disorder

continued



Psychotic disorders in DSM-5

Clinical Point

Measuring the severity of symptom dimensions may provide useful information about the specific impact of treatment

Related Resources

- American Psychiatric Association. DSM-5 Development. www.dsm5.org.
- Woods SW, McGlashan TH. The risk-benefit ratio of the proposed DSM-5 attenuated psychosis syndrome. *Am J Psychiatry*. 2011;168(12):1338.

Disclosure

Dr. Tandon is a member of the DSM-5 Psychotic Disorders Work Group. He is solely responsible for the content of this article.

- the impact of adding attenuated psychosis syndrome as a new class.

Changes proposed by the Psychosis Disorders Work Group are intended to increase clinical utility (fewer diagnoses, better demarcation between disorders, greater treatment relevance [dimensions]) and modestly improve validity (more consistent with current information about the nature of various psychotic disorders), while retaining reliability in diagnosing various psychotic disorders (and improving it for schizoaffective disorder). Proposed changes are modest by and large but hope to set a better stage for a future etiopathophysiological classification.

The Psychosis Disorders Work Group's recommendations are posted on the DSM-5 Web site² at www.dsm5.org and are being reviewed by 2 expert committees established

by the American Psychiatric Association Board of Trustees: a Scientific Review Committee and a Clinical and Public Health Implications Committee. Based on the results of the field trials, ongoing reviews, and other emerging data and discussions, additional changes to the current DSM-5 proposals may occur. DSM-5 is likely to be finalized in early 2013 and the published manual will be released in May 2013.

References

1. Diagnostic and statistical manual of mental disorders, 4th ed. Washington, DC: American Psychiatric Association; 1994.
2. American Psychiatric Association. DSM-5 development. <http://www.dsm5.org>. Accessed March 19, 2011.
3. Tandon R, Keshavan MS, Nasrallah HA. Schizophrenia, "just the facts": what we know in 2008. Part 1: overview. *Schizophr Res*. 2008;100(1-3):4-19.
4. Tandon R, Keshavan MS, Nasrallah HA. Schizophrenia, "just the facts" what we know in 2008. 2: epidemiology and etiology. *Schizophr Res*. 2008;102(1-3):1-18.
5. Keshavan MS, Tandon R, Boutros N, et al. Schizophrenia, "just the facts" what we know in 2008. Part 3: neurobiology. *Schizophr Res*. 2008;106(2-3):89-107.
6. Tandon R, Maj M. Nosological status and definition of schizophrenia. Some considerations for DSM-V and ICD-11. *Asian Journal of Psychiatry*. 2008;1(2):22-27.
7. Fiedorowicz JG, Epping EA, Flaum M. Toward defining schizophrenia as a more useful clinical construct. *Curr Psychiatry Rep*. 2008;10(4):344-351.
8. Tandon R, Nasrallah HA, Keshavan MS. Schizophrenia, "just the facts" 4. Clinical features and conceptualization. *Schizophr Res*. 2009;110(1-3):1-23.
9. McGorry PD. Risk syndromes, clinical staging, and DSM V: new diagnostic infrastructure for early intervention in psychiatry. *Schizophr Res*. 2010;120(1-3):49-53.
10. Tandon R, Nasrallah HA, Keshavan MS. Schizophrenia, "just the facts" 5. Treatment and prevention. Past, present, and future. *Schizophr Res*. 2010;122(1-3):1-23.

Bottom Line

Changes proposed to the psychotic disorders section of DSM-5 include revising the criterion for active phase symptoms of schizophrenia, eliminating schizophrenia subtypes, reconceptualizing schizoaffective disorder as a longitudinal diagnosis, measuring symptom dimensions, and introducing attenuated psychosis syndrome. These changes are intended to increase the clinical utility and validity of psychotic diagnoses.