Schizophrenia and other Psychotic Disorders in *DSM-5*: Clinical Implications of Revisions from *DSM-IV*

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Abstract

Whereas improving validity and reliability of psychiatric diagnoses were key objectives in the development of *DSM-5*, enhancing clinical utility was the primary goal. With reference to psychotic disorders, changes addressed limitations in *DSM-IV* while incorporating new information about the nature of these disorders generated over the past twenty years. With regard to schizophrenia, variation in distinct psychopathological dimensions has been found to better account for the heterogeneity of schizophrenia than traditional subtypes. Resulting changes in *DSM-5* will likely include elimination of the classic subtypes of schizophrenia and addition of unique psychopathological dimensions, along with elimination of the special treatment of Schneiderian "first-rank symptoms." In view of the poor reliability and limited validity of *DSM-IV* schizoaffective disorder, a clearer definition is provided in *DSM-5*. Considering the discrepant treatment of catatonia in *DSM-IV*, it is treated consistently across the *DSM-5* manual. Minor changes are made in the definition of delusional disorder to reduce spurious comorbidity and unnecessary complexity. A new category of "attenuated psychosis syndrome" is included in the appendix as a condition for further study. In this article, major likely revisions in the *DSM-5* (due to be published in May 2013) criteria for schizophrenia spectrum and other psychotic disorders are summarized and their implications for clinical practice are discussed.

Key Words: Schizophrenia, *DSM*, Diagnosis, Nosology, Psychosis

Introduction

Our current systems of classifying psychiatric disorders (*DSM* and *ICD*) have evolved over the past sixty years from the first edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-1)* (1) to the current *DSM-IV* (2) and the sixth revision of the *International Classification of Diseases (ICD-6)* (3) to the current *ICD-10* (4). Each revision seeks to incorporate new knowledge concerning various psychiatric disorders, improve reliability and validity, provide diagnostic clarity and enhance clinical utility. *DSM-5* has been in development for over a decade and will be published in May 2013. Limitations in the *DSM-IV* definitions of various psychotic disorders (5) include: 1) unclear boundary between schizoaffective disorder and schizophrenia; 2) variable definitions and discrepant treatment of catatonia across *DSM-IV*; 3) poor description of clinical heterogeneity of schizophrenia; 4) spurious comorbidity of delusional disorder and obsessive-compulsive disorder; 5) poor reliability and low diagnostic stability of the diagnosis of schizoaffective disorder; and, 6) inappropriate special treatment of Schneiderian first-rank symptoms ("bizarre" delusions or "special" hallucinations) in the definition of schizophrenia.

Revisions in *DSM-5* seek to address these limitations while incorporating new information concerning various psychotic disorders generated since the publication of *DSM-IV* in 1994. Additionally, revisions are intended to enhance clinical utility by reducing unnecessary complexity and im-

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proving coherence across this group of disorders. The major likely revisions in the definition of schizophrenia and other psychotic disorders from *DSM-IV* to *DSM-5* are discussed along with the implications of these changes for clinical practice.

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Schizophrenia

Changes proposed in the diagnostic criteria of schizophrenia are relatively modest and broad continuity with *DSM-IV* is maintained. The special treatment of bizarre delusions and other Schneiderian first-rank symptoms in criterion A (active phase symptoms) is eliminated because these symptoms have not been found to be specific for schizophrenia, and the distinction between bizarre versus non-bizarre delusions has been found to have poor reliability (5-7). These symptoms lack any special significance in the context of schizophrenia (8), and there is no justification for their differential treatment in its diagnosis. In *DSM-5*, "Schneiderian first-rank symptoms" will be treated like any other positive symptoms with regard to their diagnostic implication: two criterion A symptoms will be required even if one of them is a bizarre delusion. The impact of this change on clinical practice will be limited because less than 2% of *DSM-IV* schizophrenia meets criterion A exclusively by virtue of a single first-rank symptom. This small proportion of patients will instead receive a diagnosis of delusional disorder.

A second change is the addition of a requirement that at least one of two required symptoms to meet criterion A be delusions, hallucinations, or disorganized thinking. These are core "positive symptoms" and should be necessary for a reliable diagnosis of schizophrenia. Again, this change will have negligible impact on clinical practice as less than 1% of all *DSM-IV* schizophrenia meet criterion A solely on account of negative symptoms + catatonia. Such patients would appropriately be reclassified either as catatonia NEC (new residual condition added in *DSM-5*) or major depressive disorder with catatonia or other condition based on associated symptomatology.

One major change in *DSM-5* will be the elimination of the classic subtypes of schizophrenia. These subtypes have limited diagnostic stability, low reliability, poor validity, and little clinical utility (8-11). Whereas this change represents a significant departure from a one-hundred-year tradition, it will have relatively little clinical impact except for the paranoid and undifferentiated subtypes; the other subtypes are rarely utilized in most mental healthcare systems across the world. In fact, clinicians will be able to utilize dimensional assessments which better describe the heterogeneity of schizophrenia and will be much more useful in terms of providing measurement-based treatment for persons with schizophrenia (12).

Schizophrenia and other psychotic disorders are characterized by several psychopathological domains, each with distinctive courses, patterns of treatment-response, and prognostic implications (13). The relative severity of these symptom dimensions varies across patients, as well as within patients at different stages of their illness. Relevant symptom domains include reality distortion (delusions, hallucinations), negative symptoms, disorganization, cognitive impairment, motor symptoms (e.g., catatonia), and mood symptoms (depression, mania). Measuring the relative severity of these symptom dimensions through the course of illness in the context of treatment can provide useful information to the clinician about the nature of the illness in a particular patient and in assessing the specific impact of treatment on different aspects of the patient's illness (14). A 0–4 rating scale with anchor points for each of the eight items (delusions, hallucinations, negative symptoms, cognitive impairments, disorganization, catatonia, depression, and mania) to rate these six dimensions is provided in Section 3 of the *DSM-5* manual. As a simple rating scale, it should encourage clinicians to explicitly assess and track changes in the severity of these dimensions in each patient with schizophrenia, and use this information to guide measurement-based, collaborative treatment.

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These changes in the *DSM* treatment of schizophrenia are consistent with the proposed changes in *ICD-11*, which also include deletion of classic subtypes, elimination of the special treatment of Schneiderian first-rank symptoms, and addition of dimensions to characterize the heterogeneity of schizophrenia. The current discrepancy in the duration criteria for schizophrenia between *DSM* and *ICD* (six months versus one month, respectively) will likely remain.

Schizoaffective Disorder

Characterization of patients with both psychotic and mood symptoms either concurrently or at different points during their illness has always been a nosological challenge and this is reflected in the poor reliability, low diagnostic stability, and questionable validity of *DSM-IV* schizoaffective disorder (8, 15-19). In *DSM-5*, an effort is made to improve reliability of this condition by providing more specific criteria and schizoaffective disorder is explicitly conceptualized as a longitudinal and not a cross-sectional diagnosis. Changes are made in criterion C, with the requirement that a *major mood episode* be present for *a majority of the total duration of the illness* in order to make a diagnosis of schizoaffective disorder in contrast to schizophrenia with mood symptoms. This change will provide a clearer separation between schizophrenia with mood symptoms from schizoaffective disorder. This will also likely reduce rates of diagnosis of schizoaffective disorder while increasing the stability of this diagnosis once made; it should be noted that *DSM-IV* schizoaffective disorder is an unstable diagnosis over time, with the diagnosis most often changing to schizophrenia.

Catatonia

In *DSM-IV*, two different sets of criteria are used to diagnose catatonia in different parts of the manual and the syndrome is treated discrepantly (e.g., a subtype of schizophrenia, but a specifier of major mood disorders). Additionally, catatonia is found to exist in psychiatric and general medical conditions outside of *DSM-IV* conditions in which it can be diagnosed (8, 20). Given the fairly specific treatment implications of catatonia, its appropriate recognition and treatment is a clinical imperative. Catatonia will be treated consistently across the *DSM-5* manual using a single set of criteria and will be a specifier for various psychotic disorders (including schizophrenia) and major mood and bipolar disorders. Catatonia associated with a general medical condition will be retained as a category. A new residual category of catatonia NEC is added to classify individuals with catatonia associated with other psychiatric disorders or those whose contributing general medical condition has not yet been identified. These changes should improve the consistent recognition of catatonia across the range of psychiatric disorders and facilitate its specific treatment.

Delusional Disorder

In *DSM-IV*, if obsessive-compulsive symptoms reach delusional proportions, clinicians are asked to make two concurrent diagnoses: obsessive-compulsive disorder + delusional disorder. This is an example of spurious comorbidity, as the condition likely reflects a single pathology that crosses a certain threshold rather than two separate pathologies. The same is true for delusional variants of body dysmorphic disorder (21). In *DSM-5*, a clearer demarcation of delusional disorder from psychotic variants of obsessive-compulsive disorder and body dysmorphic disorder is provided, and patients with delusional forms of obsessive-compulsive disorder or body dysmorphic disorder will receive a single diagnosis: obsessive-compulsive disorder or body dysmorphic disorder with psychotic features. The impact of this change would be to simplify and provide for a more precise description of the clinical presentation.

The clinical impact of this change will be the availability of a reliable set of criteria for attenuated psychosis syndrome, which should allow its appropriate recognition and encourage careful ongoing monitoring which might facilitate early diagnosis and appropriate treatment should conversion to overt psychosis occur.

Attenuated Psychosis Syndrome

It is believed that the poor outcome of schizophrenia in many individuals with the disorder is because of the late identification and intervention in the course of the illness by which time patients have experienced a substantial amount of socio-occupational decline and brain damage (22-24). A fairly characteristic prodrome, characterized by attenuated psychotic symptoms, precedes onset of frank psychosis in schizophrenia. Although individuals with a defined attenuated psychosis syndrome are five-hundred-times more likely than the general population to develop a psychotic disorder in the next year (25), the vast majority of such individuals do not develop schizophrenia (26, 27). Additionally, many of these individuals experience a current mood or anxiety disorder which should be the focus of intervention (27, 28). In view of the uncertain nosologic status of this condition, attenuated psychosis syndrome will be added to Section 3 (Appendix) of *DSM-5* as a condition for further study. The clinical impact of this change will be the availability of a reliable set of criteria for attenuated psychosis syndrome, which should allow its appropriate recognition and encourage careful ongoing monitoring which might facilitate early diagnosis and appropriate treatment should conversion to overt psychosis occur. Data necessary to address various questions about its precise nature and nosological status can be generated and this will allow future diagnostic systems to better characterize this condition.

Conclusions

While high reliability and validity were important considerations, changes in the *DSM-5* treatment of schizophrenia and other psychotic disorders are principally designed to facilitate clinical assessment and treatment (29). Hopefully, the revisions in *DSM-5* criteria for schizophrenia and related disorders will make them more useful to patients and clinicians while providing a more useful platform for integrating emerging genetic and other neurobiological information about these conditions (30-33). The addition of psychopathology dimensions with a simple rating scale should encourage provision of measurement-based care.

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