DSM-5 Status of Psychotic Disorders: 1 Year Prepublication

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The Psychosis Work Group, of which the authors are members, will complete work in 2012. Final recommendations must be reviewed and approved in order for full text to go to publisher by January 1, 2013. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) will appear in print in May, 2013. Much remains to be done including completion of field trials, analysis of data, review for forensic implications, review of significant changes by a scientific review committee chaired by Robert Freedman and Kenneth Kendler, and a committee concerned with clinical and public health implications chaired by Jack McIntyre and Joel Yager. In this editorial, we provide a snapshot of current status of potential changes. Interesting differences in opinion within the group remain to be resolved on some issues, and our final recommendations will depend on critiques from review groups and results of field trials evaluating reliability. All recommendations will be considered by the DSM-5 Task force that, in turn, makes final recommendations to the American Psychiatric Association Board of Trustees. The aforementioned review committees report to the Board.

Modest changes from DSM-IV in the section on “Schizophrenia and Other Psychotic Disorders” are likely, but we expect considerable similarity in the list of disorders and their diagnostic criteria. Potential changes of significance include the following:

1. An expanded introduction in the chapter text in which the key defining features of psychotic disorders are more extensively described and the logic of the organization of this section is better explained. Disorders are differentiated on the basis of extent of psychopathology (single vs multiple domains, subthreshold vs threshold), duration, and presence of a known etiological factor (eg, substance-induced). Disorders flow from acute and brief psychoses to disorders that may be more chronic and from those less pervasive in psychopathology to schizophrenia and related disorders. A schizophrenia spectrum concept will include schizophrenia, schizoaffective disorder, schizotypal personality disorder, and attenuated psychosis syndrome. The latter may be a candidate for the appendix rather than the main text.

2. Schneiderian first-rank symptoms will receive less importance in diagnosing schizophrenia both in criterion A and in the text.¹ In contrast to DSM-IV, a single bizarre delusion will no longer be adequate to meet criterion A. Instead, at least 2 of the following characteristic symptoms would need to be present: delusions, hallucinations, disorganization, negative symptoms, and psychomotor abnormality, and one of them must be from the first 3.

3. The traditional subtypes of schizophrenia (disorganized, paranoid, and catatonic) are likely to be dropped. These subtypes are infrequently utilized and most persons with schizophrenia have psychopathology from several subtypes with the subtype designation changing over time. Furthermore, the traditional subtypes have little heuristic value or validity.²,³

4. Dimensional ratings of different psychopathology domains (positive, negative, cognitive, disorganized, mood, etc.) will be added. The clinical heterogeneity of schizophrenia is better explained by characterizing severity of distinct symptom dimensions.³ Although 9 different psychopathological dimensions are being evaluated in DSM-5 field trials, the issue of how many dimensions are useful, reliably assessed, necessary, and practical remains an open question.

5. Delusional disorder will now permit a bizarre delusion because a single bizarre delusion will no longer be adequate to meet criterion A for schizophrenia. Furthermore, shared delusional disorder (folie-e-deux) may no longer be a separate diagnosis but instead be described by a specifier for delusional disorder (shared).

6. Catatonia will become a specifier for psychotic disorders, mood disorders, and general medical disorders.
Identical criteria will be utilized to define catatonia across the manual. This will provide a uniform approach across the disorders in which catatonia may be a manifestation. Catatonia, not elsewhere classified, may be added for cases where the parent disorder is not yet identified.

7. The criteria and the text of schizoaffective disorder will be modified to better demarcate schizoaffective disorder from schizophrenia with mood symptomatology. The concept of schizoaffective disorder is being clarified to recognize that the concept is overlap of mood episodes with the life course of psychosis, not just the current episode in cross-section. The criteria will specify that substantial presence of mood symptoms over the total duration of illness (criterion C) means >50% of the time. These changes harmonize with the concept anticipated for International Classification of Diseases-11 and may better address problems with reliability in the current definition.

8. Attenuated psychosis syndrome is a controversial consideration for a new disorder. Whereas the validity of the condition is fairly established and the criteria require distress, disability, dysfunction, and help seeking, the reliability of the category in clinical practice has not yet been established and there is concern that the boundaries of the definition may be broader in application than in criteria. Referral to the appendix may be the optimal outcome, but much discussion and analysis of field trial data remains before a recommendation is made.

While the shortcomings of our current diagnostic approach to schizophrenia and other psychotic disorders are relatively easy to enumerate, the task of coming up with a system that is “more valid,” “more reliable,” and “more clinically useful,” all at the same time, is challenging. It is hoped that the revisions in DSM-5 will make them more useful to patients, clinicians, researchers, and society at large.

References