DSM-5 and Psychotic and Mood Disorders

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The criteria for the major psychotic disorders and mood disorders are largely unchanged in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), with a few important exceptions: a new assessment tool for the psychotic disorders based on dimensional assessment, a new scheme of specifiers for the mood disorders, the addition of three new depressive disorders, and recognition of catatonia as a separate clinical entity. In addition, subtle changes to the diagnostic criteria for longstanding disorders may have important ramifications. There are forensic implications to these changes in the psychotic and mood disorders, but in most cases, these implications should be relatively modest, as the DSM-5 Work Groups ultimately adopted a cautious approach to changes in the psychotic and mood disorders.

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This article will consider the forensic implications of the changes in the diagnostic criteria for the psychotic and mood disorders contained in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5),[1] which was published by the American Psychiatric Association (APA) in May 2013. DSM-5 includes modest changes to the criteria and descriptive text for nearly every psychotic and mood disorder, some more significant than others. New developments in the psychotic and mood disorders in DSM-5 include the recognition of catatonia as a clinical state and the addition of three new disorders: disruptive mood dysregulation disorder, persistent depressive disorder, and premenstrual dysphoric disorder.

Forensic clinicians routinely encounter psychotic and mood disorders when performing forensic evaluations and while caring for patients in correctional settings. Psychotic disorders are particularly common in criminal forensic evaluations, as they are the primary reason for requests for evaluation of competence to stand trial[2] and sanity at the time of the offense.[3] The psychotic disorders may also be seen in civil forensic evaluations, particularly in civil commitment and disability evaluations. Mood disorders are less frequent than psychotic disorders in criminal forensic evaluations, but may be pertinent to competence-to-stand-trial and insanity evaluations. They are more common in civil forensic evaluations, particularly in disability evaluations.

The members of the DSM-5 Task Force and Work Groups reviewed the results of the abundant neuroscience research published over the past two decades and realized that "the boundaries between many disorder 'categories' are more fluid over the life course than DSM-IV recognized" (Ref. 1, p 5) and considered the implementation of a dimensional approach to diagnosis, which would have dramatically changed the focus of the DSM. However, the Task Force "recognized that it is premature scientifically to propose alternative definitions for most disorders" (Ref. 1, p 13). DSM-5 thus continues to use the categorical approach to clinical diagnosis familiar to clinicians and to most consumers of forensic evaluations. Forensic clinicians may experience challenges to DSM-5 diagnoses, based on the widely published criticisms by the chair of the DSM-IV Task Force[4] and the current Director of the National Institutes of Mental Health (NIMH), who in 2009 launched the research domain criteria project to "develop, for research purposes, new ways of classifying mental disorders based on dimensions of observable behavior and neurobiological measures."[5] Familiarity with the extensive review process that led to DSM-5, which included extensive literature reviews, field trials, and public and professional review before final publica-

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tion (Ref. 1, pp 6–10), should allow for effective rebuttal of such challenges.

The Psychotic Disorders

The Psychotic Disorders Workgroup decided that DSM-IV criteria for the psychotic disorders "do not accurately capture the considerable variability of symptom profile, response to treatment, and most importantly, social function and outcome"; however, despite considerable pressure to move to a dimensional approach to the diagnosis of psychotic disorders, "the DSM-5 does not represent such a paradigm shift" (Ref. 6, p 11).

There is subtle evidence of the dimensional approach in the chapter entitled "Schizophrenia Spectrum and Other Psychotic Disorders," which begins with a description of "five domains" of psychotic symptoms (Ref. 1, p 87), the names of which are identical to the five symptoms listed in Criterion A for the diagnosis of schizophrenia in DSM-IV. In addition, the work group developed a rating instrument, the Clinician-Rated Dimensions of Psychosis Symptom Severity, to evaluate eight dimensions of psychosis, "which may help with treatment planning, prognostic decision-making and research" (Ref. 1, p 89), but placed it in Section III, "Emerging Measures and Models" (Ref. 1, pp 743–4). This instrument is mentioned in the last section of the criteria for each of the psychotic disorders, under the heading "Specify Current Severity"; clinicians are referred to the instrument after the statement "quantitative assessment of the primary symptoms of psychosis . . . may be rated for its current severity . . . on a 5-point scale" (Ref. 1, p 91). This tool appears to be easy to use, could easily be adapted for inclusion in an electronic medical record, and may prove valuable in correctional and other treatment settings where continuity of care is difficult to achieve due to clinician turnover and movement of patients within the system. However, each section ends with a note, which states "diagnosis of [the disorder] can be made without using the severity specifier," which certainly implies that the use of this instrument is not required. A PubMed search of the phrase "clinician-rated dimensions of psychosis symptom severity" returned no items; thus, this instrument appears not to have been validated, which may make it vulnerable to challenge in court.

Overall, the criteria for diagnosis of psychotic disorders in DSM-5 are little changed from those in DSM-IV. All of the psychotic disorders found in DSM-IV are present in DSM-5, and catatonia was added, as a semiautonomous clinical entity. Schizotypal personality disorder is listed at the beginning of the section, "because this disorder is considered part of the schizophrenia spectrum of disorders" (Ref. 1, p 90). However, because "only a small proportion" (Ref. 1, p 657) of people with schizotypal personality go on to develop another psychotic disorder, the diagnostic criteria and explanatory text for schizotypal personality disorder, which are essentially identical to those in DSM-IV, remain in the section on Personality Disorders. The recognition in DSM-5 of schizotypal personality as part of the schizophrenia spectrum may have implications for sanity evaluations, which typically hinge on the presence or absence of psychosis, even though people with schizotypal personality do not show persistent symptoms of psychosis, such as hallucinations or delusions.

Delusional Disorder

In DSM-5, people who show bizarre delusions are now eligible for the diagnosis of delusional disorder, which is a significant change. The criteria also include a more modest change, as course specifiers are now more detailed. The subtypes of delusions are unchanged from DSM-IV, but clinicians may now also specify if the person's delusions show "bizarre content." The addition of bizarre delusions to the diagnostic criteria may increase slightly the frequency of this uncommon diagnosis, which DSM-5 estimates has a lifetime prevalence of 0.2 percent (Ref. 1, p 92). In a recent article, bizarre delusions were rarely (<2%) identified as the sole reason for a DSM-IV diagnosis of schizophrenia,[7] so the number of people whose diagnosis would change from schizophrenia to delusional disorder is likely to be low. It is hard to predict how the shift of bizarre delusions to the criteria for delusional disorder will affect treatment; the small research literature on the treatment of delusional disorder suggests that long-term treatment with antipsychotic medication may lead to a modest decrease in the intensity of delusions.[8,9] It is unknown whether people who have delusional disorder with bizarre content will show a similar response to antipsychotic medication. Given the strong likelihood of persistent symptoms in a person with delusional disorder, assessment of the risk of violence based on bizarre delusions will require, as always, a careful evaluation of the individual

and his symptoms, particularly if the delusions involve an identifiable individual (e.g., a family member or neighbor) or a group of people (e.g., police officers), thus putting that person or group at risk of violence.

Brief Psychotic Disorder

The core diagnostic criteria for brief psychotic disorder are essentially unchanged: the symptoms must persist for one month or less, and the person must recover fully after the psychosis ends. The criteria now require the acute onset of at least one symptom: delusions, hallucinations, or disorganized speech. Grossly disorganized or catatonic behavior remains as a fourth possible symptom but is not sufficient alone to make the diagnosis. The impact of this minor revision on forensic psychiatry is likely to be minimal.

Schizophreniform Disorder

The diagnosis of schizophreniform disorder is little changed. The A, B, C, and D criteria are identical to those in DSM-IV. The text for the specifier "with good prognostic features" has been slightly revised (Ref. 1, p 97). Schizophreniform disorder remains intermediate in symptom duration between brief psychotic disorder and schizophrenia. It has no corollary in the International Classification of Diseases (ICD) scheme,[10] in which a diagnosis of schizophrenia may be made after one month of symptoms of psychosis. The forensic impact of the minor changes in the criteria for schizophreniform disorder in DSM-5 should be minimal.

Schizophrenia

Critics have described the DSM-5 criteria for schizophrenia as an evolution, not a breakthrough.[11,12] The DSM-IV criteria for schizophrenia were quite reliable and diagnoses made with these criterion were stable over time, so only modest changes were made in DSM-5.[13] The five symptoms of the A criterion, which are familiar to clinicians, have been retained, but one of the two symptoms needed to diagnose schizophrenia must be delusions, hallucinations, or disorganized thinking and speech. Schneiderian first-rank symptoms (i.e., bizarre delusions or auditory hallucinations, either conversing among themselves or providing a running commentary) are no longer sufficient to qualify a person for a diagnosis of schizophrenia. Research on these symptoms found that they had no prognostic relevance and were not linked to a family history of schizophrenia; removing the Schneiderian symptoms from the A criteria was estimated to affect fewer than 2 percent of diagnoses.[11] In another change based on recent research, the negative symptoms have been limited to two choices: "diminished emotional expression or avolition" (Ref. 1, p 99). Negative symptoms are often overlooked in criminal forensic evaluations, which typically focus on the link between positive symptoms of psychosis and behavior, but a lack of volition may have important implications for deciding whether a defendant possessed *mens rea* at the time of the alleged offense. In civil forensic evaluations, negative symptoms are well known as a primary cause of disability in schizophrenia.[14]

DSM-5 does not identify any subtypes of schizophrenia (e.g., paranoid or disorganized), due to the frequent comorbidity among the DSM-IV subtypes and their poor reliability, low stability, and limited prognostic value.[13] In contrast, the course specifiers for schizophrenia in DSM-5 are almost completely new. There are two main categories of course specifiers, first episode and multiple episodes, each of which may be described as acute, in partial remission, or in full remission; the specifier continuous is the only holdover from DSM-IV (Ref. 1, pp 99–100). These specifiers should allow clinicians to describe accurately the present clinical status of a person with schizophrenia. The specifiers are likely to see regular use in correctional psychiatry, where ongoing treatment is the norm, and in civil forensic evaluations, where the specifiers may be helpful in commitment and disability evaluations. The course specifiers are not as likely to be a factor in criminal evaluations of competence or sanity.

The connection between a given mental disorder and a risk of violence is not prominent in the psychosis and mood disorders sections of DSM-5. The closest DSM-5 comes to this topic is in the description of "associated features supporting diagnosis" of schizophrenia, which includes the observation that "hostility and aggression can be associated with schizophrenia, although spontaneous and random assault is uncommon. Aggression is more frequent for younger males and for individuals with a history of violence, non-adherence with treatment, substance abuse and impulsivity" (Ref. 1, p 101). Beyond this statement, DSM-5 has little to say about the risk of violence associated with psychosis. The "Cautionary State-

ment for Forensic Use of DSM-5," which precedes the sections of diagnostic criteria, does not mention risk of violence.

Schizoaffective Disorder

Schizoaffective disorder was considered for removal from DSM-5, in favor of a dimensional approach to the diagnosis of the psychotic disorders. This proposal was based on the low reliability of this diagnosis compared with other psychotic disorders, recent research that suggested that schizoaffective disorder is intermediate between schizophrenia and bipolar disorder and may not be a separate diagnostic entity, and the limited clinical utility of a diagnosis that practitioners make without adhering to criteria.[15] However, because the available research findings "are not yet compelling enough to justify a move to a more neurodevelopmentally continuous model of psychosis" (Ref. 16, p 131), schizoaffective disorder was retained, with revised criteria. In particular, the requirement for the presence of a mood episode was strengthened, such that "mood symptoms sufficient to meet criteria for a mood episode must be present for at least half of the total duration of the illness from the onset of the first psychosis" to make a diagnosis of schizoaffective disorder (Ref. 15, pp 23–4). Schizoaffective disorder diagnosed with DSM-IV criteria has been shown to be an unstable diagnosis.[17] Field trials of the DSM-5 criteria for schizoaffective disorder showed good test-retest reliability when rigorously applied,[18] so it is possible the new criteria will also lead to a more stable diagnostic entity.

The forensic implications of the changes in the criteria for schizoaffective disorder in DSM-5 are not clear. A proper diagnosis of schizoaffective disorder requires that a person meet all of the criteria for schizophrenia and all of the criteria for an episode of bipolar disorder or depression, with the exception of impaired function. DSM-5 estimates the prevalence of schizoaffective disorder to be one-third that of schizophrenia (Ref. 1, p 107), so it should be an uncommon disorder. Although it is important to make as accurate a diagnosis as possible to treat effectively, the alternatives to schizoaffective disorder (i.e., schizophrenia with a mood component or a mood disorder with psychosis), should also lead clinicians to treat with appropriate classes of medication. Otherwise, the forensic implications of the changes to schizoaffective disorder should be modest; the main concern will continue to be appropriate and consistent use of the criteria.

Catatonia

In DSM-5, catatonia is recognized as a separate clinical entity, though not as an independent disorder. It can be diagnosed whenever it is present, but only in the context of a mental disorder, a medical disorder, or an unspecified condition. If a person meets 3 of the 12 criteria, the specifier "with catatonia" should be added to diagnoses of most of the serious mental disorders in DSM-5 (Ref. 1, pp 119–120), to "facilitate its appropriate recognition and specific treatment."[19] Catatonia was once considered a common presentation of schizophrenia, but its reported prevalence in schizophrenia declined over the course of the 20th century[20,21]; in recent research, though, catatonia was found in up to 10 percent of people with an acute psychiatric disorder, nearly half of whom had a mood disorder and only a quarter of whom had a psychotic disorder.[22] Improved awareness of catatonia could have implications for forensic practice. In the criminal realm, catatonia could certainly contribute to a finding of incompetence to stand trial, but it is unlikely to be an element of an insanity defense, as only one of the 12 symptoms, agitation, might be a precursor to illegal activity. The primary outcome of recognition of catatonia, though, would be the impact on the person with catatonia, as this condition can be treated effectively.[22]

Attenuated Psychosis Syndrome and Shared Psychotic Disorder

The Psychotic Disorders Work Group considered adding attenuated psychosis syndrome as a new diagnosis to DSM-5, but instead decided to place it in Section III as a condition for further study, after field trial data showed that it was not diagnosed reliably by clinicians.[23] Attenuated psychosis syndrome is meant to describe people who show "recent onset of modest, psychotic-like symptoms and clinically relevant distress and disability" (Ref. 23, p 32). In addition, the person who experiences the symptoms must recognize them as unusual and experience sufficient distress or disability to seek clinical evaluation. Despite the clear guidance in the DSM-5 that conditions in Section III are not intended for clinical use, this syndrome is not just in Section III, but is also specifically identified in "Other Specified Schizophrenic Spectrum and Other Psychotic Disorder" as

one of four examples of alternative presentations of a psychotic disorder; where it is labeled "other psychotic disorder, attenuated psychosis syndrome" (Ref. 1, p 122).

The diagnosis of attenuated psychosis syndrome may contribute to a finding of incompetence to stand trial, as young adults are at highest risk for this disorder and are at highest risk for arrest, but it is unlikely to be the single reason for such a finding, given the absence of overt psychosis. Attenuated psychosis is also unlikely to be a precursor to an insanity verdict, as this syndrome is meant to identify people with symptoms that are "psychosis-like but below the threshold for a full psychiatric disorder" (Ref. 1, p 783). Attenuated psychosis may appear more frequently in civil forensic evaluations, in the context of employment and disability assessments.

Shared psychotic disorder (*folie à deux*), which was present in DSM-IV as a separate disorder, exists in DSM-5 only in the section on other specified schizophrenic spectrum and other psychotic disorders, as "delusional symptoms in partner of individual with delusional disorder" (Ref. 1, p 122). The presence of shared psychotic disorder in DSM-5 will allow continued recognition of this disorder, which, although rare, is occasionally seen in forensic cases, both criminal and civil.

Mood Disorders

The DSM-IV section on Mood Disorders has been replaced in DSM-5 with separate sections for the Bipolar Disorders and the Depressive Disorders. The section on Bipolar Disorders is placed between the Psychotic Disorders and the Depressive Disorders in DSM-5, "in recognition of their place as a bridge between the two diagnostic classes in terms of symptomatology, family history and genetics" (Ref. 1, p 123). Three new depressive disorders are included in DSM-5: disruptive mood dysregulation disorder, persistent depressive disorder, and premenstrual dysphoric disorder; the first of these will not be discussed in this article but will be considered in the review of "Neurodevelopmental and Other Disorders of Childhood and Adolescence."[24] The number of bipolar disorders is unchanged; they consist of bipolar I, bipolar II, and cyclothymic disorders, as well as bipolar disorder due to medications, drugs, or a medical condition. The criteria for episodes of mania, hypomania, and major depression are generally unchanged from DSM-IV, with a few important exceptions, which are discussed below. Missing from DSM-5 is the DSM-IV entity of mood disorder NOS, which has been replaced with unspecified bipolar disorder and unspecified depressive disorder; people who present with an unclear pattern will have to be designated as one or the other.

Specifiers for Mood Disorders

DSM-5 includes multiple specifiers to describe the Bipolar and Depressive Disorders (Ref. 1, pp 149–54, 184–8), as part of a mixed categorical-dimensional approach.[25] The specifiers are meant "to define a more homogeneous subgrouping of individuals with the disorder who share certain characteristics . . . and to convey information that is relevant to the management of the individual's disorder" (Ref. 1, pp 21–2). The presence of new and more detailed descriptive specifiers for the bipolar and depressive disorders may have some impact on forensic psychiatry. The specifiers are intended to be used to describe the course of a person's disorder and should not affect the frequency of the underlying diagnosis, but some specifiers may have implications for suicide risk. In addition, these specifiers may be useful in forensic contexts where a prediction of future course may be helpful, such as sentencing, civil commitment, and child custody.

The specifier of "with anxious distress" (Ref. 1, p 149) is the only entirely new one. It was added to account for the high prevalence of symptoms of anxiety in both manic and depressed states and because "a substantial body of research conducted over the past two decades points to the importance of anxiety as relevant to prognosis and treatment decision-making" in bipolar and depressive disorders.[26] The addition of this specifier should encourage the identification of anxiety in people who have a bipolar or depressive disorder, which should lead to improved management of suicide risk, as anxiety is a risk factor for suicide.[27] Conversely, a lack of recognition of anxiety in the medical record or treatment plan could have implications for malpractice liability in cases of attempted or completed suicide.

The DSM-IV specifier of postpartum onset has been replaced in DSM-5 by "with peri-partum onset," which may be applied if the mood episode occurs during pregnancy or within four weeks of delivery. The explanatory note for this specifier makes it clear that it was added to improve the recognition of bipolar and depressive episodes during pregnancy, in

order to prevent postpartum psychosis, which is often linked to a mood disorder and is a major risk factor for infanticide (Ref. 1, pp 152–3). The addition of peri-partum onset will thus have forensic implications, both for the management of bipolar and depressive disorders in pregnancy and for the review of cases of infanticide.

The DSM-IV entity of a mixed episode of bipolar disorder has been replaced with the specifier "with mixed features" (Ref. 1, p 149–50), which can be applied to bipolar I, bipolar II, major depressive, and persistent depressive disorders. Thus, a person with hypomania or mania who shows some symptoms of depression and a person with depression who shows some symptoms consistent with hypomania or mania should be designated as "with mixed features." Although the mixed-features specifier will "better account for the highly prevalent subsyndromal presentations" (Ref. 28, p 30) of both manic and depressed states, its addition does not solve the problems of the overlap between unipolar and bipolar depression or the gray zone of the boundary between bipolar disorder and schizoaffective disorder.[28] As a result, debate on the applicability of this specifier to a particular person could be vigorous. The DSM-5 criteria for the specifier of mixed features have also been criticized for including euphoria and excluding agitation and irritability, thus moving away from Kraepelin's original concept of mixed depression as a fairly common clinical entity.[29] Overall, the impact this specifier will have on forensic practice is unclear.

The specifier "with seasonal pattern" now includes all mood episodes (mania, hypomania, and depression) in the introduction and the criteria, instead of being limited, as in DSM-IV, only to episodes of depression. However, the explanatory note makes it clear that "the essential feature is the onset and remission of major depressive episodes at characteristic times of the year" (Ref. 1, p 153), which retains the intent of the DSM-IV criteria.

The criteria for the specifiers "with melancholic features" and "with atypical features" are largely unchanged from DSM-IV, but a detailed note on the use of each specifier has been added to the text for each. The criteria for the specifier "with psychotic features" are essentially unchanged and have no explanatory note. The criteria for "with rapid cycling" are also unchanged, but a second explanatory note was added to clarify that each of the four episodes needed in one year to qualify for this diagnosis must be marked by full remission or a switch of polarity.

Bipolar I Disorder

The Mood Disorders Work Group introduced the criteria for the bipolar disorders by noting "the bipolar I disorder criteria represent the modern understanding of the classic manic-depressive disorder" (Ref. 1, p 123). There are two changes in the criteria for bipolar I disorder in DSM-5. First, a person with mania must show elated or irritable mood or both and increased energy or activity, which modestly tightens the criteria for a manic episode. Second, "excessive involvement in activities" no longer requires these activities to be pleasurable, just to have "a high potential for painful consequences" (Ref. 1, p.134), which can be seen as a modest loosening of the criteria. The work group also clarified that mania induced by treatment with antidepressant medication counts as a manic episode for the purpose of diagnosing bipolar I disorder. The DSM-5 criteria for bipolar disorder are unlikely to have a significant impact on forensic psychiatry and are unlikely to solve the debate over whether bipolar disorder is overdiagnosed[30] or underdiagnosed.[31]

The prevalence of self-reported bipolar disorder in correctional populations is likely to remain high so long as people who report mood swings are given a prescription for a mood-stabilizing medication and a diagnosis of some form of bipolar disorder by clinicians. If the DSM-5 criteria for the diagnosis of bipolar disorder are used appropriately, the frequency of this phenomenon should decrease. However, even though the DSM-IV diagnosis of bipolar disorder NOS has been removed, DSM-5 has added "other specified bipolar and related disorders" (Ref. 1, p 148) and "unspecified bipolar disorder" (Ref. 1, p 149), which are likely to be used to describe people who report subjective mood instability that does not meet criteria for bipolar I or bipolar II disorder. In particular, the choices under other specified bipolar and related disorder include four variant presentations, including one that is also listed in Section III (depressive episodes with short-duration mania), which could account for several bipolar presentations that do not include a true manic or hypomanic episode. The report of a prior diagnosis of bipolar disorder in a forensic evaluation should prompt thorough, open-ended questioning of the person's

psychiatric history, searching for evidence of true manic or hypomanic episodes.

Bipolar II Disorder

The DSM-5 diagnosis of bipolar II continues to require at least one episode of current or past hypomania and at least one episode of current or past major depression, with no history of an episode of mania. There is a new focus in the criteria on the functional impact of the symptoms of depression in bipolar II, as the section on the diagnostic features notes that this disorder often presents with major depression and urges clinicians to ask for a history of hypomania in people who are depressed (Ref. 1, p 135). In addition, because people who have bipolar II disorder often experience repeated or prolonged episodes of depression, DSM-5 makes a point of describing bipolar II disorder as not less severe than bipolar I disorder. The observations made above regarding the prevalence of diagnoses of bipolar I disorder also apply to bipolar II disorder.

Cyclothymic Disorder

The diagnosis of cyclothymic disorder requires a two-year history of many episodes of not-quite hypomania and not-quite major depression. DSM-IV permitted this diagnosis to remain active if an episode of mania, hypomania, or major depression occurred after the first two years of subsyndromal symptoms. The DSM-5 criteria hold that "criteria for a major depressive, manic or hypomanic episode have never been met." In addition, the DSM-5 criteria clarify that hypomanic or depressive symptoms must be present at least half of the time during the required two-year period (Ref. 1, pp 139–40). These changes in the criteria will further restrict the prevalence of this relatively rare disorder, but their impact on forensic practice is likely to be minimal, as this disorder is uncommon in criminal forensic evaluations and is not a major cause of disability.

Major Depressive Disorder

The primary criteria for the diagnosis of major depression in DSM-5 are largely unchanged from DSM-IV, with one potentially significant exception. DSM-IV permitted a diagnosis of depression in a bereaved person only if the symptoms had been present for more than two months or if they had caused marked functional impairment. However, research on bereavement and depression found little reason for such a distinction. The Mood Disorders Work Group therefore proposed that symptoms of depression in the context of bereavement or other significant loss would qualify for a diagnosis of major depression, which would have removed the "normal bereavement" exception for depression found in DSM-IV and present in the ICD.[32] This proposal was met with strong criticism by many clinicians and the public, who felt that the new disorders inappropriately turned a normal psychological reaction to loss into a form of psychopathology.

The Mood Disorders Work Group did not reinstate the bereavement exception, but instead added a note to the depression criteria to explain that "responses to a significant loss . . . may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode . . . should also be carefully considered" (Ref. 1, p 161). This change to the criteria for major depression could have an impact on civil forensic psychiatric evaluations. If bereavement is no longer a barrier to a diagnosis of depression, this diagnosis can be made in survivors of wrongful or negligent deaths, which could increase claims for damages.

A more subtle change in the criteria for depression in DSM-5 can be found in the description of depressed mood, where a person who is depressed is "sad, empty or hopeless"; in DSM-IV the phrase was "sad or empty." Thus, a feeling of hopelessness alone is enough to meet the criterion for depressed mood, which could increase the frequency of the diagnosis of depression.[32] Hopelessness has long been recognized as a risk factor for suicide,[33,34] so the recognition of this symptom as characteristic of depression should encourage clinicians to inquire about hopelessness and then to take it into account in their suicide risk assessment.

A major concern for all clinicians who use the DSM is the reliability of the disorders described in the manual. Major depression does not fare well in this regard; the inter-rater reliability of DSM-5 major depression showed a κ coefficient of 0.28, well below the coefficients for the DSM-III[35] (between 0.60 and 0.80) and DSM-IV (between 0.40 and 0.80) criteria.[32]

Persistent Depressive Disorder (Dysthymia)

The diagnosis of persistent depressive disorder is new to DSM-5 and is meant to combine the DSM-IV disorders of dysthymia and chronic major depression, defined as two or more years of continuous major depression. The decision to merge these diagnostic concepts was based on research that suggested that chronic depression was prevalent in the community and could be distinguished from nonchronic depression.[36] The A, B, and C criteria for persistent depressive disorder are unchanged from the DSM-IV criteria for dysthymia, but the D criterion now reads "criteria for a major depressive disorder may be continuously present for two years" (Ref. 1, p 168). The relationship between persistent depressive disorder and major depression in DSM-5 is somewhat confusing and leads to conflicting recommendations. For example, a person "whose symptoms meet major depressive disorder criteria for two years should be given a diagnosis of persistent depressive disorder as well as major depressive disorder" (Ref. 1, p 169), whereas for a person who meets criteria for persistent depressive disorder, "if the symptom criteria are sufficient for a diagnosis of a major depressive episode at any time during this period, then the diagnosis of major depression should be noted, but it is not coded as a separate diagnosis but rather as a specifier" (Ref. 1, pp 170–1). The proper diagnosis of a person with chronic depression may thus become a fruitful area for cross-examination, given the multiple ways a person with chronic symptoms of depression could be coded. The impact of persistent depressive disorder in clinical practice may be modest, outside of the possible confusion of proper diagnosis, as people who have dysthymia or chronic depression respond to similar treatment.

Premenstrual Dysphoric Disorder

This disorder was in Appendix B of DSM-IV (Ref. 37, pp 715–18) but has been moved to the main text in DSM-5. The research criteria laid out in DSM-IV have been modified for DSM-5. This diagnosis is based on the presence of specific symptoms in the week before onset of menses followed by resolution of the symptoms after onset. The symptoms must include one or more of marked affective lability, irritability or anger, depressed mood or hopelessness, and anxiety or tension, as well as one or more of an additional seven symptoms, with a total of at least five symptoms. The criteria specifically note that "Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles" (Ref. 1, p 172), which means it will be difficult to make this diagnosis on the basis of a single evaluation; although two cycles of daily ratings are technically not required, it will be easy to challenge a diagnosis made without these data. The addition of premenstrual dysphoric disorder to DSM-5 may open up new avenues in civil forensic evaluations, most likely in the area of disability evaluations, and may make an appearance in criminal evaluations if affective instability and anger due to this disorder contribute to an individual's violent behavior.

Conclusion

Overall, because many of the changes in the criteria for these disorders are minor, the forensic implications of the DSM-5 criteria for the diagnoses of psychotic and mood disorders appear to be modest, with a few exceptions. Forensic clinicians should review the DSM-5 criteria for the mood and psychotic disorders carefully and consider how the new criteria may affect their evaluations and practice.

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