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## **Bipolar and related disorders and depressive disorders in DSM-5**

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### **Summary**

In 2013, a version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), having number 5, was published. The DSM is a textbook which aims to present diagnostic criteria for each psychiatric disorder recognized by the U.S. healthcare system. The DSM-5 comprises the most updated diagnostic criteria of psychiatric disorders as well as their description, and provides a common language for clinicians to communicate about the patients. Diagnostic criteria of the DSM-5 have been popular all over the world, including countries where the ICD-10 classification is obligatory, and are widely used for clinical and neurobiological research in psychiatry. In this article, two chapters of the DSM-5 pertained to mood (affective) disorders are presented, such as “Bipolar and related disorders” and “Depressive disorders” replacing the chapter titled “Mood disorders” in the previous version of DSM-IV. The aim of this article is to discuss a structure of new classification, to point out differences compared with previous version (DSM-IV). New diagnostic categories, such as e.g. disruptive mood dysregulation disorder or premenstrual dysphoric disorder were depicted as well as some elements of dimensional approach to mood disorders were presented.

**Key words:** bipolar disorders, depressive disorders, DSM-5

### **Introduction**

In May 2013, after 14 years of workings, a succeeding version of Diagnostic and Statistical Manual of Mental Disorders, number five (DSM-5), was introduced [1]. The DSM is a textbook aiming to present diagnostic criteria of all mental disorders recognized in the health system of the United States. In addition, the textbook provides descriptions of each diagnostic category what makes it a valuable tool for obtaining statistical data and is helpful for all health professionals to communicate. The list of mental disorders, their classification and diagnostic criteria came into existence after many years of work of many experts from multiple panels, analysing

the results of research, clinical reviews etc. This process can be observed on the web page [www.dsm5.org](http://www.dsm5.org)

The DSM-5 issued in 2013 comprises the most updated diagnostics criteria of mental disorders and their description, and provides a common updated language for clinicians to communicate about their patients. International Classification of Diseases (ICD) contains code numbers used in DSM-5 and medicine in general, necessary for monitoring morbidity and mortality statistics and for insurance purposes.

Since diagnostics criteria of the DSM have gained a considerable popularity all over the world, including countries with obligatory classification of the ICD-10 [2], and are widely used in clinical and neurobiological research in psychiatry, it seems purposeful to acquaint Polish psychiatrists, as soon as possible, with new DSM-5 classification.

In the current article, two DSM-5 chapters will be discussed, namely “Bipolar and related disorders” and “depressive disorders”, which replaced the chapter titled “Mood disorders” in the previous version of DSM-IV [3].

The aim of the article is to discuss the structure of the DSM-5 classification and to point on the differences from the previous version (DSM-IV). New diagnostic categories as well as some elements of a dimensional approach to mood disorders in the new classification will be presented. The DSM-5 has already been a topic of a number of arguable articles published in recent months in psychiatric literature [4-7].

## **Bipolar and related disorders**

### *Bipolar I disorder*

Bipolar and related disorders are separated as a distinct chapter in DSM-5 and include:

1. Bipolar I disorder
2. Bipolar II disorder
3. Cyclothymic disorder
4. Substance/medication induced bipolar and related disorder
5. Bipolar and related disorder due to another medical condition
6. Other specified bipolar and related disorder
7. Unspecified bipolar and related disorder

In this subchapter, the criteria of manic episode, hypomanic episode and major depressive episode are presented. As the episode of “major” depression denotes depression in the course both unipolar and bipolar disorder which meets symptomatic and duration criteria, in this article, the term “depressive episode” will be used. In

addition, for unipolar disorder the abbreviation UD will be used, and, for bipolar disorder – the BD.

For the diagnosis of manic episode, the DSM-5 introduced a change in criterion (A): to diagnose mania it is necessary that a distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased goal-directed activity or energy occurs. There is an added note in the diagnostic criteria for mania: a full manic episode that emerges during antidepressant treatment (medication, electroconvulsive therapy) but persists at fully syndromal level beyond the physiological effect of the treatment is sufficient evidence for manic episode and, therefore, a bipolar I diagnosis.

The DSM-IV had one more criterion for manic episode (marked as C) – the exclusion of mixed episode. In the DSM-5 there are no description and criteria for mixed episode and there is no such diagnostic category. Mixed state is placed as a specifier and can be used to describe each mood episode (manic, hypomanic and depressive) and will be discussed later in the article.

In the criterion (A) for hypomanic episode, the symptom of abnormally and persistently increased activity or energy is required. Duration criterion for hypomanic episode is 4 or more days. Short-term hypomania (lasting 1-3 days) [8] is included in DSM-5 section of other specified bipolar and related disorder.

Also hypomanic episode that emerges during antidepressant treatment and persists beyond the physiological effect of that treatment is sufficient for diagnosis of hypomanic episode, which may occur in the BD type I. The authors of DSM-5 suggest a caution in making such diagnosis as one or two hypomanic symptoms may not be sufficient for diagnosis of hypomanic episode (for example, increased irritability or agitation can be result of antidepressants use). If hypomanic symptoms cause marked impairment in any area of functioning or if there are psychotic features – manic episode should be diagnosed.

Diagnostic criteria for major depressive episode (MDE) are similar for unipolar and bipolar depression. The symptom of hopeless was added to subjective symptoms of depressive mood besides feelings of sad and empty. Duration criteria (2 weeks) for depression remained the same as in the DSM-IV, but two DSM-IV exclusion criteria: mixed episode and bereavement were deleted.

This last issue is one of the most controversial concerning changes in the DSM-5 compared to the DSM-IV and has been widely discussed in the psychiatric literature. In DSM-IV, one could diagnose a depressive episode after the death of a loved one if grief is lasting for 2 months or more, characteristic depressive symptoms occur and cause a significant impairment in functioning. DSM-5 suggests to carefully consider a possible presence of depressive episode in addition to the grief response, and, if so, to diagnose depression even after 2 weeks of its symptoms. Such a diagnosis requires

a clinical experience and taking into account the individual situation of loss as well as cultural norms.

In the process of differentiation between grief in bereavement and depressive episode it is emphasized that in grief, feelings of emptiness and loss predominate, while in depression, persistent depressed mood and the inability to anticipate happiness and pleasure (anhedonia). Symptoms of grief (sadness related to thoughts or memories about the lost one) are frequently transient (*pangs of grief*) and may decrease within days to weeks. In depressive episode depressed mood is more persistent and not tied to specific thoughts or issues. Sadness in grief might be accompanied by positive emotion, and sometimes humor, while in depressive episode pervasive unhappiness and misery is characteristic. The thought content in grief is preoccupied with memories of the deceased, and not with pessimistic ruminations or decreased self-esteem as in depressive episode. Usually, during grief, the self-esteem is preserved, while in depressive episode, feeling of worthless and self-loathing dominate. Feeling guilty in grief usually refers to failed obligations to the deceased person – for example, not visiting the grave or not reminiscing the person frequently enough, etc. During grief, thoughts of death are usually associated with a deceased person, and possibility of “joining” him/her, while in depressive episode, thoughts are associated with terminating one’s own life because of feeling worthless, undeserving of life or unable to cope with the pain of depression.

Despite these controversies, it is argued that a possibility to recognize depression in a grief is not a ‘stigma’ or ‘medicalisation’ of it but gives a better opportunity to care for such person, among others, an appropriate use of antidepressants [9].

After presentation of criteria for each mood episode, there are criteria for bipolar disorder type I: (A)- criteria have been met for at least one manic episode; and (B) the occurrence of the manic and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum or other psychotic disorder.

For bipolar and related disorders the DSM-5 suggests diagnostic coding based on type of current or most recent episode and its severity, presence of psychotic features and remission status. Remission can be diagnosed only if full criteria are not currently met for manic, hypomanic and depression episode. The recording should read in the following order: bipolar I disorder, type of most recent or current episode, severity/psychotic/remission. Then one should use as many specifiers as possible, such as anxious distress, mixed features, rapid cycling, atypical features, melancholic features, mood-congruent/mood-incongruent psychotic features, catatonia, peripartum onset and seasonal pattern. Those specifiers will be discussed in detail later in the article.

According to the DSM-5, the 12-month prevalence of BD type I (as defined in DSM-IV) in the United States is 0.6%, and across 11 countries ranged from 0 to 0.6%. The DSM-IV reported prevalence of BD type I as 0.4%-1.6%. The DSM-5 also presents the issue, less considered in the DSM-IV, of co-occurring with BD both mental disorders, including the most frequent anxiety disorders (in three-fourths of individuals), ADHD, disruptive, impulse-control disorders, substance use disorder (50%), and somatic disorders (metabolic syndrome, migraine). Substance use disorder in the DSM-5 merges the DSM-IV categories of substance abuse and substance dependence into a single disorder.

In comparison to the DSM-IV, in the DSM-5 an additional paragraph appeared that discusses the implications of disease for the patient's functioning. It was stressed that about 30% of patients experience a significant occupational impairment. This inconsistency between the resolution of symptoms, and return to the good functioning is often associated with a lower socioeconomic status than the control group, with a similar education. People with bipolar I disorder obtain worse results in cognitive tests (also during periods of remission), which can result in the difficulties of professional and interpersonal functioning throughout life.

### *Bipolar II disorder*

In the DSM-5 bipolar II disorder can be diagnosed if: (A) the criteria are met for at least one hypomanic episode AND one depressive episode, (B) there has never been manic episode, (C) the occurrence of hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder. Criterion (D) states that symptoms of depression or unpredictability caused by frequent alteration between periods of depression and hypomania cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

The diagnosis of bipolar II disorder should also provide for current severity (mild, moderate, severe), presence of psychotic features, state of remission (partial/full), and other specifiers – as in BD I.

According to the DSM-5, the 12-month prevalence of BD II in the United States is 0.8%, in international research – 0.3%. In 5-15% of persons with BD II the diagnosis is changed to BD I because they develop manic episode. About 15% of persons with BD II experience disturbances of functioning also between episodes, and about 20% switch directly into another mood episode without inter-episode recovery. As in BD I, there is inconsistency between symptomatic remission and functional recovery, mainly occupational, also in BD II what results in a lower economic status, despite a similar

education. Also, the performance of patients on tests of cognitive function is poorer than healthy controls, which may impair their professional capacity. A prolonged unemployment is related to the greater number of depressive episodes and of alcohol abuse. In the description of bipolar II, the DSM-5 takes also into account the issue of co-morbidity. It is estimated that approximately 60% of patients with bipolar II has 3 or more co-occurring psychiatric disorders. The most frequent are anxiety and substance use disorders, and eating disorders were found in 14%.

### *Cyclothymic disorder*

In comparison to the DSM-IV, the new version did not significantly change the criteria for cyclothymic disorder. They are as follows: (A) for at least 2 years (at least 1 year in children and adolescents) there have been numerous periods with hypomanic symptoms that do not meet criteria for hypomanic episode and numerous periods with depressive symptoms that do not meet criteria for depressive episode; (B) during the above 2-year period (1 year in children and adolescents), the hypomanic and depressive periods have been present for at least half the time and the person has not been without the symptoms for more than 2 months at a time; (C) Depressive, manic or hypomanic episode criteria has never been met The symptoms in Criterion A are not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum or other psychotic disorder (D) or physiological effects of a substance or a another medical condition (E). The criterion (F), necessary for diagnosis states that symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. There is 15-50% risk that individual with cyclothymic disorder will subsequently develop BD I or BD II, co-morbid sleep and substance – related disorders and ADHD in children and adolescents frequently occur.

### *Substance/medication induced bipolar and related disorder*

It replaces the category of substance-induced mood disorder, presented in the DSM-IV. The diagnosis of substance/medication induced bipolar and related disorder points in its name, that medication can induce bipolar symptoms (in DSM-IV only word substance was used). Criterion (A) was constructed as: a prominent and persistent disturbance in mood predominates, characterized by (an elevated, expansive, or irritable mood with or without depressed mood, or markedly diminished interest or pleasure in all, or almost all, activities. In the DSM-IV, symptoms from criterion (A) have to develop during or within a month after substance intoxication or withdrawal, or medication use.

The DSM-5 requires that the symptoms developed during or soon after substance intoxication or withdrawal or after exposure to a medication and requires also certainty that this substance/medication is capable to lead to symptoms of criterion (A). According to (C) the disturbance is not better explained by a bipolar or related disorder that is not substance/medication induced. Criteria (D) The disturbance did not occur exclusively during a delirium and (E) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, are similar to the DSM-IV.

In the DSM-5, the name of substance should be given (if is known) or information that name is unknown and information if beginning of disturbances is related to intoxication or withdrawal. E.g. patients with bipolar or related disorder connected with cocaine use with beginning during intoxication.

### *Bipolar and related disorder due to another medical condition*

Changed herein is the term *general medical condition to another medical condition*. The diagnostic criterion (E) is extended: the disturbances causes clinically significant distress or impairment in social, occupational or other important areas of functioning, or necessitates hospitalization to prevent harm to self or others, or there are psychotic features. The DSM-5 offers diagnosis: with manic features, with manic- or hypomanic-like episode, with mixed features. For example: Bipolar disorder due to hyperthyroidism with manic features.

### *Other specified bipolar and related disorder and unspecified bipolar and related disorder*

The DSM-5 has removed „*mood disorder not otherwise specified*” category of the DSM-IV and has introduced: *other specified bipolar and related disorder* and *unspecified bipolar and related disorder*. Other specified bipolar and related disorder is recommended to diagnose when bipolar symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning, but do not meet criteria for any diagnostic classes. Using this category one should to add information of specific reason – for example- short duration hypomania (1-3 days) or short duration cyclothymia (less than 2 years). The diagnosis of other unspecified bipolar and related disorder is used when bipolar symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning, but do not meet criteria for any diagnostic classes and clinician is not giving precise information about the specific reason, for example because of lack sufficient information due to emergency room settings.

### Specifiers for bipolar and related disorders

In the DSM-5, at the end of the chapter of bipolar disorders the specifiers are listed recommended to be used in diagnosis of manic, depressive or hypomanic episodes:

- *With anxious distress*: there are five symptoms (feeling keyed up or tense, feeling unusually restless, difficulty concentrating because of worry, fear that something awful may happen, feeling that the individual might lose control of himself/herself), one should specify current severity – mild (2 symptoms), moderate (3 symptoms), moderate –severe (4 or 5 symptoms, severe (4-5 symptoms with motor agitation). This specifier allows to identify anxiety symptoms that are not part of the bipolar diagnostic criteria.
- *With mixed features* specifier can apply to the current manic, hypomanic or depressive episode in BD I or BD II. Criteria of hypomanic / manic episode with mixed features include the presence of at least 3 of the 6 depressive symptoms. The criteria for a depressive episode with mixed features include the presence of at least 3 of 7 manic symptoms. The authors emphasize that the occurrence of mixed features in an episode of depression is a risk factor for bipolar disorder and they require careful monitoring.
- *With rapid cycling* – (for BD I or BD II)- presence of at least four mood episodes in previous 12 months that meet criteria for manic, hypomanic or depressive episode. Episodes have to be demarcated by partial or full remissions at least 2 months or switch to an episode of the opposite polarity (mania and hypomania are the same pole). Those counted episodes cannot be caused by substance/medication or another medical condition.
- *With melancholic features* – one of two (loss of pleasure in all, or almost all activities and/or lack of reactivity to usually pleasurable stimuli) and 3 or more of 6 features (significantly depressed mood, worse in the morning, early –morning awakening, marked psychomotor agitation or retardation, anorexia or weight loss, inappropriate guilt) are present during the most severe period of depressive episode. Melancholic features are more frequent in inpatients, and are more likely to occur in those with psychotic features.
- *With atypical features* – mood reactivity and 2 (or more) of 4 features (increased appetite or weight gain, hypersomnia, leaden paralysis, interpersonal reaction sensitivity) predominate during the majority of days of current episode of depression.
- *With psychotic features* – presence of delusions or hallucinations at any time in the episode, one should specify if mood congruent or mood –incongruent.
- *With catatonia* – can apply if during mania or depression catatonia features are present most of the episode

- *With peripartum onset*: this specifier in DSM-5 replaced “postpartum” and expands diagnosis to the period of pregnancy and 4 weeks after delivery. It applies to: current or recent episode of mania, depression or hypomania in BD I or BD II. According to the DSM-5 about fifty percent of “postpartum” depression actually begin prior to delivery. Prospective studies have shown that mood and anxiety symptoms during pregnancy, as well as the “baby blues” increase the risk for a postpartum depressive episode. Peripartum depression can present with psychotic features, and the risk factor for them is previous depression or BD and/or BD in the family. Psychotic features in postpartum episode increases 30-50% the risk of reoccurrence with each next delivery.
- *With seasonal pattern* – regular seasonal pattern of occurrence of at least one type of episode (mania, hypomania, depression). It is possible that one type of episode (for example – mania) regularly occurs the specific time (for example- summer) of the year but different (for example – depression)- does not. Seasonal pattern has to last at least 2 years, number of seasonal episodes must outnumber all non-seasonal episodes

For each diagnosis more specific data on the remission and severity should be given. Partial remission: there were pre-existing symptoms meeting the criteria for mania, hypomania, depression, and the current period without symptoms lasting less than two months. The full remission: a period without symptoms lasts two months. The severity of the episode may be mild, moderate or severe. This assessment depends on the number of symptoms according to the criteria of the disorder, its severity and the degree of dysfunction.

### **Depressive disorders**

The common features of all of these depressive disorders are the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual’s capacity to function. What differs among them are issues of duration, timing, or presumed etiology.

In this chapter are presented:

1. Disruptive mood dysregulation disorder – DMDD
2. Major depressive disorder – MDD, including major depressive episode – MDE
3. Persistent depressive disorder – PDD (dysthymia)
4. Premenstrual dysphoric disorder – PMDD
5. Substance/medication induced depressive disorder
6. Depressive disorder due to another medical condition
7. Other specified depressive disorder
8. Unspecified depressive disorder

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*Disruptive mood dysregulation disorder – DMDD*

In order to address concerns about the potential for overdiagnosis of (and treatment) for bipolar disorder in children, a new diagnosis, disruptive mood dysregulation disorder, was introduced. Such symptoms in children and adolescents- persistent irritability and frequent episodes of extreme behavioral dyscontrol typically are related to unipolar or anxiety disorders as they mature.

Proposed diagnostic criteria for DMDD:

- (A) Severe recurrent temper outbursts manifested verbally and/or behaviorally (e.g. physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation
- (B) The temper outbursts are inconsistent with developmental level
- (C) The temper outbursts occur, on average, three or more times per week
- (D) The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g. parents, teachers, peers)
- (E) Criteria A-D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in the Criteria A-D.
- (F) Criteria A and D are present in at least two of three settings (i.e. at home, at school, with peers) and are severe in at least one of these.
- (G) The diagnosis should not be made for the first time before age 6 years and after age 18 years.
- (H) By history or observation, the age at onset of Criteria A-E is before 10 years.
- (I) There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.
- (J) The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder.
- (K) The symptoms are not attributable to the physiological effects of substance or to another medical or neurological condition.

According to the DSM-5, the DMDD is common among children, prevalence is probably 2-5% among children and adolescents, rates are expected to be higher in school-age males. The DSM-5 emphasizes that switch rate from DMDD to bipolar disorder is low, and DMDD rather increases risk for depressive disorder and anxiety disorder in adults. It should be differentiated with of bipolar disorder, ADHD, MDD, anxiety disorders, and autism spectrum disorder.

*Major depressive disorder – MDD, with major depressive episode – MDE*

Criteria (A-C) for depressive episode are presented in the part of article about bipolar disorder. A diagnosis of MDD based on a single episode is possible, but in the majority this disorder is recurrent. Criteria (D) and (E) include the exclusion of other psychiatric disorders and episode(s) of mania and hypomania.

For differentiation with grief (in DSM-5 grief is not exclusion criterion) it is pointed out, that bereavement causes sadness and distress, but not depression. If depression and grief occur together, usually depressive symptoms and impaired functioning are more pronounced than in grief with no symptoms of depression. Depression associated with bereavement usually occurs in people with susceptibility to depression and recovery may be facilitated by antidepressant treatment (see: depressive episode in bipolar disorder)

In recording depressive disorder, information should be added in the following order: single or recurrent episode, severity/psychotic/remission specifiers, followed by the following specifiers without codes that apply to the current episode: with anxious distress, with mixed features, with melancholic features, with atypical features, with mood-congruent psychotic features, with mood-incongruent psychotic features, with catatonia, with peripartum onset, with seasonal pattern.

Diagnosis can read as follows: major depressive disorder, recurrent, moderate, with no psychotic features, with peripartum onset.

Twelve-month prevalence of major depressive disorder in the United States is approximately 7%, females experience 1.5- to 3-fold higher rates than males beginning in early adolescence, the prevalence in 18- to 29-year-old individuals is threefold higher than the prevalence in individuals age 60 years to older. According to DSM-5, the likelihood of onset appears to peak in the third decade. The course of major depressive disorder is quite variable, such that some individuals rarely, if ever, experience remission (a period of 2 or more months with no symptoms, or only one or two symptoms to no more than a mild degree), while others experience many years with chronic course. In those with chronic course, there is a greater probability of co-morbid: personality disorders, anxiety disorders, substance use disorders, and decreased likelihood that treatment will result in full symptom remission. In many patients, bipolar illness begins with one or more depressive episodes, more likely when begins in adolescence, when psychotic or mixed features occur and bipolar disorder is running in the family. Major depressive disorder, particularly with psychotic features, may be also precursor of schizophrenia. Except for the difference between men and women in the prevalence, there are no sex differences in the phenomenology, course and response to treatment.

Differential diagnosis should take into account, among others, (hypo)manic episode with mixed features, mood disorder due to another medical condition, substance/

medication induced depressive disorder, ADHD and sadness. Depressive disorders frequently co- occurs with substance-related disorders, panic disorders, obsessive-compulsive disorder, anorexia disorder, bulimia nervosa and borderline personality disorder.

#### *Persistent depressive disorder-PDD (dysthymia)*

This disorder represents a consolidation of the DSM-IV-defined: chronic major depressive disorder and dysthymic disorder. Criterion (A) is depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by other, for at least 2 years. (in children and adolescents, mood can be irritable and duration must be at least 1 year). (B): presence, while depressed, of two (or more) of the listed symptoms, and the period without the symptoms in criteria A and B no longer than 2 months at the time. Depressive episode may precede dysthymia or can develop during PDD. In the case of dysthymia and depressive episode two diagnoses should be recorded. One have to exclude: manic episode, hypomanic episode, cyclothymic disorder, relation to physiological effects of a substance or another medical condition. Fulfilled should be the criterion (H) that symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

#### *Premenstrual dysphoric disorder-PMDD*

PMDD has been moved from an appendix in DSM-IV to section depressive disorders in DSM-5 because many years of research shows that PMDD is a specific form of depressive disorder that begins after ovulation, remits within few days of menses and has a marked impact on functioning.

Criteria for PMDD are as follows:

- (A) In the majority of menstrual cycles, at least five symptoms must be present in the final week before the onset of menses, start to improve within a few days after the onset of menses, and become minimal or absent in the week postmenses.
- (B) One (or more) of the following symptoms must be present: marked affective lability (e.g. mood swings, feeling suddenly sad or tearful, or increased sensitivity to rejection); marked irritability or anger or increased interpersonal conflicts; marked depressed mood; feelings of hopelessness; or self-deprecating thoughts; marked anxiety, tension, and/or feelings of being keyed up or on the edge
- (C) One (or more) of the following symptoms must additionally be present, to reach a total of five symptoms when combined with symptoms from criterion B above: decreased interest in usual activities (e.g. work, school, friends, hobbies); sub-

jective difficulty in concentration; lethargy, easy fatigability, or marked lack of energy; marked change in appetite, overeating or food craving; hypersomnia or insomnia; a sense of being overwhelmed or out of control; physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of bloating, or weight gain.

The symptoms in Criteria A-C must have been met for most menstrual cycles that occurred in the preceding year and be associated with clinically significant distress or interference with work, school, usual social activities, or relationships with others (e.g. avoidance of social activities, decreased productivity and efficiency at work, school, or home) (D). Exclusion criteria include substance/medication/somatic induced MDE, another mental disorders (E, G). Criterion (F) requires prospective daily rating during at least two symptomatic cycles, if not-the diagnosis may be made provisionally.

According to the DSM-5, twelve-month prevalence of premenstrual dysphoric disorder is between 1.8% and 5.8% of menstruating women. Estimates are substantially inflated if they are based on retrospective reports. DSM-5 recommends to use prospective daily ratings.

*Substance/medication induced depressive disorder  
|and depressive disorder due to another medical condition*

These disorders in DSM-5 have diagnostic criteria, such as for bipolar disorders, differing in the type of mood disorders: depression only. DSM-5 offers specifiers: with depressive features, reminiscent of an episode of depression, with mixed features

*Other specified depressive disorder and unspecified depressive disorder*

In the DSM-5, the term not otherwise specified was removed and for depressive disorders, two categories were introduced. Other specified depressive disorder category applies to presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the depressive disorders diagnostic class. One should precise the reason, for example: – brief recurrent depression [10], (duration 2-13 days, duration criterion not fulfilled), minor depression, i.e. depression with less than 5 (required) symptoms.

Unspecified depressive disorder category applies to presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the depressive

disorders diagnostic class and the clinician do not to communicate the specific reason that the presentation does not meet the criteria for any specific depressive disorder because (for example) of emergency room settings.

### **Specifiers for depressive disorders**

The list of specifiers for depressive disorders was in this article mostly discussed in the chapter of bipolar disorder: with anxious distress – one should specify severity: mild, moderate, moderate-severe, severe; with mixed features – the DSM-5 presents criteria (A-D) for depressive episode with mixed features, pointing out, that it increases the risk for bipolar disorder; with melancholic features, with atypical features, with psychotic features- delusions and/or hallucinations (one should specify if congruent with mood), with catatonia; with peripartum onset (during pregnancy and in the 4 weeks following delivery), with seasonal pattern.

For each diagnosis of depressive disorders, the DSM-5 requires data on remission and severity of symptoms (mild, moderate, severe), based on the number of criterion symptoms, severity of those symptoms and degree of functional disability.

### **Final remarks: DSM-5 relationship to coding in ICD-10 and DSM-IV**

In the DSM-5, similar as in the DSM-IV, a coding system of the ICD-9-CM (International Classification of Diseases, Revision 9, Clinical Modification) is applied, an adaptation of the ICD-9, which is used and obligatory in the United States. In Europe, the ICD-10 system [2] is used, with alphanumeric code for each diagnosis. This system will be also used in the ICD-11, which is going to be introduced in 2015.

In the DSM-5, for bipolar I disorder, current or most recent manic episode, mild, is coded as 296.41 (F31.11), moderate 296.42 (F31.12) and severe 296.43 (F31.13), with psychotic features 296.44 (F31.2), in partial remission 296.45 (F31.74), in full remission 296.46 (F31.74) and unspecified 296.40 (F31.9), and current or most recent depressive episode 296.51 (F31.31), 296.52 (F31.32), 296.53 (F31.4), 296.54 (F31.5), 296.55 (F31.75), 296.56 (F31.76) and 296.50 (F31.9), respectively. For bipolar II disorder, the 296.89 (F31.81) code is proposed in the DSM-5, although the intensity, course and other specifiers are not coded. Cyclothymic disorder has the 301.13 (F34.0) code.

Disruptive mood dysregulation disorder (DMDD) is coded as 296.99 (F34.8), persistent depressive disorder (dysthymia, PDD) as 300.4 (F34.1), and premenstrual dysphoric disorder (PMDD) as 625.4 (N94.3),

ICD coding for substance/medication induced bipolar and related or depressive disorder depends on whether or not there is a comorbid substance use disorder pre-

sent for the same class of substance. E.g. mild cocaine use disorder with onset during intoxication with cocaine-induced bipolar disorder is coded as 292.84 (F14.14). For substances not listed in the ICD-10 (e.g. steroids), the code „other substances” – 292.84 should be used, or F19 in ICD-10, with information about severity of substance use disorder, e.g. mild F19.14) or such disorder not present (F19.94). Bipolar or depressive disorder due to another medical condition is coded in the ICD-9-CM as 293.83, and in the ICD-10-CM it depends on specifiers (e.g. depressive episode with mixed features – F06.34). It is recommended to give first the ICD-10 code for the somatic illness (e.g. 242.90, E05.90- hyperthyreosis) and then 293.83 (F06.34) code.

Other specified bipolar and related disorder or depressive disorder should be coded as 296.89 (F31.89) and 311 (F32.8), respectively, and unspecified bipolar and related disorder or depressive disorder as 296.80 (F31.9) and 311 (F32.9), respectively.

For catatonic symptoms occurring during bipolar or depressive disorder, an additional code: 293.89 (F06.1) is proposed.

Finally, it should be noticed that the DSM-5 gave up the axial system of diagnosis (previously axis I, II and III), having a separate description of important psychosocial and contextual factors (previously axis IV), and disability (previously axis V). Such approach is consistent with the WHO recommendations for considering a functional status of given person regardless of a diagnosis or symptoms. The authors contributing to a concept of the DSM-5 did not recommend specific classification of environmental or psychosocial factors for DSM-5, but rather to use selected elements from the ICD-9-CM or ICD-10-CM codes. Both the DSM-5 and the ICD working teams put emphasis on distinguishing disability (impairment in social, occupational, or other important areas of functioning) from mental disorder.

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