Changes In The DSM-5 Associated With The BR

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Bipolar disorder (BR) is one of the most common affective disorders, characterized by an alternation of depressive and (hypo-) manic phases. Due to the differences in diagnostic criteria in different nosological classification systems such as DSM-V, there remains a large number of unaccounted cases of the disease; difficulties remain in the differential diagnosis of BR with other mental and physical diseases; and epidemiological indicators vary significantly. Currently, there is a discussion on the overdiagnosis of BR in connection with the expansion of criteria for type II BR in DSM-5, while some researchers, on the contrary, believe that BR is characterized by a hypodiagnosis. The ambiguity of the criteria significantly complicates the diagnosis and treatment of this disease.

Diagnostic Challenges in Bipolar Disorder

The nosological significance of the symptoms and the differential diagnosis of BR are not only scientific and academic tasks but also play a decisive role in the selection of rational tactics for patients. Currently, diagnostic criteria are used to diagnose BR in most countries of the world, as specified in official diagnostic guidelines. Changes in the new version of DSM, in comparison with the previous ones, also touched upon the diagnosis of bipolar disorder. Some of these changes have been criticized, while others have been well accepted by clinicians and researchers.

Schizophrenia Diagnosis in Clinical Practice

The diagnosis of schizophrenia, in some cases, was made hastily based on the relative specificity of productive symptoms, for example, the presence of pseudo-hallucinations or paranoid syndrome. At one time, the approach was quite typical for many American psychiatrists and was reflected in the DSM-V. Many doctors, faced with a variegated clinical picture of the disease, claimed that schizophrenia is a typical polymorphism and variability of symptoms as the disease progresses (American Psychiatric Association, 2013).

According to M. Bleuler, there are three main diagnostic criteria for schizophrenia: the presence of manifestations; disunity of thinking, emotional, motor, splitting; depersonalization, mental automatisms, catatonia, delirium, hallucinations; absence of syndromes of an exogenous type of reactions. Some psychiatrists believe that the clinical syndromes characteristic of schizophrenia are

absent and that every symptom encountered in this disease can occur in other psychiatric disorders. This view contradicted the accepted view that there are symptoms specific to schizophrenia, and they are the basis for diagnosing the disease. Many clinicians note that when talking with a patient suspected of schizophrenia, to exclude prejudice, the only last thing is to pay attention to the family history and then analyze in detail the cases of the mental disorder in the patient's relatives. The primary diagnosis of schizophrenia requires the collection of anamnesis and a complete neurological examination of the patient. It is necessary for neurophysiological (EEG, CT, MRI, etc.) and cardiological examination, as well as for the analysis of laboratory data, including tests for the presence of drugs. With a clear neurological disease of the brain, an infectious or intoxicating lesion, the diagnosis of schizophrenia is not recommended. The examination of patients in a state of acute psychosis or its continuous but prolonged course is practically not carried out in practice.

Clinical Presentation and Patient Assessment

A sick schizophrenic is convinced of the reality of his experiences, believes only in himself, and is often alert and suspicious, tense, and frightened. Often, he denies having a mental disorder. The medical personnel who face the debut of schizophrenia usually do not have enough time to form a trusting relationship with the patient. Attempts to penetrate into the spiritual world of the patient are often met with strong resistance. The situation can be complicated by relatives who underestimate or, on the contrary, unduly dramatize what is happening.

Diagnostic Boundaries and Epidemiological Variation

Timely diagnosis of schizophrenia is complicated by the fact that its onset often occurs in adolescence, which is a period when it is difficult to differentiate the initial symptoms of the disease from premorbid personality characteristics. Some syndromes of the disease (hypochondriacal, dysmorphophobic, depressive) can proceed monosyndromically. In these cases, for a long time, there are no characteristic changes in the personality of schizophrenia. The vagueness of the clinical boundaries of schizophrenia over a long period made it difficult to classify this disease and was a source of discrepancies in epidemiological studies of schizophrenia in different countries (American Psychiatric Association, 2013).

In 1972, a diagnostic project (US / UK) showed that the diagnosis of schizophrenia was much more common in the United States than in the UK. In a series of 250 cases in New York, 62% of patients were diagnosed with schizophrenia in the hospital, while in London it was 34%.

Many psychiatrists believe that the diagnosis of schizophrenia cannot be made only by the presence of specific symptoms, for example, hallucinations or delusions.

For the diagnosis of schizophrenia, it is important to remember that an experienced psychiatrist can reveal signs of this mental disorder already from the child's age of the patient; first of all, it is a

question of peculiar negative symptomatology and manifestations of a neurocognitive deficiency.

Principles of Comprehensive Diagnosis

For the modern diagnosis of schizophrenia, the general principles of clinical diagnosis, formulated in particular by the classics of Russian medicine, are still relevant. Diagnosis does not represent only a brief medical conclusion about the nature of the disease and the condition of the patient expressed regarding medicine. Diagnosis involves the entire process of patient research: both observation and isolation of symptoms and their evaluation in terms of correlating the anatomical and physiological characteristics of a person with the environment, evaluating their cohesion (syndromic), and evaluating the variability of the syndrome (flow), and the diagnostic the meaning of the symptom and the syndrome (semiology), and the features of thinking when recognizing the disease (the diagnosis method).

Changes In The DSM-5 Associated With The BR

In DSM-5, bipolar and related disorders are presented in a separate chapter located between the chapters “Disorders of the Schizophrenic Spectrum and Other Psychotic Disorders” and “Depressive Disorders.” The chapter describes that such an order was established due to the absence of clear boundaries between schizophrenic spectrum disorders and affective disorders, as well as the generality of their pathogenetic mechanisms, including data from modern neurobiological and genetic studies (American Psychiatric Association, 2013).

One of the most important changes in comparison with the previous version of DSM-V concerned the diagnostic criteria for manic and hypomaniacal episodes. Currently, the diagnosis of the episode of mania and hypomania requires the patient not only to have a constantly upbeat mood or irritability but also an abnormally increased activity aimed at achieving a specific goal. Obviously, such limitations can lead to a hypodiagnosis of the BR. Meanwhile, according to Severus and Bayer, more stringent criteria may help reduce the likelihood of false positive diagnoses and avoid unnecessary psychopharmacological interventions.

Another important point is the change in the exclusion criteria for the diagnosis of BR I and BR II 7.8. The earlier appearance of the symptoms of mania or hypomania in the treatment of a depressive episode (drugs, electroconvulsive therapy or bright light therapy) is currently a diagnostic criterion for the diagnosis of BR I or II. This change has met with support from a wide range of psychiatrists because induction of hypo-manic symptoms in the treatment of depression, in the opinion of many specialists, is indeed a sign of bipolarity.

The former diagnosis of ” Bipolar disorder, the current mixed episode,” which required simultaneous compliance with the criteria of manic and depressive episodes, is currently illegal. Instead, it is recommended that the DSM-5 use a “mixed-feature” qualifier that applies to patients whose condition

fully meets the criteria (hypo-) manic episode but who, in the mental state, have symptoms of depression. In this context, mention should be made of the possibility in DSM-5 to use a “mixed-feature” specifier in patients with unipolar depression. However, the validity of such a diagnosis remains questionable since, most likely, this group of patients requires mood stabilizers to achieve a satisfactory outcome of therapy (American Psychiatric Association, 2013).

Some specifiers in the DSM-5 are worthy of a separate mention. Thus, the qualifier “with anxious distress” emphasizes the presence in the clinical picture of anxiety, which does not belong to the diagnostic criteria of BR. Specifier “with mixed features” is an important addition both for everyday clinical practice and for research work.

Diagnostic categories of bipolar and associated disorders in DSM-5

“Bipolar and related disorders” in DSM-5

Bipolar disorder type I

Bipolar disorder type II

cyclothymia

Bipolar and related disorders induced by the use of psychoactive substances/medicines

Bipolar and related disorders due to other medical conditions

Other specified bipolar and related disorders

Unspecified bipolar and associated disorders

Bipolar Disorder Type I

In contrast, to the classical notion of manic-depressive psychosis, only a confirmed manic episode is required to establish a diagnosis of type 1 BR in DSM-5. Neither the hypomanic nor the major depressive episode is a prerequisite. A manic episode should be characterized by 1) increased, expansive or angry affect and 2) increased energy or activity aimed at achieving a specific goal. Both symptoms should be presented at least within a week. Also, at least 3 out of 7 additional symptoms (overestimated self-esteem, decreased need for sleep, increased sociability, a jump in ideas, increased distraction, physical anxiety, risky actions), as well as a pronounced disruption in functioning, are necessary to establish a diagnosis of BR. It is important to emphasize that if a manic episode appears as a result of treatment of depression and meets the temporary and other criteria of the BR, then according to the DSM-5, it is considered within the framework of the BR type I.

Bipolar II Disorder

According to DSM-5, at least one episode of hypomania and one episode of major depression throughout life are required to establish a diagnosis of bipolar disorder. In the new version of the American diagnostic guide, BR II is no longer considered a softer form of BR.

Cyclothymic Disorder

The diagnosis of “cyclothymic disorder” according to DSM-5 can be established by detecting episodes of hypomania and depression for at least two years that do not fully meet the criteria of hypomania or depression. Within the specified period, symptoms should be detected at least half the time, and there should not be “light” gaps of more than two months. One of the problems that the clinicians faced earlier was the uncertain situation with the symptoms of BR, which are revealed in the background of the use of psychoactive substances (including medicines). The DSM-5 proposes a solution to this problem by isolating the category of psychoactive substance-induced BRs.

Diagnostic Criteria For Schizophrenia According To DSM-V

Currently, Russian and European psychiatrists are guided by the internationally accepted diagnostic criteria for schizophrenia in the International Classification of Diseases 10 revision (DSM – V) (Mental and Behavioral Disorders) when diagnosing schizophrenia. According to DSM-V, the diagnosis of schizophrenia requires the presence of at least one clear symptom (or two less distinct symptoms), mainly related to symptoms of a hallucinatory-paranoid syndrome, or two symptoms related to other symptoms (hallucinations, severity of thinking, manifestations of catatonia, negative symptoms), which should be noted for at least a month.

Diagnostic Symptoms Of Schizophrenia (DSM-V)

- Echo of thoughts, their investing or rejecting thoughts, translation or openness.
- Delusions of influence, influence or mastery, related to movements of the body, limbs, thoughts, actions or sensations; delirium.
- Hallucinatory “voices” comment on the patient’s behaviour or discuss it among themselves. Other types of hallucinatory voices emanating from any part of the body.
- Persistent crazy ideas of a different kind that are not adequate for a given social culture and do not have a rational explanation for their content.
- Constant hallucinations of any sphere, accompanied by unstable or incompletely formed delusional ideas without a clear emotional resonance or persistent overvalued ideas that can

appear daily for several weeks;

- Interrupting the processes of thinking or “intervening” thoughts, which can lead to the severance or diversity of speech, the emergence of neologisms.
- Catatonic disorders, such as undifferentiated, in some cases, stereotyped excitation, impulsive actions, congealing or waxy flexibility, negativism, mutism, stupor, exaggerated mannerisms, and grimacing.
- Negative symptoms such as severe apathy, poor speech, and smoothed or inadequate emotional reactions, which usually lead to social isolation and a decrease in social productivity, and these signs should not be caused by depression or medication (neuroleptic).
- A significant progressive qualitative change in behaviour, manifested by loss of interest and non-purposefulness. Inactivity, preoccupation with their inner world, and social autonomy (American Psychiatric Association, 2013).

As can be seen from the above diagnostic criteria for schizophrenia, the vital importance of the diagnosis of schizophrenia (DSM-V) is given to produce symptoms. When listing the diagnostic criteria for negative symptoms, some symptoms partly repeat each other, such as social isolation and social autism. Great importance is given to the time interval for the existence of symptoms of the disease. If the patient’s condition meets the criteria given but lasts less than a month, regardless of whether the patient has received treatment or not, it should be classified as an acute schizophrenic psychotic disorder in DSM-V and recorded if the symptoms persist for a longer period. According to DSM-V, for the diagnosis of schizophrenia, it is necessary that its symptoms be fixed for at least six months. During this time, at least one month, there should be a picture of psychosis with more than two characteristic symptoms of this disease. Symptoms of schizophrenia should be present for a fairly long time, can not be explained by the abuse of psychoactive drugs or neurological disease, and monitoring of patients shows a marked decrease in social activity.

Differential Diagnosis Of Schizophrenia

Differential diagnosis of schizophrenia from other mental disorders is often complicated, especially when there is a question of the initial period of the disease. Most psychiatrists warn against haste when diagnosing schizophrenia, recommending that the patient be observed for a sufficiently long time, for example, for at least six months. In addition to talking with a psychiatrist, not only the patient but also his relatives, neurophysiological research (electroencephalography, evoked potentials, duplex scanning of the brain vessels) and modern methods of neuroimaging (magnetic resonance imaging) are important. Psychological and laboratory diagnostics play a major role. It is advisable to include an evaluation of the activity of the nervous, cardiovascular, endocrine, gastrointestinal, and other body systems in the screening of a medical examination of schizophrenia (American Psychiatric Association, 2013).

At the first stage of differential diagnosis of schizophrenia, it is necessary to reject various organic diseases of the central nervous system. First of all, we are talking about the exclusion of the

volumetric process, especially tumours of the pituitary gland and frontal cortex, which are the brain structures that are responsible for thinking and the emotional sphere.

The main mental disorders with which schizophrenia should be differentiated

- Organic diseases of the central nervous system: brain tumors and other intracranial formations (malformations, hemorrhages, abscesses, cysts); consequences of neuro infections (herpes virus, HIV infection, syphilis, rheumatism, systemic lupus erythematosus, tuberculosis meningitis, and another encephalitis); craniocerebral trauma; neurodegenerative diseases; pathology of the cerebral vascular system; epilepsy; metabolic disorders (Wilson-Konovalov's disease, B12 deficiency, folate, metachromatic leukodystrophy, Niemann-Pick's disease).
- Substance Abuse
- Affective disorders
- An acute short-term psychotic disorder
- Induced mental disorder
- Chronic delusional disorder
- Personality disorder
- Neurotic disorder
- Diseases of the endocrine system (diseases of the thyroid gland, adrenal glands, pituitary gland).

The second most important, but probably the first diagnostic error, is the elimination of various neuro infections, especially viral etiology: encephalitis, meningitis caused by various viruses, for example, herpes (cytomegalovirus), HIV infection, etc.

Herpes simplex is a latent infection. Often there is a lifelong persistence of the virus, which activates under various stressful effects on the patient's body (immune and hormonal suppressions, hypothermia, trauma, etc.). Along with the defeat of the central and peripheral nervous system, the viral infection affects many organs and systems (liver, vascular endothelium, blood cells). Recurrent infection with the herpes virus is observed in 2-12% of the population. Persistent forms of herpes were called latent-associated transcripts. The degree of CNS damage during the reactivation of the herpes simplex virus depends on the reaction of active intrathecal antibodies. This is seen in herpetic encephalitis in patients with impaired cellular immunity and gammaglobulin. In the pathogenesis of the damage to the central nervous system by the virus, the reactions of cellular immunity, carried out by astroglial cells, providing the development of local immunity, acquire special significance.

It is important to differentiate schizophrenia from psychosis caused by substance abuse, especially amphetamines, cocaine, antihistamines, and codeine-containing medicines.

In affective disorders (bipolar affective disorder, recurrent depression, etc.) and schizoaffective disorders, unlike schizophrenia, the duration of an acute episode is relatively small. Manifestations of schizophrenia, in particular, negative symptoms can be identified before an acute episode of

psychosis with a thorough interview of the patient's relatives. Patients with schizophrenia respond better to antipsychotics, in contrast to patients with the bipolar affective disorder who are more sensitive to lithium and valproate. Statistics show that in at least 5-8% of cases, among patients with diagnosed schizophrenia, in fact, patients with various diseases of the central nervous system is diagnosed: a brain tumors, neuro infections, vascular disorders, degenerative diseases, etc. Somewhat less often – in 3 % of cases of schizophrenia are autoimmune diseases, endocrine pathology, hypovitaminosis B. $_{12}$, and substance abuse.

Problems arising in the translation of the name of the section (Substance-Related and Addictive Disorders) are due to the fact that in DSM-5 the term "substance" is used without the usual "psychoactive" (SAA) specification. And although there are certain substantive reasons for this, the literal translation of "substance-related disorders" sounds clearly unsatisfactory. The wording of "substance use disorders" sounds better, but there is still a lack of clarifying definition. What substance? Of course, in almost all cases it is a matter of substances with psychotropic effects, but only in the narrative part of the manual is it indicated mainly in psychoactive substances.

Substance-Related Disorder

The entire section of substance-related disorders in DSM-5 is proposed to be divided into substance use disorders (Substance Use Disorder), and disorders induced by this use (Substance-Induced Disorder). At the same time, eating disorders are defined as problematic use, leading to clinically significant harm or distress.

Diagnostic Headings In DSM-5

Instead Of Individual Criteria For Abuse And Dependence, The DSM-5 Has 11 Common Criteria. At the same time, for the diagnosis of the disorder associated with the use of surfactants, you must have at least 2 criteria within 12 months.

1. The substance is often taken in large quantities or for a longer time than anticipated.
2. There is a constant desire or unsuccessful attempts to reduce or control the use of the substance.
3. The amount of time spent searching for, using substances, and overcoming the consequences of intoxication is greatly increased.
4. An irresistible attraction to substance use.
5. Repeated use of substances, leading to a loss of ability to fulfill basic obligations at work, at the place of study, and in the family (absenteeism, deterioration in the quality of work, and declining academic performance).
6. Continuation of the use of the substance, despite the constant or recurring social or interpersonal problems caused or exacerbated by the effects of the substance (family conflicts,

quarrels with others, etc.).

7. As a result, of the use of substances, important manifestations of social, professional, and leisure activity cease or diminish markedly.
8. Repeated use of the substance in situations involving physical hazards (for example, when driving, resting on water, etc.).
9. The use of substances continues, despite the knowledge of permanent or recurring problems with physical or mental health, caused or aggravated by the ingestion of the substance.
10. Signs of tolerance are determined by any of the following phenomena: a) the need for a marked increase in the amount of substance to achieve intoxication or the desired effect; b) A marked decrease in the effect when the same amount of substance is used (it does not apply to cases of taking medication under medical supervision).
11. Presence of withdrawal syndrome, manifested by one of the following phenomena: a) the appearance of physical symptoms when the dose is reduced or substance is withdrawn; b) the Use of a substance to alleviate or avoid withdrawal symptoms (does not apply to cases of taking medication under medical supervision).

It is easy to see that the first 4 criteria reflect the loss of control over consumption. In this case, the need to introduce the 4th criterion (an irresistible attraction), which was not in the DSM-IV, was actively challenged.

Personality Related Disorders

Personality disorders are a kind of mental disorder that affects how people manage their emotions, behaviors, and attitudes. Personality disorders can be diagnosed in 40-60% of cases, and they are characterized by a steady collection of behavioral patterns, often associated with significant personal, social and occupational disorders. This behavior can lead to non-adaptive coping skills and personal problems that cause extreme anxiety, malaise, or depression.

1. Paranoid personality disorder
2. Schizoid personality disorder
3. Schizotypal personality disorder
4. Antisocial personality disorder
5. Borderline personality disorder
6. Hysterical personality disorder
7. Narcissistic personality disorder
8. Avoiding personality disorder
9. Dependent personality disorder
10. Obsessive-compulsive personality disorder

The concept of personality disorder itself is much later and tentatively appeared in 1801, described by psychiatrist Philippe, as a state of an outbreak of rage and violence in the absence of any symptoms

of psychosis, such as delirium and hallucinations. According to the Diagnostic and Statistical Manual for the 5th Revision of Mental Disorders (DSM-5), there are ten types of personality disorders, and they can be grouped into three clusters:

- Cluster a (unusual, strange, eccentric)
- Paranoid, schizoid, schizotypic
- Cluster B (dramatic, unstable)
- Antisocial, borderline, hysterical, narcissistic
- Cluster C (anxious, fearful)
- Avoiding, dependent, obsessive-compulsive

A personality disorder is a personality type or behavioral tendency characterized by considerable discomfort and deviations from the norms accepted in the given culture. This is a serious violation of the character's logical constitution and behavioral tendencies of the individual, involving usually several spheres of the personality and almost always accompanied by personal and social disintegration.

Diagnosis By DSM-IV

Only when the individual personality traits are not adaptable, not adaptable and lead to a significant deterioration in life can they be called personality disorder:

1. Internal experience and behaviour deviate significantly from the requirements imposed by the culture to which the person belongs, and this manifests itself in two or more of the following areas:
2. Cognitive (that is, the path of comprehension, interpretation of oneself, other people, or events).
3. Affective (degree, intensity, liability, and adequacy of emotional reactions).
4. In the features of the internal functioning of the personality.
5. In control of impulsivity.
6. Patterns demonstrate inflexibility and extend to a wide range of personal and social situations.
7. Patterns lead to serious clinical distress or problems in the social, professional, or other important area of life.
8. Patterns are stable over time and can be traced back to early adolescence or maturity.
9. Patterns cannot be considered a manifestation or consequence of another mental disorder.
10. Patterns are not the result of direct exposure to substances or general health, such as head trauma.

Persons under the age of 18 who meet the criteria cannot be diagnosed with the corresponding disorder. To diagnose at this age, symptoms should be recorded for at least one year. Antisocial personality disorder, in general, cannot be diagnosed before age 18.

References

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