DSM-5 and mood disorders:
The Good, the Bad and the Ugly

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Département de psychiatrie, Université McGill
## Disclosures

### Speaker bureau:
- Bristol Myers Squibb (BMS)
- Janssen-Ortho
- Sunovion

### Consultant/Advisory Board:
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- Lundbeck
- Otsuka

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- Organon
- Wyeth Pfizer
- BMS
- Janssen-Ortho
- Merck
- Forest
- FRSQ
- STANLEY FOUNDATION
- Biovail
- Janssen-Ortho
- Novartis
- Otsuka
- N/A
WARNING
FISHING POX

VERY CONTAGIOUS TO ADULT MALES

SYMPTOMS — Continual complaint as to need for fresh air, sunshine and relaxation. Patient has blank expression, sometimes deaf to wife and kids. Has no taste for work of any kind. Frequent checking of tackle catalogues. Hangs out in Sporting Goods Stores longer than usual. Secret night phone calls to fishing pals. Mumbles to self. Lies to everyone.

Expert diagnosis and treatment at any Canadian Tire Corporation Tackle Bar.

NO KNOWN CURE
Quarantine unnecessary

TREATMENT — Medication is useless. Disease is not fatal. Victim should go fishing as often as possible.

Visit your local CANADIAN TIRE CORP. ASSOCIATE STORE for the "BEST" in fine Fishing Tackle.
Identification of risk loci with shared effects on five major psychiatric disorders: a genome-wide analysis

Cross-Disorder Group of the Psychiatric Genomics Consortium

The Lancet - 28 February 2013
**Figure 1:** Manhattan plot of primary fixed-effects meta-analysis

Horizontal line shows threshold for genome-wide significance ($p < 5 \times 10^{-8}$).
**Figure 3:** Pair-wise cross-disorder polygene analysis

We derived polygene risk scores for each disorder (discovery sets) and applied them sequentially to the remaining disorders (target sets). Results are grouped by each discovery set. Each pair is shown on the x-axis and the proportion of variance explained for the target disorder (estimated via Nagelkerke’s pseudo $R^2$) on the y-axis. For purposes of illustration, three $p_t$ cutoffs are shown, but appendix p 62 shows the proportion of variance results for a broader range of cutoffs. $p_t =$ training-set $p$ value (used to select training set SNPs). Significance of results: $a=p<0.05$; $b=p<10^{-1}$; $c=p<10^{-2}$; $d=p<10^{-2}$. ADHD = attention deficit-hyperactivity disorder. ASD = autism spectrum disorders. BPD = bipolar disorder. MDD = major depressive disorder.
Young at heart. Slightly older in other places.
From DSM-IV to DSM-5: Depressive disorders

- The *bereavement* exclusion in DSM-IV was removed from *depressive* disorders in DSM-5.
- New *disruptive mood dysregulation disorder* (DMDD) for children (from 6 up to 18 years).
- *Premenstrual dysphoric disorder* moved from an appendix for further study, and became a disorder.
- *Specifiers* were added for *mixed symptoms* and for *anxiety*, along with guidance to physicians for *suicidality*.
- The term *dysthymia* now also would be called *persistent depressive disorder*. 
Major Depressive Disorder

- Recurrence: (single Episode / recurrent)
- Severity: (mild/moderate/severe)
- With psychotic features
- Remission (in partial or in full remission)
- And then as many specifiers 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
Disruptive Mood Dysregulation Disorder (DMDD)

A. Severe recurrent temper manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression towards 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 3 or more consecutive months without all the symptoms in Criteria A-D.

F. Criteria A or D is present in at least two of the three settings (i.e. at home, at school, with peers) and are severe in at least in one these.

G. The diagnosis should not be made for the first time before age 6 or after age 18.
H. By history or observation, the age at onset of Criteria A-E is before age 10 years.
I. There has never been a distinct period lasting more than one day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.

Note: Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.

J. The behaviors do not occur exclusively during an episode of Major Depressive Disorder and are not better accounted for by another mental disorder (e.g., Autism Spectrum Disorder, Posttraumatic Stress Disorder, Separation Anxiety Disorder, Persistent Depressive Disorder Dysthymic Disorder).

Note: This diagnosis cannot co-exist with Oppositional Defiant Disorder, Intermittent Explosive Disorder, or Bipolar Disorder, though it can co-exist with others, including Major Depressive Disorder, Attention Deficit/Hyperactivity Disorder, Conduct Disorder, and Substance Use Disorders. Individuals whose symptoms meet criteria for both DMDD and Oppositional Defiant Disorder should only be given the diagnosis of DMDD. If an individual has ever experienced a manic or hypomanic episode, the diagnosis of DMDD should not be assigned.

K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition
Disruptive Mood Dysregulation Disorder (DMDD)

• No specifiers.
DMDD: rationale and limitations

• Youths with chronic irritability and anger outbursts are being increasingly misdiagnosed as having bipolar disorder\(^1\).
• Scientific support came from Severe Mood Dysregulation (SMD) which is not identical to DMDD (eliminating hyperarousal as a criterial symptom and age at onset of 10).
• No justification associated with the age of diagnosis > 6.
• It is unclear which aspects of the pathophysiology are unique to DMDD and which are shared with the individual emotional and behavioral disorders with which it so commonly occurs.

Persistent Depressive Disorder (previously Dysthymia)

This disorder represents a consolidation of DSM-IV-defined chronic major depressive disorder and dysthmic disorder.

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.

Note: In children and adolescents, mood can be irritable and duration must be at least one year.

B. Presence while depressed, of two (or more) of the following:
   - Poor appetite or overeating.
   - Insomnia or hypersomnia.
   - Low energy or fatigue.
   - Low self-esteem.
   - Poor concentration or difficulty making decisions.
   - Feelings of hopelessness.

C. During the two-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at the time.

D. Criteria for a MDD may be continuously present for 2 years.
E. There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder.

F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other psychotic disorder.

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hypothyroidism).

H. The symptoms cause a clinical significant distress or impairment in social, occupational, or other important areas of functioning.

Note: Because the criteria for a MDE include four symptoms that are present from the symptom list for persistent depressive disorder, a very limited number of individuals will have depressive symptoms that have persisted longer than 2 years but will not meet criteria for persistent depressive disorder. If full criteria for a MDE have been met at some point during the current episode of illness, they should be given a diagnosis of MDD. Otherwise, a diagnosis of other specified depressive disorder or unspecified depressive disorder is warranted.
Persistent Depressive Disorder (previously Dysthymia)

- Specify if:
  - With anxious distress / with mixed features / with melancholic features / with atypical features / with mood-congruent psychotic features / with mood-incongruent psychotic features / with peripartum onset
  - In partial remission / in full remission
  - Early onset (before age 21) / Late onset
  - With pure dysthymic syndrome / with persistent MDE / with intermittent MDE, with current episode / with intermittent MDE, without current episode.
  - Current severity: Mild / Moderate / Severe
Gradations of “Mixededness”

Mixed Mania
- Full Mania
- 2+ Mania Symptoms

Dysphoric Mania
- Full Mania
- 2+ Depressive Symptoms

Depressive Mixed States¹
- 2+ Mania Symptoms
- Full MDE

MDE = major depressive episode, ¹Agitated depressions ²,³
“Mixed Depression” or “Depressive Mixed States”

STEP-BD: Presence of sub-syndromal mania (1-3 mania symptoms) is frequent during index bipolar MDE

Prospective follow-up of 219 BDI patients
- 122 (56%) followed for \( \geq 20 \) years

1,208 episodes observed
- Only 2 pure mixed episodes (<1%)
  - Defined as concurrent depression and mood elevation throughout the entire episode
- 94 episodes (8%) of “mixed major cycling”
  - Episode of major cycling that at some point included a mixed state of concurrent depression and mood elevation

Mixed States:
Diagnostic Complexities

- There is concordance among many researchers that mixed states are not simply a simultaneous or sequential occurrence of affective symptoms of opposite polarity, i.e., depression and mania, but rather complex, fluctuating and unstable clinical pictures\(^1\).

- This may not be captured by DSM-IV criteria alone which operationalizes mixed states as a stable construct.

- Mixed states may be better defined along a continuum/spectrum (consistent with clinical practice) as opposed to being a static/modal phenomenon.

- The “degree of mixity” becomes the operational term.

### Bipolar Disorders Classification

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>296.4X / 296.5X</td>
<td>Bipolar I Disorder</td>
</tr>
<tr>
<td>296.89</td>
<td>Bipolar II Disorder</td>
</tr>
<tr>
<td>301.13</td>
<td>Cyclothymic Disorder</td>
</tr>
<tr>
<td>291.89 / 292.84</td>
<td>Substance-Induced Bipolar Disorder</td>
</tr>
<tr>
<td>293.83</td>
<td>Bipolar and Related Disorder Due to Another Medical Condition</td>
</tr>
<tr>
<td>296.89</td>
<td>Other Specified Bipolar and Related Disorder</td>
</tr>
<tr>
<td>296.80</td>
<td>Unspecified Bipolar and Related Disorder</td>
</tr>
</tbody>
</table>
Bipolar I Disorder (296.4X or 296.5X)

- Type of current or most recent episode; his status with respect to current severity, presence of psychotic features and remission status.

<table>
<thead>
<tr>
<th>Bipolar I</th>
<th>Current or most recent episode manic</th>
<th>Current or most recent episode hypomanic</th>
<th>Current or most recent episode depressed</th>
<th>Current or most recent episode unspecified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>296.41</td>
<td>NA</td>
<td>296.51</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>296.42</td>
<td>NA</td>
<td>296.52</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>296.43</td>
<td>NA</td>
<td>296.53</td>
<td></td>
</tr>
</tbody>
</table>
# Bipolar I Disorder (296.4X or 296.5X)

<table>
<thead>
<tr>
<th>Bipolar I</th>
<th>Current or most recent episode manic</th>
<th>Current or most recent episode hypomanic</th>
<th>Current or most recent episode depressed</th>
<th>Current or most recent episode unspecified</th>
</tr>
</thead>
<tbody>
<tr>
<td>With psychotic features</td>
<td>296.44</td>
<td>NA</td>
<td>296.54</td>
<td>NA</td>
</tr>
<tr>
<td>In partial remission</td>
<td>296.45</td>
<td>296.45</td>
<td>296.55</td>
<td>NA</td>
</tr>
<tr>
<td>In full remission</td>
<td>296.46</td>
<td>296.46</td>
<td>296.56</td>
<td>NA</td>
</tr>
<tr>
<td>Unspecified</td>
<td>296.40</td>
<td>296.40</td>
<td>296.50</td>
<td>NA</td>
</tr>
</tbody>
</table>
Bipolar I Disorder (296.4X or 296.5X)

- Specify if:
  - With anxious distress
  - With mixed features
  - With rapid cycling
  - With melancholic features
  - With atypical features
  - With mood-congruent psychotic features
  - With mood-incongruent psychotic features
  - With catatonia (293.89)
  - With peripartum onset
  - With seasonal pattern
Bipolar II Disorder (296.89)

- Specify current or most recent episode:
  - Hypomanic or Depressed

- Specify if:
  - With anxious distress
  - With mixed features
  - With rapid cycling
  - With mood-congruent psychotic features
  - With mood-incongruent psychotic features
  - With catatonia (add 293.89)

- With peripartum onset
- With seasonal pattern

- Specify course if full criteria for a mood episode are not currently met:
  - In partial remission or In full remission

- Specify severity if full criteria for a mood episode are currently met:
  - Mild / Moderate / Severe
Other Specified Bipolar and Related Disorder (296.89)

- Short-duration hypomanic Episodes (2-3) & MDEs
- MDEs & Hypomanic Episodes characterized by insufficient symptoms
- Hypomanic Episode without MDE
- Short Duration (less than 2 years) Cyclothymia
- * Uncertain Bipolar Conditions
Proposed revision on Bipolar Disorder diagnostic category (2/3)

Bipolar Disorder not Elsewhere Classified (NEC)

- Subclassification will be used for this diverse group of conditions.
- The recorded name of the condition should NOT be “Bipolar Disorder NEC” but rather, one of the following diagnostic terms:
Proposed ICD – 11
Mood Disorders Classification

F30 First manic episode
F31 Bipolar affective disorder
F32 First depressive episode
F33 Recurrent depressive disorder
F34 First mixed affective episode
F35 Persistent mood disorders
F38 Other mood disorders
F39 Unspecified mood disorders
Three-Fold Higher Rate of Bipolar Disorder Amongst Individuals with MDD When Using Bipolar Specifier

Table 1. Demographic Features of the Study Sample

<table>
<thead>
<tr>
<th>Country</th>
<th>Patients, No.</th>
<th>Hospitalized, %</th>
<th>Age, Mean (SD), y</th>
<th>Male Sex, %</th>
<th>Bipolar DSM-IV-TR</th>
<th>Bipolar Specifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bosnia</td>
<td>200</td>
<td>46.5</td>
<td>46.3 (10.9)</td>
<td>32.5</td>
<td>45 (22.5)</td>
<td>111 (55.5)</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>300</td>
<td>46.0</td>
<td>49.8 (12.5)</td>
<td>36.5</td>
<td>56 (18.7)</td>
<td>171 (57.0)</td>
</tr>
<tr>
<td>China</td>
<td>727</td>
<td>45.9</td>
<td>39.7 (14.4)</td>
<td>39.1</td>
<td>105 (14.4)</td>
<td>290 (39.9)</td>
</tr>
<tr>
<td>Egypt</td>
<td>306</td>
<td>24.2</td>
<td>37.7 (12.8)</td>
<td>49.0</td>
<td>42 (13.7)</td>
<td>144 (47.1)</td>
</tr>
<tr>
<td>Georgia</td>
<td>254</td>
<td>18.5</td>
<td>46.5 (15.0)</td>
<td>32.9</td>
<td>39 (15.4)</td>
<td>103 (40.6)</td>
</tr>
<tr>
<td>Germany</td>
<td>251</td>
<td>59.4</td>
<td>48.0 (12.3)</td>
<td>36.8</td>
<td>29 (11.6)</td>
<td>102 (40.6)</td>
</tr>
<tr>
<td>Iran</td>
<td>313</td>
<td>37.4</td>
<td>38.4 (12.3)</td>
<td>33.9</td>
<td>57 (18.2)</td>
<td>169 (54.0)</td>
</tr>
<tr>
<td>Korea</td>
<td>212</td>
<td>25.5</td>
<td>45.0 (14.5)</td>
<td>27.8</td>
<td>15 (7.1)</td>
<td>55 (25.9)</td>
</tr>
<tr>
<td>Macedonia</td>
<td>224</td>
<td>26.8</td>
<td>47.5 (13.3)</td>
<td>28.6</td>
<td>29 (12.9)</td>
<td>107 (47.8)</td>
</tr>
<tr>
<td>Morocco</td>
<td>317</td>
<td>20.8</td>
<td>39.7 (11.5)</td>
<td>38.3</td>
<td>55 (17.4)</td>
<td>148 (46.7)</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>220</td>
<td>12.7</td>
<td>46.1 (13.7)</td>
<td>40.0</td>
<td>28 (12.7)</td>
<td>81 (36.8)</td>
</tr>
<tr>
<td>Pakistan</td>
<td>265</td>
<td>37.0</td>
<td>38.2 (12.0)</td>
<td>50.4</td>
<td>60 (22.6)</td>
<td>158 (59.6)</td>
</tr>
<tr>
<td>Portugal</td>
<td>311</td>
<td>11.9</td>
<td>45.9 (13.0)</td>
<td>25.7</td>
<td>45 (14.5)</td>
<td>172 (55.3)</td>
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<tr>
<td>Slovakia</td>
<td>297</td>
<td>57.6</td>
<td>48.4 (13.2)</td>
<td>38.0</td>
<td>50 (16.8)</td>
<td>166 (55.9)</td>
</tr>
<tr>
<td>Spain</td>
<td>655</td>
<td>25.5</td>
<td>47.2 (13.9)</td>
<td>33.1</td>
<td>100 (15.3)</td>
<td>324 (49.5)</td>
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<tr>
<td>Taiwan</td>
<td>420</td>
<td>14.8</td>
<td>45.3 (12.7)</td>
<td>27.2</td>
<td>64 (15.2)</td>
<td>149 (35.5)</td>
</tr>
<tr>
<td>Ukraine</td>
<td>297</td>
<td>73.7</td>
<td>46.9 (13.1)</td>
<td>29.6</td>
<td>65 (21.9)</td>
<td>156 (52.5)</td>
</tr>
<tr>
<td>Vietnam</td>
<td>66</td>
<td>37.9</td>
<td>40.7 (11.1)</td>
<td>51.5</td>
<td>19 (28.8)</td>
<td>41 (62.1)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5635</strong></td>
<td><strong>34.4</strong></td>
<td><strong>44.1 (13.7)</strong></td>
<td><strong>35.5</strong></td>
<td><strong>903 (16.0)</strong></td>
<td><strong>2647 (47.0)</strong></td>
</tr>
</tbody>
</table>

Patients With Mixed Episodes Have Poor Treatment Outcomes

- More severe course of illness\(^1,2\)
- Less frequent remission/higher risk of reoccurrence\(^1,2\)
- More substance abuse\(^1,2\)
- Poorer response to some medications\(^2\)
- Increased risk of suicide\(^3,4\)

Certificate of Analysis from DR. JOHN MUTER, F.R.S.E., Past President of the Society of Public Analysts; Editor of the "Analyst"; Author of "Manuals of Analytical and Pharmaceutical Chemistry and of Materials Materia." "I have examined SALT REGAL with the following results: That it is an effervescent saline, compounded from absolutely pure ingredients. When it is placed in contact with water, the chemical combination which ensues results in the formation of two of the best known saline aperients, and in addition to these there is also developed a small quantity of an oxidising disinfectant tending to destroy any impurities present in the water used. "I have not before met with so well manufactured and ingenious combination, at once perfectly safe and yet so entirely efficient for the purposes for which it is recommended."—JOHN MUTER.

HER MAJESTY'S ROYAL LETTERS PATENT.

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FOR SAFETY,

FOR EXCELLENCE,

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"ELECTROPATHIC" TREATMENT.

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HARD FACTS. Every advertised article is not a cure. The patient had no relief. Alication. Thousands of Patients gratefully acknowledge the benefit derived from the use of the HARNESS' ELECTROPATHIC BELT.

Residents at a distance, and those unable to call, should write to Mr. Harness, 52, Oxford Street, London, W. An Address will be sent, together with Pamphlet and Copy of Testimonials, post-free on application to M R. HARNES S' ELECTROPATHIC BELT.

NOTE ONLY ADDRESS, and if you want to be permanently and speedily Cured, without medicine, without Frequent visits to the Doctor, you must obey the instructions given in Mr. Harness' new Pamphlet, entitled "Electropathic grats and Povre."
Comorbidity is the rule, not the exception

Many possible combinations of comorbidities

Few high quality studies to guide treatment decisions

Clinicians still request guidance for treatment options

<table>
<thead>
<tr>
<th>Comorbid DSM-IV Disorder</th>
<th>Comorbid Chronic Physical Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depression</td>
<td>62%</td>
</tr>
<tr>
<td></td>
<td>72%</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td>59%</td>
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</tbody>
</table>

CANMAT Clinical Guidelines

CanMAT Task Force Recommendations for Mood Disorders and Comorbid Conditions

- Roger McIntyre, Ayal Schaffer, Serge Beaulieu
- Published February, 2012
- Anxiety, medical, personality, substance use, ADHD, metabolic syndrome
- Available at www.canmat.org
ICI
LE POSSIBLE
EST DEJA FAIT
L'IMPOSSIBLE
EST EN COURS
POUR LES
MIRACLES
PREVOIR 48H
DE DELAI
Arguments en faveur d’une classification dimensionnelle

“Nearly all genetic factors identified thus far... seem to confer somewhat comparable risk for schizophrenia and bipolar disorder and, perhaps, for other disorders such as unipolar depression, substance abuse, and even epilepsy.”

“... the biology of psychotic illnesses may fail to align neatly with the classic Kraepelinian distinction between schizophrenia and manic-depressive illness... However, they do resonate with clinical observations that many patients present with a mix of bipolar and schizophrenia symptoms, both at a single admission and also across time.”

“These clinical observations support the accelerating body of literature over the last decade arguing that Kraepelin’s classic dichotomy for psychotic disorders may need to be superseded by a new system based on biology as well as observed clinical phenomenology.”

<table>
<thead>
<tr>
<th>Domains/constructs</th>
<th>Units of analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative valence systems</strong></td>
<td></td>
</tr>
<tr>
<td>Active threat (&quot;fear&quot;)</td>
<td>Genes</td>
</tr>
<tr>
<td>Potential threat (&quot;anxiety&quot;)</td>
<td>Molecules</td>
</tr>
<tr>
<td>Sustained threat</td>
<td>Cells</td>
</tr>
<tr>
<td>Loss</td>
<td>Circuits</td>
</tr>
<tr>
<td>Frustrative nonreward</td>
<td>Physiology</td>
</tr>
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<td><strong>Positive valence systems</strong></td>
<td>Behavior</td>
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<td>Approach motivation</td>
<td>Self-reports</td>
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<td>Initial responsiveness to reward</td>
<td>Paradigms</td>
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<td>Sustained responsiveness to reward</td>
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<td>Reward learning</td>
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<td>Habit</td>
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<td><strong>Cognitive systems</strong></td>
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<td>Attention</td>
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<td>Perception</td>
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<td>Working memory</td>
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<td>Declarative memory</td>
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<td>Language behavior</td>
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<tr>
<td>Cognitive (effortful) control</td>
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<td><strong>Systems for social processes</strong></td>
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<td>Imitation, theory of mind</td>
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<tr>
<td>Social dominance</td>
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<td>Facial expression identification</td>
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<td>Attachment/separation fear</td>
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<td>Self-representation areas</td>
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<td><strong>Arousal/regulatory systems</strong></td>
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<tr>
<td>Arousal and regulation (multiple)</td>
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<td>Resting state activity</td>
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La Théorie,
c'est quand on comprend tout
et que rien ne marche.

La Pratique,
c'est quand tout marche,
mais on ne sait pas pourquoi.

Ici
nous avons réussi les deux :
rien ne marche
et personne ne sait pourquoi.
In many of the results of randomized clinical trials or of risk studies that use categorical measures, a report of statistical non-significance may be partially or wholly due to the lack of power to detect effects due to use of categorical measures, particularly when the cutoff defining the categorical measures is set by intuition rather than optimally based on empirical evidence.

Approche Dimensionnelle: “The Good, the Bad and the Ugly”

- Approche empirique

- Permet des analyses statistiques plus ciblées sur les modérateurs et médiateurs donc plus en harmonie avec les stratifications cliniques

- Rapprochement avec les symptômes cliniques observés par les cliniciens et vécus par les patients

- Pourrait donc éventuellement créer une classification plus écologiquement valide

Approche Dimensionnelle: “The Good, the Bad and the Ugly”

- Meilleure modélisation de la psychopathologie dans des modèles animaux
- Approche qui favorise l’étude de l’aspect développemental des maladies
Approche Dimensionnelle: “The Good, the Bad and the Ugly”

• Faibles validités inter-juges (Kappa ratings) obtenues lors des essais en milieux cliniques (même académiques)
• Dépression: 0.34 !!!!
Approche Dimensionnelle: “The Good, the Bad and the Ugly”

• Risquons de devoir redéfinir l’ensemble des traitements en fonction des nouveaux critères
DSM-5 update

- DSM-5 will move to a nonaxial documentation of diagnosis, combining the former Axes I, II, and III, with separate notations for psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V)
- Incorporation of a developmental approach to psychiatric disorders
- Harmonization of the text with ICD
- Integration of genetic and neurobiological findings by grouping clusters of disorders that share genetic or neurobiological substrates
- Recognition of the influence of culture and gender on how psychiatric illness presents in individual patients
- Introduction of dimensional assessments
- DSM-5 not DSM-V: new updates will be possible without waiting for DSM-6!
I can only please one person per day. Today is not your day. Tomorrow doesn't look good either.