A Clinician's Guide to the DSM-5-TR

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Faculty

Meriah Ward, DNP, FNP-BC, PMHNP-BC, is a highly accomplished healthcare professional with a Doctor of Nursing Practice (DNP) degree and dual certifications as a Family Nurse Practitioner (FNP-BC) and Psychiatric-Mental Health Nurse Practitioner (PMHNP-BC). They currently serve as a nurse practitioner at Advance Community Health in Raleigh, North Carolina, while holding the adjunct professor position at Old Dominion University's advanced practice registered nursing family nurse practitioner program. In addition to their clinical roles, Dr. Ward is a contract content creator for Continuing Medical Education (CME) and a healthcare advisor for Vance-Granville Community College's medical assistant program.

Dr. Ward has authored numerous continuing education courses on a wide range of topics, including HIV, Type 2 Diabetes (T2D), Pre-Exposure Prophylaxis (PrEP), neurodivergence, and substance use disorder (SUD). Their work primarily addresses healthcare disparities in underserved communities and explores the relationship between social determinants of health and health outcomes. Within the organization, Dr. Ward also serves as a clinical informaticist, actively involved in quality improvement projects to enhance patient care, improve outcomes, and increase provider satisfaction. Dr. Ward completed the MSN, DNP, and Post-Graduate Certificate (PGC) at Old Dominion University in 2020, 2021, and 2024, respectively. They identify as non-binary and use they/them pronouns, and their personal experience as an autistic individual informs their perspective on neurodivergence in healthcare.

Faculty Disclosure

Contributing faculty, Meriah Ward, DNP, FNP-BC, PMHNP-BC, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for social workers, marriage and family therapists, mental health counselors, and other ancillary behavioral health staff.

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Course Objective

The purpose of this course is to provide clinicians with the most up-to-date information on the DSM-5-TR, relative to the previous edition (DSM-5), including diagnostic criteria needed to assess the presence of various disorders.

Learning Objectives

Upon completion of this course, you should be able to:

1. Describe the history of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).
2. Explain the structural and organizational changes made in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, text revision (DSM-5-TR).
3. Identify psychiatric diagnoses that are newly included in DSM-5-TR.
4. Identify changes to psychiatric diagnoses made in the transition from DSM-5 to DSM-5-TR, including the recategorization, renaming, and modification of criteria.
5. List psychiatric disorders and the criteria recommended for further study by the DSM-5-TR.
6. Describe the controversies and criticisms arising from the publication of DSM-5-TR and the alternative diagnostic systems proposed in place of DSM-5-TR.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

COURSE OVERVIEW

With the development of the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, text revision (DSM-5-TR), professionals who work with people who have mental health diagnoses will be responsible for learning and understanding the changes that have taken place in the new diagnostic manual [1]. The transition from using the previous edition of DSM-5 to the new DSM-5-TR presents a challenge for any clinician [1; 2]. Given the extent of the changes that have occurred for DSM-5, reading through DSM-5-TR and piecing together these changes should be quick but done thoroughly.

This course provides clinicians with the most up-to-date information on DSM-5-TR, relative to the previous edition, DSM-5, including diagnostic criteria needed to assess the presence of various disorders. This course will not only present newly classified disorders and identify those that have been removed or reclassified but will also illuminate any changes to diagnostic criteria for disorders in the previous manual and continue to be defined as disorders in DSM-5-TR. The course will cover the development process used by the DSM-5-TR task force in deciding the diagnostic system's new structure and removing the multiaxial system. Alternative diagnostic systems proposed in place of DSM-5-TR will also be described.

This course is designed for social workers, psychologists, marriage and family therapists, mental health counselors, occupational therapists, nurses, advanced practice registered nurses, and other ancillary behavioral health staff. Summary tables are provided to assist with understanding the significant changes that have taken place. Without a strong understanding of these changes, clinicians may be more prone to making psychiatric diagnoses based on out-of-date criteria, or they may make a diagnosis that no longer formally exists (e.g., Asperger syndrome). This knowledge will benefit treatment in various settings, whether addressing psychiatric symptoms directly or understanding the impact of the symptoms on other aspects of the person's functioning. This course concludes with a discussion of the controversies and criticisms that arose with the publication of DSM-5-TR and the alternative diagnostic systems that have recently been proposed instead of DSM-5-TR.

HISTORY OF THE DSM

The DSM aims to provide a common language for clinicians, a tool for researchers, a bridge between research and clinical work, and a textbook of information for students and educators. The DSM also provides a coding system for statistics, insurance, and administrative processes [3]. However, despite being commonly referred to by the media as the "bible" of psychiatry, the DSM is a constantly changing manual that has undergone extensive revision over time. Publication of the fifth edition, text revision of the DSM, known as the DSM-5-TR, is the culmination of many decades of research and countless arguments for how such a diagnostic manual should be structured. To understand the advances of DSM-5-TR, it is also essential to know the history of the DSM and how it has changed over the years. Understanding this is also relevant to understanding current controversies with the DSM-5-TR. Clinicians must possess this knowledge to function within their specific scope of practice and ethical guidelines and provide best practices to clients [4; 5; 6].

Before the development of a comprehensive diagnostic system, there was little agreement on categories of psychological disorders or what disorders were psychological versus medical. The first large-scale attempt at generating mental health diagnoses was published in the 1840s, and it was primarily an attempt to obtain statistical data through the census and consisted of a single diagnosis of idiocy/insanity. Following this, in 1917, to better standardize the classification of mental disorders across mental hospitals, the American Psychiatric Association (APA) developed a standard nomenclature for some psychological disorders that would be included in the *American Medical Association's Standard Classified*

Nomenclature of Disease. Although this was an essential step in the direction of identifying standardized psychological diagnoses, it was limited in that it did little to distinguish between psychological and medical disorders, and it was primarily focused on the most severe disorders that were seen in inpatient units.

Following World War II, to better classify and distinguish the presentations of psychological disorders in service veterans, the U.S. Army, Veterans Administration, and World Health Organization (WHO) worked to incorporate a section for mental disorders into the sixth edition of the International Classification of Disease (ICD), which was published in 1949. In 1952, the APA published a manual solely focused on mental health diagnoses called the *Diagnostic and Statistical Manual: Mental Disorders* [7]. This volume is now referred to as DSM-I and was an essential development in the progress of diagnostic structure because it was heavily focused on clinical utility and provided additional descriptions of disorders beyond what was available in the ICD-6. Importantly, DSM-I was also more extensive than previous attempts at classifying psychiatric conditions and listed 106 mental disorders ranging from neurosis to personality disturbance.

Although DSM-I was a significant advancement, it was still limited in many ways, particularly by the lack of a consistent and agreed-upon definition for mental illness. As an example, homosexuality was listed in DSM-I as a sociopathic personality diagnosis, which reflected more on the social traditions at the time of DSM-I than on the actual psychological aspects of homosexuality. By the 1960s, many viewed the concept of mental illness as a myth or as a way for society to exert control over those who might deviate from societal norms [8; 9]. In 1968, in conjunction with the development of the ICD-7, the APA published a revision of the manual DSM-II [10]. This revision was like DSM-I in many ways, and it increased the number of psychological diagnoses to 182 disorders. DSM-II also no longer made use of the term reaction, which was used throughout much of DSM-I to indicate that all mental disorders were reactions to environmental factors [11]. For example, there was a section on schizophrenic reaction, which implied that psychotic symptoms arose from environmental stressors such as insufficient mothering. DSM-II was still heavily influenced by psychodynamic theory, and disorders such as neurosis and homosexuality continued to appear in the manual. In 1974, during the seventh printing of DSM-II, homosexuality was removed from the DSM, following controversy over the diagnosis and over data indicating that there were few differences in the psychological adjustment between heterosexual and homosexual men [12].

In the mid-1970s, the DSM came under scrutiny by clinicians who questioned the DSM's utility from both a clinical and a research perspective. Spitzer and Fleiss published a highly influential paper indicating that DSM-II diagnoses were unreliable, meaning that they did not yield consistent results across diagnosticians and settings [13]. A vital aspect of a diagnosis involves consistent communication between clinicians about the diagnosis, and a diagnostic system that yields unreliable results across most diagnostic categories is a significant problem. Thus, in 1974, only a few years after the publication of DSM-II, the decision was made to revise the DSM again, with Robert Spitzer as the chairman of the DSM-III task force. The primary goals for DSM-III were to make the DSM more consistent with the ICD, standardize diagnostic practices between the United States and other countries, and improve the standardization and validity of diagnoses. To make these improvements, the methods for establishing the diagnostic criteria for a disorder were changed. In previous versions of the DSM, diagnoses consisted of brief and sometimes vague descriptions of the disorder, with many descriptions being heavily influenced by theory rather than observable factors. In DSM-III, diagnoses were structured using the research diagnostic criteria and the Feighner criteria, which were published scientific reports for how a psychiatric diagnostic system should be structured [14; 15]. It was here that many DSM diagnoses, like their current descriptions, began to fully appear, with the inclusion of diagnostic categories such as anxiety and affective disorders, schizophrenia, and antiso-

cial personality disorder. When published in 1980, DSM-III contained 265 mental health diagnoses, which was a significant increase from DSM-II [16]. In addition to including more explicit diagnostic criteria, DSM-III introduced a multiaxial system that allowed for multiple facets of diagnosis and the notation of medical diagnoses, acknowledging that mental and physical health problems often co-occur. The multiaxial system also allowed attention to be given to more chronic disorders, with Axis II diagnoses including mental retardation and personality disorders. Finally, DSM-III also included more textual descriptions of theoretically neutral disorders dispensed with previous theoretically driven diagnoses. Many of these changes resulted in DSM-III being a far more reliable tool than DSM-II and facilitated better communication among professionals about the disorders they were treating.

DSM-III was revised in 1987 to DSM-III-R, and these changes primarily involved restructuring and renaming some diagnostic categories and removing certain controversial disorders, such as premenstrual dysphoric disorder [17]. The number of diagnostic categories in DSM-III-R increased to 292 diagnoses. In 1994, the fourth version of the DSM was published (DSM-IV) [18]. The task force for DSM-IV, chaired by Allen Frances, aimed to integrate more empirical evidence into the diagnostic system than had DSM-III [3; 19]. DSM-IV had extensive reviews of the existing literature and multicenter field trials that established diagnostic reliability rates and relevance to clinical practice. In addition to increasing the number of psychological disorders to 297, DSM-IV also added a criterion to many disorders that required the disorder to result in "clinically significant distress." In 2000, DSM-IV was updated with changes primarily involving text revisions and finalizing the five-axis multiaxial system (DSM-IV-TR) [20]. The purpose of including the multiaxial system was to encourage clinicians to think about the interaction among psychological, medical, and social factors and to distinguish between acute and chronic psychological disorders.

Nineteen years elapsed between the publication of DSM-IV and the release of DSM-5. The revision process for DSM-5 began in 1999 and was a long one that involved substantial efforts by many key leaders in the field of psychopathology, considerable debate about what changes should or should not be made to diagnostic categories and criteria, and extensive field-testing of diagnoses for reliability [21]. In coordination with large health institutions, such as the National Institute of Mental Health and the World Health Organization, the APA began in 1999 to evaluate the strengths and weaknesses of DSM-IV. David Kupfer and Darrel Regier chaired the DSM-5 task force of 28 people, with 6 to 12 task force members assigned to each work group. Each work group was responsible for meeting in person and communicating frequently throughout the year to determine the changes that should be made for each assigned category (e.g., mood disorders, eating disorders, personality disorders). These work groups then drafted proposals for changes to each area, which were posted on the APA DSM-5 website (http://www.dsm5.org) for public evaluation and commentary. Field trials for potential DSM-5 diagnostic criteria began in 2011 to establish inter-rater reliability for all diagnoses. In December 2012, the APA Board of Trustees voted to approve DSM-5, published in May 2013. However, it is essential to remember that the DSM is a constantly evolving manual.

The DSM-5 was released in 2013, and nearly a decade later received a text revision, colloquially known as the DSM-5-TR [1]. The development of the DSM-5-TR involved over 200 experts, including many who had worked on the DSM-5, and took approximately three years to complete [22]. The revision process incorporated three main components: the original DSM-5 diagnostic criteria and text, updates made through an iterative revision process overseen by the DSM Steering Committee, and a comprehensive text update managed by the Revision Subcommittee. The DSM-5-TR introduced several changes, including a new diagnosis (prolonged grief disorder), clarifications to existing diagnostic criteria, updated terminology, and comprehensive

text revisions [1]. Additionally, four cross-cutting review groups focused on culture, sex and gender, suicide, and forensic issues, while a Work Group on Ethnoracial Equity and Inclusion ensured appropriate attention to risk factors such as racism and discrimination [23]. The revision aimed to reflect current scientific literature, address inconsistencies, and improve the manual's utility for clinicians and researchers.

OVERVIEW OF CHANGES MADE IN THE DSM-5-TR

COMPREHENSIVE TEXT REVISION AND ADDITION OF NEW DIAGNOSTIC ENTITIES

The comprehensive text revision in the DSM-5-TR represents a significant update to the descriptive content for most mental disorders compared to the DSM-5. This revision focused on several key areas [1]:

- **Prevalence**: Updated information on how common each disorder is in the population, based on newer epidemiological studies conducted since the DSM-5 was published in 2013.
- **Risk and prognostic factors**: Revised details on factors that may increase the risk of developing a disorder or influence its course and outcome. It incorporates new research findings on genetic, environmental, and developmental factors.
- **Culture-related diagnostic issues**: Expanded information on how cultural factors may impact mental disorders' presentation, diagnosis, and understanding across different populations. This reflects an increased emphasis on cultural competence in mental health care.
- **Sex- and gender-related diagnostic issues**: Updated content on how biological sex and gender identity may influence the manifestation and prevalence of disorders. It incorporates newer understandings of gender diversity and its relationship to mental health.
- **Association with suicidal thoughts or behavior**: Enhanced information on the relationship between specific disorders and suicide risk, reflecting the critical importance of suicide prevention in mental health care.
- **Comorbidity**: Revised details on how different disorders commonly co-occur, which is crucial for comprehensive diagnosis and treatment planning.

The extensive text revisions in the DSM-5-TR serve several vital purposes. They incorporate the latest research findings and clinical knowledge accumulated since the DSM-5 was published in 2013, providing clinicians with more up-to-date and nuanced information to aid in accurate diagnosis and treatment planning. These revisions reflect evolving understandings of how factors like culture, gender, and comorbidity impact mental health, aligning the manual more closely with current best practices in mental health care [24; 25]. This emphasis on cultural competence, gender-affirming care, and comprehensive assessment of suicide risk represents a significant advancement in the field. Additionally, the updated text helps researchers by providing revised frameworks for studying mental disorders and their various dimensions. By addressing these critical areas, the DSM-5-TR aims to enhance the clinical utility of the manual and ensure it reflects the most current knowledge in the field of mental health by focusing on these areas; the DSM-5-TR aims to enhance the clinical utility of the manual and ensure it reflects current knowledge in the field of mental health. This comprehensive revision underscores the dynamic nature of psychiatric diagnosis and the ongoing efforts to refine our understanding of mental disorders.

The DSM-5-TR also added several new diagnostic entities and symptom codes (***Table 1***) [1].

CLARIFICATIONS AND MODIFICATIONS

The DSM-5-TR included clarifying modifications to the diagnostic criteria for more than 70 disorders [1]. These modifications were primarily aimed at improving clarity and reducing ambiguity in the criteria sets rather than fundamentally changing the conceptual definitions of the disorders. Here is a description of these changes:

- **Nature of the changes**: The modifications were mostly minor clarifications to wording, designed to resolve ambiguities or inconsistencies in the original DSM-5 criteria.
- **Purpose**: These changes were intended to enhance the reliability and validity of diagnoses by making the criteria more precise and more accessible to interpret consistently across clinicians.
- **Scope**: The modifications affected a wide range of disorders across multiple categories in the DSM, indicating a comprehensive review of the manual.
- **Process**: These changes underwent a formal review process, including approval by the DSM Steering Committee, the APA Board of Trustees, and the APA Assembly.
- **Clinical impact**: While these modifications do not fundamentally alter the disorders, they may lead to more accurate and consistent diagnoses in clinical practice.
- **Examples**: Typical clarifications might involve specifying time frames more precisely, clarifying the meaning of specific terms, or providing more detailed descriptions of symptoms.
- **Importance for clinicians**: These changes underscore the need for mental health professionals to stay updated with the latest version of the DSM to ensure they are using the most current and accurate diagnostic criteria.
- **Research implications**: Clear criteria can produce more consistent research results across different studies and settings.

It is important to note that while these modifications are significant for ensuring diagnostic accuracy, they are not as substantial as adding new disorders or significant revisions to existing ones. Clinicians are encouraged to review the specific changes relevant to their practice areas.

UPDATED TERMINOLOGY

The DSM-5-TR incorporated updated terminology throughout the manual in its comprehensive revision process. This update in terminology serves several important purposes:

- **Reflecting current scientific understanding**: The updated terminology aligns with the latest research and clinical understanding of mental disorders, ensuring that the language used is consistent with contemporary knowledge in the field.
- **Reducing stigma**: Some terms were updated to use less stigmatizing language, crucial in promoting a more compassionate and understanding approach to mental health.
- **Improving clarity and precision**: The revised terminology aims to provide more accurate and specific descriptions of symptoms and disorders, facilitating better communication among clinicians and researchers.
- **Enhancing cultural sensitivity**: The updates include more culturally sensitive language to describe various aspects of mental health, including sexual orientation, gender identity, and cultural experiences.

NEW DIAGNOSTIC ENTRIES IN DSM-5-TR		
Diagnostic Entity	**Description**	**Key Features**
Prolonged grief disorder	Prolonged grief disorder (PGD) is characterized by a persistent, intense longing for or preoccupation with a deceased loved one, accompanied by significant emotional distress and functional impairment lasting at least 12 months after the loss (6 months for children and adolescents). PGD is distinct from normal grief and other disorders like depression or PTSD. Its inclusion in the DSM-5-TR aims to improve the recognition and treatment of maladaptive grief responses.	1. Intense yearning for the deceased or preoccupation with thoughts/memories of them 2. At least 3 of 8 additional symptoms, such as: • Identity disruption • Disbelief about the death • Avoidance of reminders • Intense emotional pain • Difficulty reintegrating into life • Emotional numbness • Feeling life is meaningless • Intense loneliness 3. The symptoms cause clinically significant distress or impairment. 4. The grief reaction exceeds cultural, social, or religious norms. 5. The symptoms are not better explained by another mental disorder.
Unspecified mood disorder	Unspecified mood disorder is used for presentations that include symptoms characteristic of mood disorders but do not meet the full criteria for any specific mood disorder in either the bipolar or depressive categories. This diagnosis is applied when the clinician chooses not to specify the reason that the criteria are not met for a specific mood disorder, or when there is insufficient information to make a more specific diagnosis. This category is particularly useful in clinical situations where immediate treatment decisions need to be made, but the full diagnostic picture is not yet clear, such as in emergency room settings.	1. The presence of mood disorder symptoms that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. 2. The symptoms do not meet the full criteria for any specific bipolar or depressive disorder. 3. It allows clinicians to avoid prematurely choosing between bipolar disorder and depressive disorder when the presentation is unclear or information is limited. 4. It provides a diagnostic option for cases where it is challenging to determine whether the appropriate diagnostic class is bipolar or depressive, especially when irritable mood or agitation predominates. 5. The diagnosis can serve as a temporary placeholder until more information becomes available to make a more specific diagnosis.
Stimulant-induced mild neurocognitive disorder	Stimulant-induced mild neurocognitive disorder is characterized by persistent cognitive deficits resulting from stimulant use, particularly cocaine and amphetamine-type substances. The cognitive impairments are not severe enough to interfere significantly with independence in everyday activities but are severe enough to require more significant mental effort, use of compensatory strategies, or accommodation. This diagnosis was added to the existing types of substance-induced mild neurocognitive disorders (such as those induced by alcohol, inhalants, and sedatives) in recognition of the growing evidence that chronic stimulant use can lead to persistent cognitive impairments, even after cessation of use.	1. Evidence of cognitive decline from a previous level of performance in one or more cognitive domains (e.g., complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition). 2. The cognitive deficits do not occur exclusively during the course of delirium and persist beyond the usual duration of intoxication and acute withdrawal. 3. There is evidence from the history, physical examination, or laboratory findings that the deficits are etiologically related to the persisting effects of stimulant use. 4. The deficits cause mild interference in independence in everyday activities. 5. The deficits are not better explained by another mental disorder.

Table 1 continues on next page.

NEW DIAGNOSTIC ENTRIES IN DSM-5-TR (*Continued*)		
Diagnostic Entity	**Description**	**Key Features**
No diagnosis or condition	The DSM-5-TR introduced a new code for "no diagnosis or condition" to address situations where a clinician needs to indicate that no mental disorder or condition is present. The code for "no diagnosis or condition" allows clinicians to document that a comprehensive diagnostic evaluation was conducted explicitly, but no mental disorder or condition warranting clinical attention was found. This code helps improve the accuracy of clinical documentation and provides a straightforward way to communicate that a mental health evaluation was conducted with a finding of no diagnosable condition. It is beneficial in contexts where the absence of a diagnosis needs to be formally recorded.	1. An individual undergoes a mental health assessment but does not meet the criteria or any mental disorder. 2. A clinician must indicate the absence of a mental health diagnosis for administrative or billing purposes. 3. There is a need to document that a thorough evaluation was performed, even though no diagnosis was made. 4. To differentiate between cases where no disorder is present versus cases with insufficient information to diagnose.
Suicidal behavior	The DSM-5-TR defines suicidal behavior as "potentially self-injurious behavior with at least some intent to die as a result of the action."	1. Current suicidal behavior (initial encounter) 2. Current suicidal behavior (subsequent encounter) 3. History of suicidal behavior
Nonsuicidal self-injury (NSSI)	NSSI is defined as intentionally inflicting damage to one's body that will "likely induce bleeding, bruising or pain."	1. Current nonsuicidal self-injury 2. History of nonsuicidal self-injury
These new codes serve several important purposes: 1. They allow clinicians to document these behaviors without requiring other mental health diagnoses. 2. They help improve the accuracy of clinical documentation and risk assessment. 3. They facilitate better tracking and research on suicidal behavior and self-injury. 4. They encourage clinicians to assess these behaviors in routine clinical practice. The inclusion of these codes in the DSM-5-TR aims to draw attention to these critical issues in mental health care and improve the overall assessment and treatment of individuals at risk for suicide or self-harm.		
Source: [1]		*Table 1*

The DSM-5-TR incorporates several important terminology updates to reflect current scientific understanding and promote more sensitive, accurate language. Throughout the text, "neuroleptic medications" have been replaced with "antipsychotic medications or other dopamine receptor blocking agents," providing a more precise description of these drugs' mechanisms. In sections on gender dysphoria, "desired gender" has been updated to "experienced gender," acknowledging individuals' lived experiences better. The language surrounding substance use disorders has been revised to reduce stigma and align with the understanding of addiction as a medical condition. Terminology related to neurodevelopmental disorders has been updated to reflect current research and clinical practice. Additionally, the manual refines language used to describe cultural factors in mental health, emphasizing the importance of cultural competence in diagnosis and treatment. These changes demonstrate the ongoing effort to keep the DSM-5-TR relevant, accurate, and sensitive. The manual aims to improve communication among professionals, enhance diagnostic accuracy, and foster a more nuanced understanding of mental health conditions by adopting more precise, less stigmatizing, and culturally appropriate language.

ICD-10-CM CODE UPDATES

The DSM-5-TR incorporated several updates to ICD-10-CM codes to align with the latest changes in diagnostic classifications (***Table 2***) [1]. Critical updates to the ICD-10-CM codes in the DSM-5-TR include the following.

New Codes Added

- Prolonged grief disorder was added with the code F43.8.
- New symptom codes were introduced for:
  - Suicidal behavior (R45.851)
  - Nonsuicidal self-injury (R45.88)
- Codes for homelessness were expanded:
  - Sheltered homelessness (Z59.01)
  - Unsheltered homelessness (Z59.02)

Code Modifications

- Unspecified depressive disorder was changed from F32.9 to F32.A.
- Food insecurity now has a specific code, Z59.41, previously part of a broader category.
- Lack of safe drinking water received its code Z58.6.
- Personal history of self-harm was split into:
  - Personal history of suicidal behavior (Z91.51)
  - Personal history of nonsuicidal self-injury (Z91.52)

Ongoing Updates

The APA updates ICD-10-CM codes in response to broader medical coding system changes [22]. For example, in September 2023, Parkinson disease received an updated code G20.C and inadequate housing changed from Z59.1 to Z59.10.

It is important to note that these coding updates are part of an ongoing process. The DSM-5-TR aims to maintain alignment with the ICD-10-CM, the official coding system used in the United States for diagnostic and billing purposes.

Clinicians should regularly check for the most current coding updates, as they can affect diagnosis documentation and insurance reimbursement. The APA provides resources for staying informed about these changes, including periodic updates on their website.

FOCUS ON CULTURE, RACISM, AND DISCRIMINATION

The DSM-5-TR addressed culture, racism, and discrimination, representing a notable shift from the DSM-5 [1; 2].

Work Group on Ethnoracial Equity and Inclusion

A dedicated Work Group on Ethnoracial Equity and Inclusion was established to review the entire manual for the first time in DSM history. This group, composed of ten diverse mental health practitioners, ensured appropriate attention was given to risk factors such as racism and discrimination and that non-stigmatizing language was used throughout the text. This was a significant departure from the DSM-5, which had no comprehensive review process focused on these issues.

Updated Terminology

The DSM-5-TR adopted a more inclusive and precise language than its predecessor. For example, "racialized" replaced "race/racial" to highlight the socially constructed nature of race. "Ethnoracial" was used for U.S. Census categories, and terms like "minority" and "non-White" were avoided. "Latinx" replaced "Latino/Latina" for gender inclusivity. These changes reflect a more nuanced understanding of cultural and racial identities than the DSM-5.

Expanded Cultural Formulation

The DSM-5-TR built upon the Cultural Formulation Interview (CFI) introduced in DSM-5 and provides more comprehensive guidance on assessing cultural factors in diagnosis and treatment planning. This expansion aims to improve clinicians' ability to consider cultural context in their assessments.

DSM-5-TR CODE UPDATES		
Disease	**Previous Code**	**Current Code**
Prolonged Grief Disorder	Not Applicablea	F43.8
Suicidal Behavior	Not Applicablea	R45.851
Nonsuicidal Self-Injury	Not Applicablea	R45.88
Sheltered Homelessness	Not Applicablea	Z59.01
Unsheltered Homelessness	Not Applicablea	Z59.02
Unspecified Depressive Disorder	F32.9	F32.A
Food Insecurity	Not Applicablea	Z59.41
Lack of Safe Drinking Water	Not Applicablea	Z58.6
September 2023 Updates		
Parkinson Disease	G20	G20.C
Inadequate Housing	Z59.1	Z50.10
September 2022 Updates		
Diffuse Traumatic Brain Injury With Loss of Consciousness of Unspecified Duration, Sequela	S06.2X9S	S06.2XAS
Hepatic Encephalopathy	K72.90	K76.82
Impairing Emotional Outbursts	Not Applicablea	R45.89
Other Specified Delirium	R41.0	F05
Unspecified Delirium	R41.0	F05
Major Neurocognitive Disorder Due to Medical Etiology, With Behavioral Disturbance	F02.81	Specific replacements below
Mild Neurocognitive Disorder Due to Medical Etiology, With Behavioral Disturbance	G31.84	F06.71
Mild Neurocognitive Disorder Due to Medical Etiology, Without Behavioral Disturbance	G31.84	F06.70
Mild Neurocognitive Disorder Due to Possible Medical Etiology, With Behavioral Disturbance	G31.84	G31.84
Mild Neurocognitive Disorder Due to Possible Medical Etiology, Without Behavioral Disturbance	G31.84	G31.84
Mild Neurocognitive Disorder Due to Probable Medical Etiology, With Behavioral Disturbance	G31.84	F06.71
Mild Neurocognitive Disorder Due to Probable Medical Etiology, Without Behavioral Disturbance	G31.84	F06.70
Mild Neurocognitive Disorder Due to Unknown Etiology	G31.84	G31.84
Nonadherence to Medical Treatment	Z91.19	Z91.199
Other Specified Trauma-and Stressor-Related Disorder	F43.8	F43.89
Prolonged Grief Disorder	F43.8	F43.81
Opioid-Induced Anxiety Disorder, With Mild Use Disorder	F11.180	F11.188
Opioid-Induced Anxiety Disorder, With Moderate/Severe Use Disorder	F11.280	F11.288
Opioid-Induced Anxiety Disorder, Without Use Disorder	F11.980	F11.988
Current Suicidal Behavior, Initial Encounter	T14.91A	T13.81XA
Current Suicidal Behavior, Subsequent Encounter	T14.91D	T14.91XD
Major Neurocognitive Disorder Due to Medical Etiology, Mild, With Agitation	Not Applicable	F02.A11

Table 2 continues on next page.

DSM-5-TR CODE UPDATES (*Continued*)		
Disease	**Previous Code**	**Current Code**
Major Neurocognitive Disorder Due to Medical Etiology, Mild, With Anxiety	Not Applicable	F02.A4
Major Neurocognitive Disorder Due to Medical Etiology, Mild, With Mood Symptoms	Not Applicable	F02.A3
Major Neurocognitive Disorder Due to Medical Etiology, Mild, With Psychotic Disturbance	Not Applicable	F02.A2
Major Neurocognitive Disorder Due to Medical Etiology, Mild, With Other Behavioral or Psychological Disturbance	Not Applicable	F02.B11
Major Neurocognitive Disorder Due to Medical Etiology, Mild, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F02.A0
Major Neurocognitive Disorder Due to Medical Etiology, Moderate, With Agitation	Not Applicable	F02.B11
Major Neurocognitive Disorder Due to Medical Etiology, Moderate, With Anxiety	Not Applicable	F02.B4
Major Neurocognitive Disorder Due to Medical Etiology, Moderate, With Mood Symptoms	Not Applicable	F02.B3
Major Neurocognitive Disorder Due to Medical Etiology, Moderate, With Psychotic Disturbance	Not Applicable	F02.B2
Major Neurocognitive Disorder Due to Medical Etiology, Moderate, With Other Behavioral or Psychological Disturbance	Not Applicable	F02.B18
Major Neurocognitive Disorder Due to Medical Etiology, Moderate, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F02.B0
Major Neurocognitive Disorder Due to Medical Etiology, Severe, With Agitation	Not Applicable	F02.C11
Major Neurocognitive Disorder Due to Medical Etiology, Severe, With Anxiety	Not Applicable	F02.C4
Major Neurocognitive Disorder Due to Medical Etiology, Severe, With Mood Symptoms	Not Applicable	F02.C3
Major Neurocognitive Disorder Due to Medical Etiology, Severe, With Psychotic Disturbance	Not Applicable	F02.C2
Major Neurocognitive Disorder Due to Medical Etiology, Severe, With Other Behavioral or Psychological Disturbance	Not Applicable	F02.C18
Major Neurocognitive Disorder Due to Medical Etiology, Severe, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F02.C0
Major Neurocognitive Disorder Due to Medical Etiology, Unspecified Severity, With Agitation	Not Applicable	F02.811
Major Neurocognitive Disorder Due to Medical Etiology, Unspecified Severity, With Anxiety	Not Applicable	F02.84
Major Neurocognitive Disorder Due to Medical Etiology, Unspecified Severity, With Mood Symptoms	Not Applicable	F02.83
Major Neurocognitive Disorder Due to Medical Etiology, Unspecified Severity, With Psychotic Disturbance	Not Applicable	F02.82
Major Neurocognitive Disorder Due to Medical Etiology, Unspecified Severity, With Other Behavioral or Psychological Disturbance	Not Applicable	F02.818
Major Neurocognitive Disorder Due to Medical Etiology, Unspecified Severity, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F02.80

Table 2 continues on next page.

DSM-5-TR CODE UPDATES (*Continued*)		
Disease	**Previous Code**	**Current Code**
Major Neurocognitive Disorder Due to Possible Medical Etiology, Mild, With Agitation	Not Applicable	F03.A11
Major Neurocognitive Disorder Due to Possible Medical Etiology, Mild, With Anxiety	Not Applicable	F03.A4
Major Neurocognitive Disorder Due to Possible Medical Etiology, Mild, With Mood Symptoms	Not Applicable	F03.A3
Major Neurocognitive Disorder Due to Possible Medical Etiology, Mild, With Psychotic Disturbance	Not Applicable	F03.A2
Major Neurocognitive Disorder Due to Possible Medical Etiology, Mild, With Other Behavioral or Psychological Disturbance	Not Applicable	F03.A18
Major Neurocognitive Disorder Due to Possible Medical Etiology, Mild, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F03.A0
Major Neurocognitive Disorder Due to Possible Medical Etiology, Moderate, With Agitation	Not Applicable	F03.B11
Major Neurocognitive Disorder Due to Possible Medical Etiology, Moderate, With Anxiety	Not Applicable	F03.B4
Major Neurocognitive Disorder Due to Possible Medical Etiology, Moderate, With Mood Symptoms	Not Applicable	F03.B3
Major Neurocognitive Disorder Due to Possible Medical Etiology, Moderate, With Psychotic Disturbance	Not Applicable	F03.B2
Major Neurocognitive Disorder Due to Possible Medical Etiology, Moderate, With Other Behavioral or Psychological Disturbance	Not Applicable	F03.B18
Major Neurocognitive Disorder Due to Possible Medical Etiology, Moderate, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F03.B0
Major Neurocognitive Disorder Due to Possible Medical Etiology, Severe, With Agitation	Not Applicable	F03.C11
Major Neurocognitive Disorder Due to Possible Medical Etiology, Severe, With Anxiety	Not Applicable	F03.C4
Major Neurocognitive Disorder Due to Possible Medical Etiology, Severe, With Mood Symptoms	Not Applicable	F03.C3
Major Neurocognitive Disorder Due to Possible Medical Etiology, Severe, With Psychotic Disturbance	Not Applicable	F03.C2
Major Neurocognitive Disorder Due to Possible Medical Etiology, Severe, With Other Behavioral or Psychological Disturbance	Not Applicable	F03.C18
Major Neurocognitive Disorder Due to Possible Medical Etiology, Severe, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F03.C0
Major Neurocognitive Disorder Due to Possible Medical Etiology, Unspecified Severity, With Agitation	Not Applicable	F03.911
Major Neurocognitive Disorder Due to Possible Medical Etiology, Unspecified Severity, With Anxiety	Not Applicable	F03.94
Major Neurocognitive Disorder Due to Possible Medical Etiology, Unspecified Severity, With Mood Symptoms	Not Applicable	F03.93
Major Neurocognitive Disorder Due to Possible Medical Etiology, Unspecified Severity, With Psychotic Disturbance	Not Applicable	F03.92
Major Neurocognitive Disorder Due to Possible Medical Etiology, Unspecified Severity, With Other Behavioral or Psychological Disturbance	Not Applicable	F03.918

Table 2 continues on next page.

DSM-5-TR CODE UPDATES (*Continued*)		
Disease	**Previous Code**	**Current Code**
Major Neurocognitive Disorder Due to Possible Medical Etiology, Unspecified Severity, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F03.90
Major Neurocognitive Disorder Due to Probable Medical Etiology, Mild, With Agitation	Not Applicable	F02.A11
Major Neurocognitive Disorder Due to Probable Medical Etiology, Mild, With Anxiety	Not Applicable	F02.A4
Major Neurocognitive Disorder Due to Probable Medical Etiology, Mild, With Mood Symptoms	Not Applicable	F02.A3
Major Neurocognitive Disorder Due to Probable Medical Etiology, Mild, With Psychotic Disturbance	Not Applicable	F02.A2
Major Neurocognitive Disorder Due to Probable Medical Etiology, Mild, With Other Behavioral or Psychological Disturbance	Not Applicable	F02.A18
Major Neurocognitive Disorder Due to Probable Medical Etiology, Mild, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F02.A0
Major Neurocognitive Disorder Due to Probable Medical Etiology, Moderate, With Agitation	Not Applicable	F02.B11
Major Neurocognitive Disorder Due to Probable Medical Etiology, Moderate, With Anxiety	Not Applicable	F02.B4
Major Neurocognitive Disorder Due to Probable Medical Etiology, Moderate, With Mood Symptoms	Not Applicable	F02.B3
Major Neurocognitive Disorder Due to Probable Medical Etiology, Moderate, With Psychotic Disturbance	Not Applicable	F02.B2
Major Neurocognitive Disorder Due to Probable Medical Etiology, Moderate, With Other Behavioral or Psychological Disturbance	Not Applicable	F02.B18
Major Neurocognitive Disorder Due to Probable Medical Etiology, Moderate, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F02.B0
Major Neurocognitive Disorder Due to Probable Medical Etiology, Severe, With Agitation	Not Applicable	F02.C11
Major Neurocognitive Disorder Due to Probable Medical Etiology, Severe, With Anxiety	Not Applicable	F02.C4
Major Neurocognitive Disorder Due to Probable Medical Etiology, Severe, With Mood Symptoms	Not Applicable	F02.C3
Major Neurocognitive Disorder Due to Probable Medical Etiology, Severe, With Psychotic Disturbance	Not Applicable	F02.C2
Major Neurocognitive Disorder Due to Probable Medical Etiology, Severe, With Other Behavioral or Psychological Disturbance	Not Applicable	F02.C18
Major Neurocognitive Disorder Due to Probable Medical Etiology, Severe, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F02.C0
Major Neurocognitive Disorder Due to Probable Medical Etiology, Unspecified Severity, With Agitation	Not Applicable	F02.811
Major Neurocognitive Disorder Due to Probable Medical Etiology, Unspecified Severity, With Anxiety	Not Applicable	F02.84
Major Neurocognitive Disorder Due to Probable Medical Etiology, Unspecified Severity, With Mood Symptoms	Not Applicable	F02.83
Major Neurocognitive Disorder Due to Probable Medical Etiology, Unspecified Severity, With Psychotic Disturbance	Not Applicable	F02.82

Table 2 continues on next page.

DSM-5-TR CODE UPDATES (*Continued*)		
Disease	**Previous Code**	**Current Code**
Major Neurocognitive Disorder Due to Probable Medical Etiology, Unspecified Severity, With Other Behavioral or Psychological Disturbance	Not Applicable	F02.818
Major Neurocognitive Disorder Due to Probable Medical Etiology, Unspecified Severity, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F02.80
Major Neurocognitive Disorder Due to Probable Vascular Disease, Mild, With Agitation	Not Applicable	F01.A11
Major Neurocognitive Disorder Due to Probable Vascular Disease, Mild, With Anxiety	Not Applicable	F01.A4
Major Neurocognitive Disorder Due to Probable Vascular Disease, Mild, With Mood Symptoms	Not Applicable	F01.A3
Major Neurocognitive Disorder Due to Probable Vascular Disease, Mild, With Psychotic Disturbance	Not Applicable	F01.A2
Major Neurocognitive Disorder Due to Medical Etiology, Mild, With Other Behavioral or Psychological Disturbance	Not Applicable	F02.B11
Major Neurocognitive Disorder Due to Probable Vascular Disease, Mild, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F01.A18
Major Neurocognitive Disorder Due to Probable Vascular Disease, Moderate, With Agitation	Not Applicable	F01.B11
Major Neurocognitive Disorder Due to Probable Vascular Disease, Moderate, With Anxiety	Not Applicable	F01.B4
Major Neurocognitive Disorder Due to Probable Vascular Disease, Moderate, With Mood Symptoms	Not Applicable	F01.B3
Major Neurocognitive Disorder Due to Probable Vascular Disease, Moderate, With Psychotic Disturbance	Not Applicable	F01.B2
Major Neurocognitive Disorder Due to Probable Vascular Disease, Moderate, With Other Behavioral or Psychological Disturbance	Not Applicable	F01.B18
Major Neurocognitive Disorder Due to Probable Vascular Disease, Moderate, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F01.B0
Major Neurocognitive Disorder Due to Probable Vascular Disease, Severe, With Agitation	Not Applicable	F01.C11
Major Neurocognitive Disorder Due to Probable Vascular Disease, Severe, With Anxiety	Not Applicable	F01.C4
Major Neurocognitive Disorder Due to Probable Vascular Disease, Severe, With Mood Symptoms	Not Applicable	F01.C3
Major Neurocognitive Disorder Due to Probable Vascular Disease, Severe, With Psychotic Disturbance	Not Applicable	F01.C2
Major Neurocognitive Disorder Due to Probable Vascular Disease, Severe, With Other Behavioral or Psychological Disturbance	Not Applicable	F01.C18
Major Neurocognitive Disorder Due to Probable Vascular Disease, Severe, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F01.C0
Major Neurocognitive Disorder Due to Probable Vascular Disease, Unspecified Severity, With Agitation	Not Applicable	F01.511
Major Neurocognitive Disorder Due to Probable Vascular Disease, Unspecified Severity, With Anxiety	Not Applicable	F01.54
Major Neurocognitive Disorder Due to Probable Vascular Disease, Unspecified Severity, With Mood Symptoms	Not Applicable	F01.53

Table 2 continues on next page.

DSM-5-TR CODE UPDATES (*Continued*)		
Disease	**Previous Code**	**Current Code**
Major Neurocognitive Disorder Due to Probable Vascular Disease, Unspecified Severity, With Psychotic Disturbance	Not Applicable	F01.53
Major Neurocognitive Disorder Due to Probable Vascular Disease, Unspecified Severity, With Other Behavioral or Psychological Disturbance	Not Applicable	F01.52
Major Neurocognitive Disorder Due to Probable Vascular Disease, Unspecified Severity, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F01.518
Major Neurocognitive Disorder Due to Unknown Etiology, Mild, With Agitation	Not Applicable	F01.50
Major Neurocognitive Disorder Due to Unknown Etiology, Mild, With Anxiety	Not Applicable	F03.A11
Major Neurocognitive Disorder Due to Unknown Etiology, Mild, With Mood Symptoms	Not Applicable	F03.A4
Major Neurocognitive Disorder Due to Unknown Etiology, Mild, With Psychotic Disturbance	Not Applicable	F03.A3
Major Neurocognitive Disorder Due to Unknown Etiology, Mild, With Other Behavioral or Psychological Disturbance	Not Applicable	F03.A2
Major Neurocognitive Disorder Due to Unknown Etiology, Mild, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F03.A18
Major Neurocognitive Disorder Due to Unknown Etiology, Moderate, With Agitation	Not Applicable	F03.A0
Major Neurocognitive Disorder Due to Unknown Etiology, Moderate, With Anxiety	Not Applicable	F03.B11
Major Neurocognitive Disorder Due to Unknown Etiology, Moderate, With Mood Symptoms	Not Applicable	F03.B4
Major Neurocognitive Disorder Due to Unknown Etiology, Moderate, With Psychotic Disturbance	Not Applicable	F03.B3
Major Neurocognitive Disorder Due to Unknown Etiology, Moderate, With Other Behavioral or Psychological Disturbance	Not Applicable	F03.B18
Major Neurocognitive Disorder Due to Unknown Etiology, Moderate, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F03.B0
Major Neurocognitive Disorder Due to Unknown Etiology, Severe, With Agitation	Not Applicable	F03.C11
Major Neurocognitive Disorder Due to Unknown Etiology, Severe, With Anxiety	Not Applicable	F03.C4
Major Neurocognitive Disorder Due to Unknown Etiology, Severe, With Mood Symptoms	Not Applicable	F03.C3
Major Neurocognitive Disorder Due to Unknown Etiology, Severe, With Psychotic Disturbance	Not Applicable	F03.C2
Major Neurocognitive Disorder Due to Unknown Etiology, Severe, With Other Behavioral or Psychological Disturbance	Not Applicable	F03.C18
Major Neurocognitive Disorder Due to Unknown Etiology, Severe, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F03.C0
Major Neurocognitive Disorder Due to Unknown Etiology, Unspecified Severity, With Agitation	Not Applicable	F03.911
Major Neurocognitive Disorder Due to Unknown Etiology, Unspecified Severity, With Anxiety	Not Applicable	F03.94

Table 2 continues on next page.

DSM-5-TR CODE UPDATES (*Continued*)		
Disease	**Previous Code**	**Current Code**
Major Neurocognitive Disorder Due to Unknown Etiology, Unspecified Severity, With Mood Symptoms	Not Applicable	F03.93
Major Neurocognitive Disorder Due to Unknown Etiology, Unspecified Severity, With Psychotic Disturbance	Not Applicable	F03.92
Major Neurocognitive Disorder Due to Unknown Etiology, Unspecified Severity, With Other Behavioral or Psychological Disturbance	Not Applicable	F03.918
Major Neurocognitive Disorder Due to Unknown Etiology, Unspecified Severity, Without Accompanying Behavioral or Psychological Disturbance	Not Applicable	F03.90
[a]New entry did not previously exist.		
Source: [22; 32]		*Table 2*

Prevalence and Risk Factors

The DSM-5-TR focused on ensuring that reported differences in disorder prevalence among ethnic groups were based on reliable studies with sufficient sample sizes. It also provided context to avoid misinterpreting these differences as genetic rather than social or environmental. This represents a more critical approach to epidemiological data than in the DSM-5.

Misdiagnosis Risk

The manual explicitly highlighted the risk of misdiagnosis when evaluating individuals from socially oppressed ethnoracial groups. This acknowledgment of potential bias in diagnosis was not as prominently featured in the DSM-5.

Social Determinants of Health

There was increased recognition of how social status, including experiences of racism and discrimination, can impact mental health outcomes. This reflects a broader understanding of mental health that goes beyond the more individualistic focus of the DSM-5.

Structural Factors

The DSM-5-TR accelerated the inclusion of structural factors in the concept of culture, particularly in response to calls for social justice following events like George Floyd's death. This represents a more explicit acknowledgment of systemic issues affecting mental health than was present in the DSM-5.

These changes collectively represent a significant shift towards a more culturally informed, socially aware, and inclusive approach to mental health diagnosis and treatment compared to the DSM-5. The DSM-5-TR aims to provide clinicians with better tools to understand and address the complex interplay between culture, social structures, and mental health.

ITERATIVE REVISION PROCESS

The DSM-5-TR incorporates an iterative revision process that allows for ongoing updates and improvements to the diagnostic manual [1]. This approach represents a significant shift from previous editions of the DSM, enabling more responsive and timely updates based on emerging research and clinical evidence.

Key Features of the Iterative Revision Process

Continuous Updates

Unlike previous versions that remained static between significant revisions, the DSM-5-TR is designed to be updated incrementally. This allows for more frequent incorporation of new scientific findings and clinical insights.

DSM Steering Committee

The iterative revision process is overseen by the DSM Steering Committee, which evaluates proposals for changes and updates to the manual. This committee plays a crucial role in maintaining the DSM's scientific integrity and clinical utility.

Proposal Submission

Mental health professionals can submit change proposals through the APA's DSM web portal. The Steering Committee and relevant Review Committees rigorously evaluate these proposals.

Public Comment Period

After preliminary approval, proposed changes are posted on the DSM-5 website for public comment. This allows for broader input from the psychiatric community before final decisions are made.

Scope of Changes

The iterative revision process allows for various updates, as discussed below and throughout this course.

Text Updates

Comprehensive revisions to the descriptive text accompanying each disorder, based on literature reviews covering the past decade.

Criteria Clarifications

Minor adjustments to diagnostic criteria for clarity or consistency.

New Diagnostic Entities

Addition of new disorders or specifiers, such as prolonged grief disorder in the DSM-5-TR.

Terminology Updates

Language changes to reflect current understanding and promote non-stigmatizing descriptions.

Impact on Clinical Practice

This iterative approach ensures that clinicians have access to the most up-to-date diagnostic guidelines and information. It allows for more rapid incorporation of scientific advances, potentially improving diagnostic accuracy and treatment outcomes.

Future Outlook

The iterative revision process is expected to continue, with future updates identified by decimal points (e.g., DSM-5.1, DSM-5.2). This model aims to balance the need for stability in diagnostic practice with the imperative to incorporate new scientific knowledge promptly. By adopting this iterative revision process, the DSM-5-TR represents a more dynamic and responsive approach to psychiatric diagnosis, reflecting the evolving nature of mental health research and practice.

CRITERIA CLARIFICATIONS

The DSM-5-TR included clarifying modifications to the diagnostic criteria for more than 70 disorders. These modifications improved clarity and reduced ambiguity in the criteria sets without fundamentally changing the conceptual definitions of the disorders. The main goal was to enhance the reliability and validity of diagnoses by making the criteria more precise and more accessible to interpret consistently across clinicians.

The modifications affected a wide range of disorders across multiple categories in the DSM, indicating a comprehensive review of the manual. Most modifications were minor clarifications to wording designed to resolve ambiguities or inconsistencies in the original DSM-5 criteria. These changes underwent a formal review process, including approval by the DSM Steering Committee, the APA Board of Trustees, and the APA Assembly. Examples of clarifications include:

- Autism Spectrum Disorder: Criterion A was revised to require that all three deficits be present, stating "as manifested by all of the following."
- Major Depressive Disorder: Criterion D was revised to allow diagnosis of MDD whether the current episode includes psychotic symptoms, if there was at least one major depressive episode without concurrent symptoms of another mental disorder in the patient's lifetime.

- Manic Episode: The severity specifiers were revised in order to be consistent with the diagnostic criteria.

While these modifications do not fundamentally alter the disorders, they may lead to more accurate and consistent diagnoses in clinical practice. Clear criteria can produce more consistent research results across different studies and settings.

These clarifications underscore the ongoing effort to improve the precision and utility of the DSM for both clinical and research purposes. They reflect the dynamic nature of psychiatric diagnosis and the importance of continually refining diagnostic criteria based on clinical experience and emerging research.

NEWLY CLASSIFIED DIAGNOSES IN THE DSM-5-TR

PROLONGED GRIEF DISORDER

The development and inclusion of prolonged grief disorder (PGD) in the DSM-5-TR represents a significant milestone in the field of mental health and bereavement research. Historically, research on pathological grief reactions dates to the 1990s, with various terms and criteria sets proposed over the years, including "complicated grief" and "persistent complex bereavement disorder" [26]. The concept of prolonged grief as a distinct disorder has been debated for decades among researchers and clinicians. Numerous studies have demonstrated that a small but significant portion of bereaved individuals experience persistent, intense grief that impairs their functioning, showing that prolonged grief is distinct from other mental health conditions like depression and post-traumatic stress disorder.

The proposal to include PGD was submitted to the APA nearly two decades ago and underwent extensive review and debate within the psychiatric community. Officially included in the DSM-5-TR published in March 2022, PGD replaced the previous persistent complex bereavement disorder, which had appeared in the DSM-5's Section III (Conditions for Further Study). The DSM-5-TR defines PGD as persistent yearning or longing for the deceased or preoccupation with thoughts of the deceased, along with several other symptoms lasting at least 12 months for adults and six months for children [1]. The symptoms must cause clinically significant distress or impairment and exceed cultural, religious, or age-appropriate norms.

However, the inclusion of PGD has sparked debate within the psychiatric community. Some critics argue that it pathologizes normal grief, while others contend that it is necessary to identify and treat those experiencing severe, persistent grief reactions [26]. The inclusion of PGD in the DSM-5-TR also aligns with its recognition in the ICD-11, although there are some differences in specific criteria. Overall, the incorporation of PGD reflects a growing acknowledgment of prolonged, impairing grief as a distinct clinical entity, aiming to improve diagnosis and treatment for individuals suffering from severe grief reactions while recognizing the need for careful differentiation from normal grieving processes.

Prolonged grief disorder was newly added to the DSM-5-TR as a formal diagnosis in the category of Trauma- and Stressor-Related Disorders. Here are the critical points about PGD and its diagnostic requirements in the DSM-5-TR [1]:

- **Definition**: PGD is characterized as a maladaptive grief reaction that persists for an extended period after the death of someone with whom the bereaved had a close relationship.
- **Time criteria (Criterion A)**:
  - For adults: At least 12 months must have passed since the death
  - For children and adolescents: At least six months must have passed since the death

- **Core symptoms (Criterion B)**: The person must experience at least one of the following nearly every day for at least the last month:
  - Intense yearning/longing for the deceased person
  - Preoccupation with thoughts or memories of the deceased person (for children/adolescents, this may focus on the circumstances of the death)
- **Additional symptoms (Criterion C)**: At least three of the following eight symptoms must be present nearly every day for at least the last month:
  - Identity disruption (feeling as though part of oneself has died)
  - Marked sense of disbelief about the death
  - Avoidance of reminders that the person is dead
  - Intense emotional pain related to the death
  - Difficulty moving on with life
  - Emotional numbness
  - Feeling that life is meaningless
  - Intense loneliness
- **Functional impairment (Criterion D)**: The disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- **Cultural considerations (Criterion E)**: The duration and severity of the grief reaction must clearly exceed expected social, cultural, or religious norms for the individual's culture and context.
- **Differential diagnosis (Criterion F)**: The symptoms are not better explained by another mental disorder.

The inclusion of PGD in the DSM-5-TR aims to improve the recognition and treatment of maladaptive grief responses, particularly in the context of increased deaths due to the COVID-19 pandemic. However, its inclusion has also sparked some controversy in the psychiatric community, with debates about the potential medicalization of normal grief processes.

UNSPECIFIED MOOD DISORDER

The development and inclusion of unspecified mood disorder in the DSM-5-TR represents a vital update aimed at addressing a gap in diagnostic options [1]. This category was added to provide clinicians with a diagnostic option when it is challenging to distinguish between unipolar and bipolar presentations, particularly in cases where irritable mood or agitation predominates. Historically, this category was unintentionally removed from the DSM-5 when the mood disorders diagnostic class was eliminated in favor of separate bipolar and depressive disorder classifications. The inclusion of unspecified mood disorder allows clinicians to avoid prematurely choosing between bipolar disorder and depressive disorder, which can have significant implications for treatment and long-term patient outcomes.

The unspecified mood disorder category also enhances compatibility with other diagnostic systems, such as ICD-10-CM and ICD-11, which include similar classifications. Due to the absence of a mood disorders grouping in the DSM-5-TR, unspecified mood disorder is located within both the depressive disorders and the bipolar disorders chapters. It applies to presentations with symptoms characteristic of a mood disorder that cause clinically significant distress or impairment but do not meet the full criteria for any specific mood disorder. This category serves as a diagnostic placeholder when there is insufficient information to make a more specific diagnosis, with the expectation that a more precise diagnosis may be made later as more information becomes available. Overall, including unspecified mood disorder reflects an effort to provide clinicians with greater flexibility in diagnosis, particularly in complex or unclear cases, while aligning the manual more closely with other diagnostic systems.

STIMULANT-INDUCED MILD NEUROCOGNITIVE DISORDER

The development and inclusion of stimulant-induced mild neurocognitive disorder in the DSM-5-TR represents an essential update to the classification of substance-induced cognitive impairments [1]. Historically, the DSM-IV included a category for persisting dementia resulting from four substance classes: alcohol, sedatives/hypnotics/anxiolytics, inhalants, and other/unknown substances [18]. The DSM-5 replaced this single dementia category with major and mild neurocognitive disorders for these same substance classes [2]. A growing literature on stimulant-induced neurocognitive impairments supported the existence of persistent cognitive deficits resulting from stimulant use, with studies demonstrating that these deficits, while not severe enough to interfere with independence in daily activities, were significant enough to require more tremendous mental effort, compensatory strategies, or accommodation.

In the DSM-5-TR, cocaine-induced mild neurocognitive disorder and amphetamine-type substance–induced mild neurocognitive disorder were added to acknowledge the increasing evidence that chronic stimulant use can lead to lasting cognitive impairments, even after cessation of use [1]. This inclusion provides a diagnostic category for clinicians to capture the cognitive effects of stimulant use accurately. While specific diagnostic criteria are not detailed in the search results, it likely follows the general structure for substance-induced disorders, requiring evidence of cognitive decline that is etiologically related to stimulant use. The inclusion of this disorder allows for better recognition and potential treatment of cognitive impairments associated with stimulant use. It may facilitate research into the long-term effects of such substances on cognitive functioning. Overall, this addition aligns stimulant-induced cognitive impairments with other recognized substance-induced neurocognitive disorders in the DSM, reflecting an ongoing effort to refine and update the manual based on emerging research and clinical observations in substance-related disorders.

The diagnostic criteria for stimulant-induced mild neurocognitive disorder are as follows [1]:

- Evidence of modest cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on (Criterion A):
  - Concern about a mild decline in cognitive function, expressed by the individual, a knowledgeable informant, or the clinician.
  - A modest impairment in cognitive performance, documented by objective cognitive assessment.
- The cognitive deficits do not interfere with independence in everyday activities. However, greater effort, compensatory strategies, or accommodation may be required to maintain independence (Criterion B).
- The cognitive deficits do not occur exclusively in the context of delirium (Criterion C).
- The cognitive deficits are not better explained by another mental disorder (Criterion D).

Additionally, the clinician should specify the etiological subtype if possible (e.g., due to Alzheimer disease, vascular disease, traumatic brain injury, etc.). The presence or absence of behavioral disturbances should be noted. For some etiological subtypes, the level of certainty of the diagnosis (possible or probable) can be specified.

It is important to note that while these criteria help identify mild neurocognitive disorder, clinical judgment and comprehensive assessment are crucial for accurate diagnosis.

NO DIAGNOSIS OR CONDITION

Including a code for "no diagnosis or condition" in the DSM-5-TR represents an essential addition to the manual, addressing a longstanding need in clinical practice and documentation [1]. This new code allows clinicians to indicate that a comprehensive diagnostic evaluation was conducted explicitly, but no mental disorder or condition warranting clinical attention was found. The development of this code stemmed from the recognition that there are situations where individuals undergo mental health assessments but do not meet the criteria for any mental disorder. Nevertheless, there was previously no standardized way to document this outcome.

The addition of this code serves several vital purposes in clinical practice. It clearly communicates that a thorough evaluation was performed, even when no diagnosis was made. This is particularly useful in contexts where the absence of a diagnosis needs to be formally recorded, such as in administrative or billing processes. The code also helps differentiate between cases where no disorder is present versus cases with insufficient information to diagnose. Furthermore, it can be valuable in research settings, allowing for more accurate categorization of study participants. Including this code in the DSM-5-TR reflects the manual's ongoing efforts to improve the accuracy and utility of clinical documentation in mental health care, providing clinicians with a more comprehensive set of tools for describing the outcomes of their diagnostic assessments.

CASE STUDY

Case Presentation

Sarah, a 32-year-old woman, was referred to the outpatient psychiatric clinic by her primary care physician due to persistent depressive symptoms and difficulty functioning in daily life.

Background

Fifteen months ago, Sarah's mother died suddenly from a heart attack at age 58. Sarah and her mother had been extremely close, speaking daily and seeing each other multiple times per week. Sarah described her mother as her "best friend" and primary source of emotional support.

Symptoms

Since her mother's death, Sarah has experienced:

- Intense yearning and longing for her mother daily
- Preoccupation with thoughts and memories of her mother
- Difficulty accepting the reality of the loss
- Avoidance of places and activities that remind her of her mother
- A sense that life is meaningless without her mother
- Emotional numbness and detachment from others
- Bitterness and anger about the loss
- Difficulty engaging in work and social activities

These symptoms have persisted without significant improvement for over a year since the loss. Sarah reports that the intensity of her grief feels just as strong now as it did immediately after her mother's death.

Functional Impairment

Sarah's work performance has declined significantly. She has been reprimanded for excessive absences and missed deadlines. Her social relationships have deteriorated as she isolates herself and avoids social gatherings. Sarah has also neglected her physical health, skipping meals and doctor's appointments.

Previous Treatment

Sarah attended three grief counseling sessions shortly after her mother's death but found them unhelpful and discontinued. She has been taking an SSRI antidepressant prescribed by her primary care doctor for the past six months with minimal effect on her symptoms.

Diagnosis

Based on the persistent and impairing nature of Sarah's grief symptoms more than 12 months after her loss, she meets the criteria for prolonged grief disorder. Her symptoms go beyond customary cultural and religious norms for grief and are causing significant functional impairment.

Treatment Plan

A comprehensive treatment approach is recommended, including:

- Prolonged grief disorder-specific psychotherapy (e.g., complicated grief therapy)
- Continued antidepressant medication with potential adjustment
- Behavioral activation to increase engagement in meaningful activities
- Grief support group to reduce isolation

The goals are to help Sarah process her grief, find ways to maintain a healthy connection to her mother's memory, and gradually re-engage in life. Regular monitoring of suicidal ideation is also warranted, given the elevated suicide risk associated with prolonged grief.

SYMPTOM CODE UPDATES: PRESENCE/HISTORY OF SUICIDAL BEHAVIOR AND NSSI

PRESENCE/HISTORY OF SUICIDAL BEHAVIOR

The DSM-5-TR introduced significant changes regarding the documentation of suicidal behavior by adding new symptom codes to indicate both the presence and history of suicidal behavior [1]. This addition was part of a broader effort to improve the assessment and documentation of suicide risk in clinical practice. The DSM-5 had already included a Suicide Risk section in the text for most disorders to emphasize the importance of suicide risk assessment during clinical evaluations [2]. In the DSM-5-TR, these sections were expanded and renamed "Association with Suicidal Thoughts or Behavior."

The new symptom codes for suicidal behavior were added to the chapter "Other Conditions That May Be a Focus of Clinical Attention" in the DSM-5-TR. These codes allow clinicians to document current suicidal behavior (for both initial and subsequent encounters) as well as a history of suicidal behavior. Including these codes serves several important purposes: it helps improve the accuracy of clinical documentation, facilitates better tracking and research on suicidal behavior, and encourages clinicians to assess for these behaviors as part of routine clinical practice. Importantly, these codes can be used without requiring any other mental health diagnosis, recognizing that suicidal behavior can occur in various contexts. This change reflects a growing recognition of the need to address suicidal behavior as a distinct clinical concern, separate from, but often related to, other mental health conditions.

NSSI

The DSM-5-TR introduced new symptom codes for nonsuicidal self-injury (NSSI), representing a significant update in the documentation and recognition of this clinically meaningful behavior [1]. This addition was part of a broader effort to improve the assessment and documentation of self-harming behaviors in clinical practice. The inclusion of these codes allows clinicians to document both current nonsuicidal self-injury and a history of nonsuicidal self-injury.

The new symptom codes for NSSI were added to the "Other Conditions That May Be a Focus of Clinical Attention" chapter in the DSM-5-TR. These codes serve several important purposes: they help improve the accuracy of clinical documentation, facilitate better tracking and research on self-injurious behaviors, and encourage clinicians to assess for these behaviors as part of routine clinical practice. Importantly, these codes can be used without requiring any other mental health diagnosis, recognizing that NSSI can occur in various contexts and may not always be associated with a specific mental disorder. This change reflects a growing recognition of the need to address self-injurious behaviors as distinct clinical concerns, separate from, but often related to, other mental health conditions. Including these codes in the DSM-5-TR aims to draw attention to the importance of assessing and documenting NSSI, potentially leading to improved identification and treatment of individuals engaging in these behaviors.

DISORDERS RECOMMENDED FOR FURTHER STUDY

Section III Conditions for Further Study in the DSM serves several important purposes:

- **Research promotion**: This section includes proposed diagnostic categories and criteria sets that require further research before they can be considered official diagnoses in the main sections of the DSM. The DSM encourages and stimulates additional research to validate these proposed disorders by including these conditions.
- **Provisional recognition**: This provides provisional recognition for conditions with some empirical support but is not well-established enough to be included in formal diagnoses. This allows clinicians and researchers to have a common language for discussing these potential disorders.
- **Clinical utility testing**: Including these conditions allows for testing their clinical utility in real-world settings. Clinicians can use these proposed criteria sets and provide feedback on their usefulness and validity.
- **Future development**: This section serves as a developmental ground for future additions to the main diagnostic categories in subsequent DSM editions.
- **Addressing emerging issues**: This allows the DSM to be responsive to emerging mental health issues and new research findings without prematurely including them as official diagnoses.
- **Continuity and evolution**: It bridges current diagnostic practices and potential future directions in psychiatric nosology.
- **Transparency**: The DSM demonstrates transparency in developing new diagnostic categories by including these proposed disorders.
- **Flexibility**: This section allows for more flexibility in considering new diagnostic entities compared to the more established categories in the main sections of the manual.

Thus, the Conditions for Further Study section plays a crucial role in the ongoing development and refinement of psychiatric diagnosis, balancing the need for diagnostic stability with the importance of incorporating new research findings and clinical observations.

ATTENUATED PSYCHOSIS SYNDROME

Attenuated psychosis syndrome (APS) is characterized by the presence of attenuated (less severe) psychotic symptoms that do not meet the full criteria for a psychotic disorder. These symptoms typically include delusions, hallucinations, or disorganized speech in a milder form, with relatively intact reality testing.

The inclusion of APS in the DSM aims to identify individuals who may be at high risk for developing a full psychotic disorder, particularly schizophrenia. To meet the criteria for APS, symptoms must have begun or worsened in the past year, be present at least once per week in the last month, and cause distress or disability to the individual [1]. Notably, the symptoms should not be better explained by another mental disorder or substance use. The concept of APS has sparked debate in the psychiatric community, with some arguing for its potential in early intervention and prevention of psychosis. In contrast, others express concerns about potential overdiagnosis and stigmatization. As research continues, the status of APS may evolve in future editions of the DSM.

Proposed Criteria for APS

- At least one of the following symptoms is present and is of sufficient severity or frequency to warrant clinical attention:
  - Attenuated delusions
  - Attenuated hallucinations
  - Attenuated disorganized speech

- Symptom(s) must have been present at least once per week for the past month.
- Symptom(s) must have begun or worsened in the past year.
- Symptom(s) is sufficiently distressing and disabling to the individual to warrant clinical attention.
- Symptom(s) is not better explained by another mental disorder, including a depressive or bipolar disorder with psychotic features, and is not attributable to the physiological effects of a substance or another medical condition.
- Criteria for any psychotic disorder have never been met.

DEPRESSIVE EPISODES WITH SHORT-DURATION HYPOMANIA

Depressive episodes with short-duration hypomania is a condition included in the Conditions for Further Study section of the DSM-5-TR, indicating that more research is needed before it can be considered an official diagnosis. This proposed disorder is characterized by individuals who experience major depressive episodes along with brief periods of hypomania that last less than four days. These short hypomanic episodes do not meet the current DSM criteria for bipolar II disorder, which requires hypomanic episodes to last at least four consecutive days.

The inclusion of this condition in the DSM-5-TR reflects growing recognition that shorter periods of hypomania may be clinically significant and more common than previously thought. Research suggests that individuals with depressive episodes and short-duration hypomania may represent a distinct clinical group that falls on a spectrum between unipolar depression and bipolar II disorder. These patients often experience mood instability, increased energy levels, and changes in behavior during their brief hypomanic periods, which can impact their overall functioning and treatment needs. The study of this condition aims to improve diagnostic accuracy and potentially lead to more appropriate treatment strategies for individuals who may be currently misdiagnosed with unipolar depression. However, there is ongoing debate in the psychiatric community about the optimal duration criterion for hypomania and the potential implications of broadening the bipolar spectrum.

Proposed Criteria for Depressive Episodes with Short-Duration Hypomania

Lifetime experience of at least one major depressive episode meeting the following criteria [1]:

- Five (or more) of the following criteria have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) a depressed mood or (2) loss of interest or pleasure. (Note: Do not include symptoms clearly attributable to a medical condition.):
  - Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (Note: It can be an irritable mood in children and adolescents.)
  - Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation)
  - Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly daily (Note: In children, consider failure to make expected weight gain.)
  - Insomnia or hypersomnia nearly every day
  - Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

  - Fatigue or loss of energy nearly every day
  - Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
  - Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
  - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The disturbance is not attributable to the physiological effects of a substance or another medical condition.
- The disturbance is not better explained by schizoaffective disorder. It is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorders.

At least two lifetime episodes of hypomanic periods that involve the required criterion symptoms below but are of insufficient duration (at least two days but less than four consecutive days) to meet the criteria for a hypomanic episode. The criterion symptoms are as follows [1]:

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy.
- During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, and have been present to a significant degree:
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
  - More talkative than usual or pressured to keep talking
  - Flight of ideas or subjective experience that thoughts are racing
  - Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed
  - Increase goal-directed activity (socially, at work or school, or sexually) or psychomotor agitation
  - Excessive involvement in activities with a high potential for painful consequences (e.g., the individual engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
- The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
- The disturbance in mood and the change in functioning are observable by others.
- The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.
- The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment).

CAFFEINE USE DISORDER

Caffeine use disorder (CUD) is a condition included in the DSM-5-TR under the Conditions for Further Study section, indicating that more research is needed before it can be considered an official diagnosis. The proposed criteria for CUD are like other substance use disorders but with a more conservative threshold to prevent overdiagnosis, given the prevalence of nonproblematic caffeine use in the general population. For a potential CUD diagnosis, an individual must endorse at least three criteria [1]:

- A persistent desire or unsuccessful effort to control caffeine use
- Continued use despite harm
- Withdrawal symptoms

Research suggests that CUD may affect a significant portion of caffeine consumers, with one study finding that 8% of a sample of U.S. adults met the proposed DSM-5 criteria [2]. Individuals meeting these criteria tend to consume more caffeine, are often younger, and are more likely to be cigarette smokers. They may experience caffeine-related functional impairment, poorer sleep, and greater levels of depression, anxiety, and stress. Symptoms of CUD can include anxiety, insomnia, and other issues that interfere with daily life. While caffeine is widely consumed and generally considered safe, CUD highlights that, for some individuals, caffeine use can become problematic and may require clinical attention. However, more research is needed to fully understand this condition's prevalence, severity, and clinical significance before it can be officially recognized as a disorder in future editions of the DSM.

Proposed Criteria for CUD

A problematic pattern of caffeine use leading to clinically significant impairment or distress, as manifested by at least three of the following criteria occurring within a 12-month period [1]:

- A persistent desire or unsuccessful efforts to cut down or control caffeine use.
- Continued caffeine use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by caffeine.
- Withdrawal, as manifested by either of the following:
  - The characteristic withdrawal syndrome for caffeine
  - Caffeine (or a closely related substance) is taken to relieve or avoid withdrawal symptoms
- Caffeine is often taken in larger amounts or over a longer period than was intended.
- Recurrent caffeine use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated tardiness or absences from work or school related to caffeine use or withdrawal).
- Continued caffeine use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of caffeine (e.g., arguments with spouse about consequences of use, medical problems, cost).
- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of caffeine to achieve the desired effect
  - Markedly diminished effect with continued use of the same amount of caffeine
- A great deal of time is spent on activities necessary to obtain caffeine, use caffeine, or recover from its effects.
- Craving or a strong desire or urge to use caffeine.

INTERNET GAMING DISORDER

Internet gaming disorder (IGD) is a condition included in the Conditions for Further Study section of the DSM-5-TR, indicating that more research is needed before it can be considered an official diagnosis [1]. The DSM-5 defines IGD as "a pattern of excessive and prolonged Internet gaming that results in a cluster of cognitive and behavioral symptoms, including progressive loss of control over gaming, tolerance, and withdrawal symptoms, analogous to the symptoms of substance use disorders" [1]. To meet the criteria for IGD, an individual must experience five or more of nine specified symptoms within a year, such as preoccupation with gaming, withdrawal symptoms when gaming is taken away, and loss of interest in other activities.

The inclusion of IGD in the DSM-5 reflects growing concern about the potential negative impacts of excessive online gaming, particularly among young people. Research suggests that individuals with IGD may experience significant impairment in various areas of life, including academic performance, social relationships, and mental health. However, the prevalence of IGD appears to be relatively low, with studies estimating that between 0.3% and 1.0% of the general population might qualify for a potential diagnosis. The condition criteria focus on Internet games and do not include general Internet use, online gambling, or social media use. While IGD's inclusion in the DSM-5 has stimulated further research and clinical attention, debate continues in the scientific community about whether gaming addiction should be classified as a distinct mental disorder. As research in this area progresses, our understanding of IGD and its potential impacts on mental health may evolve.

Proposed Criteria for IGD

Persistent and recurrent use of the Internet to engage in games, often with other players, leading to clinically significant impairment or distress as indicated by five (or more) of the following in a 12-month period [1]:

- Preoccupation with Internet games. (The individual thinks about previous gaming activity or anticipates playing the next game; Internet gaming becomes the dominant activity in daily life.) Note: This disorder is distinct from Internet gambling, which is included under gambling disorder.
- Withdrawal symptoms when Internet gaming is taken away. (These symptoms are typically described as irritability, anxiety, or sadness, but there are no physical signs of pharmacological withdrawal.)
- Tolerance—the need to spend increasing amounts of time engaged in Internet games.
- Unsuccessful attempts to control the participation in Internet games.
- Loss of interests in previous hobbies and entertainment as a result of, and with the exception of, Internet games.
- Continued excessive use of Internet games despite knowledge of psychosocial problems.
- Has deceived family members, therapists, or others regarding the amount of Internet gaming.
- Use of Internet games to escape or relieve a negative mood (e.g., feelings of helplessness, guilt, anxiety).
- Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of participation in Internet games.

Note: Only nongambling Internet games are included in this disorder. Use of the Internet for required activities in a business or profession is not included; nor is the disorder intended to include other recreational or social Internet use. Similarly, sexual Internet sites are excluded.

Internet gaming disorder can be mild, moderate, or severe depending on the degree of disruption of normal activities. Individuals with less severe Internet gaming disorder may exhibit fewer symptoms and less disruption of their lives. Those with severe Internet gaming disorder will have more hours spent on the computer and more severe loss of relationships or career or school opportunities.

NEUROBEHAVIORAL DISORDER ASSOCIATED WITH PRENATAL ALCOHOL EXPOSURE

Neurobehavioral disorder associated with prenatal alcohol exposure (ND-PAE) is a condition included in the DSM-5-TR under the Conditions for Further Study section [1]. It is characterized by a pattern of impairments in neurocognition, self-regulation, and adaptive functioning resulting from prenatal alcohol exposure. To meet the diagnostic criteria for ND-PAE, there must be confirmed prenatal alcohol exposure, along with evidence of impaired neurocognitive functioning, self-regulation, and adaptive functioning. Symptoms typically manifest in childhood and lead to significant distress or impairment in social, academic, or other important areas of functioning [1].

Individuals with ND-PAE may experience cognitive deficits, such as planning, attention, learning, and memory difficulties. Behavioral regulation issues, including mood or behavioral regulation problems, attention deficits, and impulse control challenges, can also arise. Additionally, these individuals may face difficulties in adaptive functioning, including social communication and interaction problems and impaired daily living skills. Estimates suggest that 2-5% of children in the United States may have a fetal alcohol spectrum disorder (FASD), with ND-PAE being a subset of this group [22]. Diagnosis requires confirmation of prenatal alcohol exposure and a comprehensive assessment of neurocognitive, behavioral, and adaptive functioning. Treatment typically involves a multidisciplinary approach that includes educational interventions, behavioral therapies, and sometimes medication for specific symptoms. While ND-PAE is a lifelong condition, early intervention and appropriate support can improve outcomes significantly. Notably, the only way to prevent ND-PAE is to avoid alcohol consumption during pregnancy. This condition represents an effort to capture better the range of effects that prenatal alcohol exposure can have on a child's development and functioning, extending beyond the physical features associated with fetal alcohol syndrome [1].

Proposed Criteria for ND-PAE

- More than minimal exposure to alcohol during gestation, including prior to pregnancy recognition. Confirmation of gestational exposure to alcohol may be obtained from maternal self-report of alcohol use in pregnancy, medical or other records, or clinical observation.
- Impaired neurocognitive functioning as manifested by one or more of the following:
  - Impairment in global intellectual performance (i.e., IQ of 70 or below, or a standard score of 70 or below on a comprehensive developmental assessment)
  - Impairment in executive functioning (e.g., poor planning and organization; inflexibility; difficulty with behavioral inhibition)
  - Impairment in learning (e.g., lower academic achievement than expected for intellectual level; specific learning disability)
  - Memory impairment (e.g., problems remembering information learned recently; repeatedly making the same mistakes; difficulty remembering lengthy verbal instructions)
  - Impairment in visual-spatial reasoning (e.g., disorganized or poorly planned drawings or constructions; problems differentiating left from right)
- Impaired self-regulation as manifested by one or more of the following:
  - Impairment in mood or behavioral regulation (e.g., mood lability; negative affect or irritability; frequent behavioral outbursts)
  - Attention deficit (e.g., difficulty shifting attention; difficulty sustaining mental effort)
  - Impairment in impulse control (e.g., difficulty waiting turn; difficulty complying with rules)

- Impairment in adaptive functioning as manifested by two or more of the following, including at least one of the first two criteria:
  - Communication deficit (e.g., delayed acquisition of language; difficulty understanding spoken language)
  - Impairment in social communication and interaction (e.g., overly friendly with strangers; difficulty reading social cues; difficulty understanding social consequences)
  - Impairment in daily living skills (e.g., delayed toileting, feeding, or bathing; difficulty managing daily schedule)
  - Impairment in motor skills (e.g., poor fine motor development; delayed attainment of gross motor milestones or ongoing deficits in gross motor function; deficits in coordination and balance)
- Onset of the disorder (symptoms in Criteria B, C, and D) occurs in childhood.
- The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.
- The disorder is not better explained by the direct physiological effects associated with postnatal use of a substance (e.g., a medication, alcohol, or other drugs), a general medical condition (e.g., traumatic brain injury, delirium, dementia), another known teratogen (e.g., fetal hydantoin syndrome), a genetic condition (e.g., Williams syndrome, Down syndrome, Cornelia de Lange syndrome), or environmental neglect.

SUICIDAL BEHAVIOR DISORDER

Suicidal behavior disorder (SBD) was introduced in the DSM-5 as a condition for further study, indicating that more research was needed before it could be considered for inclusion as an official diagnosis [2]. SBD is characterized by a self-initiated sequence of behaviors believed at the time of initiation to cause one's death, occurring within the last 24 months. The proposal aimed to improve the recognition, documentation, and treatment of suicidal behavior as a distinct clinical concern, separate from, but often related to, other mental health conditions.

The inclusion of SBD in the DSM-5 sparked debate in the psychiatric community [2]. Proponents argued that it could enhance research, improve communication during clinical hand-offs, and maintain focus on suicidal behavior as a significant clinical concern. Critics, however, raised concerns about the potential over-medicalization of behavior and increased liability for mental health professionals. Research on SBD over the past decade has primarily focused on its clinical utility in predicting future suicide risk, its association with related disorders, the development of psychometric measures, its pathophysiology, and potential interventions. However, studies have shown that the clinical utility of SBD for predicting future suicide risk is limited. In the DSM-5-TR, published in 2022, SBD was not included as a formal diagnosis. Instead, new symptom codes were added to indicate current suicidal behavior and history of suicidal behavior, allowing clinicians to document these behaviors without requiring any other mental health diagnosis. This change reflects ongoing efforts to improve the assessment and documentation of suicide risk in clinical practice while acknowledging the complexities involved in classifying suicidal behavior as a distinct disorder.

Proposed Criteria for SBD

- Within the last 24 months, the individual has made a suicide attempt. Note: A suicide attempt is a self-initiated sequence of behaviors by an individual who, at the time of initiation, expected that the set of actions would lead to his or her own death. (The "time of initiation" is the time when a behavior took place that involved applying the method.)
- The act does not meet criteria for nonsuicidal self-injury—that is, it does not involve self-injury directed to the surface of the body undertaken to induce relief from a negative feeling/cognitive state or to achieve a positive mood state.
- The diagnosis is not applied to suicidal ideation or to preparatory acts.
- The act was not initiated during a state of delirium or confusion.
- The act was not undertaken solely for a political or religious objective.
- Specify if:
  - Current: not more than 12 months since the last attempt
  - In early remission: 12 to 24 months since the last attempt

NONSUICIDAL SELF-INJURY

Nonsuicidal self-injury disorder (NSSID) is a condition included in the Conditions for Further Study section of the DSM-5-TR, indicating that more research is needed before it can be considered an official diagnosis [1]. NSSID is characterized by deliberate self-inflicted damage to the surface of one's body without suicidal intent. To meet the diagnostic criteria, an individual must have engaged in self-injury for at least five days within the past year, with the expectation that the injury will lead to minor or moderate physical harm. The behavior is typically associated with interpersonal difficulties or negative feelings and thoughts, such as depression, anxiety, or self-criticism. Individuals with NSSID often report engaging in self-injury to obtain relief from negative emotions, to resolve interpersonal difficulties, or to induce positive feelings.

Studies have shown that individuals meeting NSSID criteria often experience more severe psychopathology and impairment compared to those who self-injure but do not meet full criteria. NSSID can occur both independently and comorbidly with other mental health conditions, such as depression, anxiety disorders, and borderline personality disorder. Including NSSID in the DSM-5-TR aims to improve the recognition and treatment of clinically significant self-injurious behaviors while stimulating further research to understand this condition better. However, there is ongoing debate regarding the optimal diagnostic criteria, particularly concerning the frequency threshold and the potential risk of pathologizing behaviors that may be transient or part of normal development, especially in adolescents [1].

Proposed Criteria for NSSID

- In the last year, the individual has, on five or more days, engaged in intentional self-inflicted damage to the surface of his or her body of a sort likely to induce bleeding, bruising, or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), with the expectation that the injury will lead to only minor or moderate physical harm (i.e., there is no suicidal intent).

  Note: The absence of suicidal intent has either been stated by the individual or can be inferred by the individual's repeated engagement in a behavior that the individual knows, or has learned, is not likely to result in death.
- The individual engages in the self-injurious behavior with one or more of the following expectations:
  - To obtain relief from a negative feeling or cognitive state
  - To resolve an interpersonal difficulty
  - To induce a positive feeling state

Note: The desired relief or response is experienced during or shortly after the self-injury, and the individual may display patterns of behavior suggesting a dependence on repeatedly engaging in it.

- The intentional self-injury is associated with at least one of the following:
  - Interpersonal difficulties or negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act
  - Prior to engaging in the act, a period of preoccupation with the intended behavior that is difficult to control
  - Thinking about self-injury that occurs frequently, even when it is not acted upon
- The behavior is not socially sanctioned (e.g., body piercing, tattooing, part of a religious or cultural ritual) and is not restricted to picking a scab or nail biting.
- The behavior or its consequences cause clinically significant distress or interference in interpersonal, academic, or other important areas of functioning.
- The behavior does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal. In individuals with a neurodevelopmental disorder, the behavior is not part of a pattern of repetitive stereotypies. The behavior is not better explained by another mental disorder or medical condition (e.g., psychotic disorder, autism spectrum disorder, intellectual developmental disorder [intellectual disability], Lesch-Nyhan syndrome, stereotypic movement disorder with self-injury, trichotillomania [hair-pulling disorder], excoriation [skin-picking disorder]).

CRITICISMS AND CONTROVERSIES WITH THE DSM-5-TR

The DSM-5-TR has faced several criticisms and controversies [1].

ADDITION OF PROLONGED GRIEF DISORDER

The inclusion of prolonged grief disorder has been one of the most controversial changes. Critics argue that it may pathologize normal grief reactions, potentially leading to overdiagnosis and unnecessary treatment. Some concerns defining grief as a disorder after just one year (or six months in children) may not account for cultural variations in grieving processes.

MEDICALIZATION OF NORMAL HUMAN EXPERIENCES

Some mental health professionals worry that the DSM-5-TR continues the trend of medicalizing typical human experiences. This concern extends beyond just grief to other areas of human distress that may be inappropriately labeled as disorders.

POTENTIAL FOR OVERDIAGNOSIS AND OVERTREATMENT

With the addition of new disorders and modifications to existing criteria, there are concerns about potential overdiagnosis and subsequent overtreatment, particularly with psychiatric medications.

CULTURAL SENSITIVITY AND BIAS

Despite efforts to improve cultural sensitivity, some critics argue that the DSM-5-TR still does not adequately account for cultural variations in the expression of mental distress.

VALIDITY AND RELIABILITY OF DIAGNOSES

There are ongoing debates about the validity and reliability of specific diagnoses, with some arguing that the categorical approach to mental disorders does not accurately reflect the complexity and dimensionality of mental health.

INFLUENCE OF PHARMACEUTICAL INDUSTRY

Some critics raise concerns about the potential influence of the pharmaceutical industry on diagnostic criteria, suggesting that new or broadened diagnoses might benefit drug companies.

LACK OF BIOMARKERS

Like its predecessors, the DSM-5-TR relies primarily on observable symptoms rather than biological markers. Given advancements in neuroscience and genetics, some argue that this approach is outdated.

DIMENSIONAL VS. CATEGORICAL APPROACH

There is ongoing debate about whether a dimensional approach to mental health (as proposed by alternative systems like the RDoC) might be more appropriate than the DSM's categorical approach.

FINANCIAL CONFLICT OF INTEREST

Some critics argue that the APA, which publishes the DSM, has a financial conflict of interest that may influence decisions about what to include in the manual.

These controversies highlight the ongoing challenges in developing a comprehensive and universally accepted system for diagnosing mental disorders. They also underscore the importance of continued research and debate in mental health.

ALTERNATIVE DIAGNOSTIC APPROACHES

The criticisms against the DSM-5 and the DSM-5-TR highlight that although the DSM is the most comprehensive and widely utilized diagnostic system currently available, it is not necessarily the only or the best system to classify and diagnose mental disorders. Along these lines, there have been advances in the generation of new diagnostic systems or approaches in recent years.

HIERARCHICAL TAXONOMY OF PSYCHOPATHY (HiTOP)

The Hierarchical Taxonomy of Psychopathology (HiTOP) represents a significant departure from the traditional categorical approach of the DSM-5-TR. While the DSM-5-TR relies on discrete diagnostic categories mainly determined by expert consensus, HiTOP adopts a dimensional, data-driven approach to classifying mental health problems [27]. HiTOP organizes psychopathology into a hierarchical structure, ranging from broad, general dimensions to more specific symptoms, based on empirical evidence from large-scale studies. This dimensional approach addresses several DSM limitations, including arbitrary boundaries between normality and pathology, high comorbidity rates, within-disorder heterogeneity, and diagnostic instability.

One of the critical differences between HiTOP and the DSM-5-TR is how they conceptualize mental health problems. The DSM-5-TR views disorders as distinct categories with clear boundaries, while HiTOP sees them as existing on continua of severity. For example, where the DSM-5-TR might diagnose social anxiety disorder as a discrete condition, HiTOP would place an individual on a spectrum of social anxiety, ranging from mild discomfort to severe impairment. This dimensional approach allows for more nuanced assessment and potentially more tailored treatment planning. Additionally, HiTOP's hierarchical structure explicitly accounts

for comorbidity by grouping related syndromes, whereas the DSM-5-TR's categorical approach often results in multiple, seemingly separate diagnoses for a single individual. While HiTOP shows promise in addressing some of the DSM-5-TR's limitations, it is still a work in progress and faces widespread clinical implementation and acceptance challenges.

RESEARCH DOMAIN CRITERIA (RDoC)

The Research Domain Criteria (RDoC) framework and the DSM-5-TR represent two distinct approaches to understanding and classifying mental health disorders. While the DSM-5-TR is a categorical system primarily designed for clinical diagnosis, RDoC is a dimensional, research-oriented framework that aims to integrate multiple levels of information to understand the fundamental mechanisms underlying mental health and illness [28]. The DSM-5-TR provides specific diagnostic criteria for mental disorders, organized into distinct categories, and is widely used by clinicians for diagnosis and treatment planning. In contrast, RDoC does not provide diagnostic categories but focuses on examining functional dimensions of behavior across a spectrum from normal to abnormal.

One of the critical differences between RDoC and DSM-5-TR lies in their underlying philosophies and goals. The DSM-5-TR aims to provide a common language for clinicians and researchers, facilitating communication and standardizing diagnoses. It is based on observable symptoms and clinical presentation. RDoC, on the other hand, was developed to address limitations in the current diagnostic systems by focusing on neurobiology and behavioral dimensions that cut across traditional diagnostic boundaries. RDoC organizes research into five main domains (negative valence systems, positive valence systems, cognitive systems, social processes, and arousal/regulatory systems), each of which can be studied at various levels of analysis, from genes to self-report.

While the DSM-5-TR is immediately applicable in clinical settings, RDoC is primarily a research framework aimed at advancing our understanding of the biological and psychological mechanisms underlying mental health disorders, with the long-term goal of informing future diagnostic systems and treatment approaches.

NETWORK ANALYSIS APPROACH

The Network Analysis Approach represents a significant shift in how mental disorders are conceptualized and studied, with implications for the DSM-5-TR and future iterations of diagnostic manuals [29]. Unlike the traditional DSM approach, which views mental disorders as discrete categories caused by underlying latent variables, the Network Analysis Approach posits that mental disorders are complex systems of interacting symptoms. This approach focuses on how symptoms directly influence each other rather than being caused by an underlying disorder. For example, insomnia might lead to fatigue, which could then cause concentration problems.

Network analysis offers a new perspective on comorbidity, suggesting that disorders co-occur because of shared symptoms that bridge different symptom networks. While the DSM-5-TR still essentially uses a categorical approach to diagnosis, network analysis aligns more closely with dimensional models of psychopathology, which are gaining traction in psychiatric research. This approach allows for a more personalized understanding of an individual's symptom patterns, potentially leading to more tailored treatment approaches than those based on broad DSM categories.

Studies using network analysis have provided insights into the structure of various DSM disorders, including depression, anxiety, and PTSD, potentially informing future revisions of the manual. The network approach suggests that targeting central symptoms in a network might be more effective than treating all symptoms equally, which could influence how DSM disorders are conceptualized and treated.

While not directly incorporated into the DSM-5-TR, network analysis can be seen as complementary to current diagnostic practices, offering additional insights into the structure and dynamics of mental disorders. As network analysis gains more empirical support, it may influence future revisions of the DSM, potentially leading to more dynamic and interconnected models of mental disorders.

TRANSDIAGNOSTIC APPROACHES

Transdiagnostic approaches represent a shift from the traditional categorical diagnostic system used in the DSM-5-TR, instead focusing on standard processes and factors that cut across multiple disorders [30]. While the DSM-5-TR maintains a categorical approach to diagnosis, it has incorporated some transdiagnostic elements, reflecting the growing recognition of shared features across disorders. For example, the DSM-5-TR includes dimensional assessments and cross-cutting symptom measures that can be applied across diagnostic categories. Additionally, the manual's text revisions have emphasized common risk factors, comorbidities, and overlapping symptoms between disorders.

The transdiagnostic perspective aligns with emerging research, suggesting that many mental health conditions share underlying psychological and biological mechanisms. This approach aims to identify core processes that contribute to developing and maintaining various disorders, potentially leading to more efficient and effective treatments. While the DSM-5-TR does not fully embrace a transdiagnostic framework, its updates reflect a growing awareness of the limitations of strict categorical diagnoses. The inclusion of dimensional assessments and the emphasis on comorbidity in the DSM-5-TR can be seen as steps toward a more nuanced understanding of mental health that aligns with transdiagnostic principles. However, the fundamental structure of the DSM-5-TR remains rooted in discrete diagnostic categories, highlighting the ongoing tension between categorical and dimensional approaches to understanding and treating mental health disorders.

CLINICAL STAGING MODELS

Clinical staging models represent an alternative approach to psychiatric diagnosis and treatment that has gained attention in recent years [31]. However, they are not formally incorporated into the DSM-5-TR. These models aim to identify where individuals lie along a continuum of illness, from at-risk to chronic and severe conditions. Unlike the categorical approach of the DSM-5-TR, clinical staging models emphasize the progression and extension of mental disorders over time. They propose that mental health problems develop through a series of stages, each with distinct clinical and neurobiological features.

While the DSM-5-TR maintains a primarily categorical approach to diagnosis, it does acknowledge the potential utility of dimensional assessments and cross-cutting symptom measures, which align somewhat with the principles of clinical staging. The DSM-5-TR's emphasis on early identification and intervention for mental health problems also resonates with the goals of clinical staging models. However, the DSM-5-TR does not formally adopt a staging framework for any disorders. Some researchers argue that integrating clinical staging models into future revisions of the DSM could enhance its clinical utility, particularly for youth mental health and early intervention services. These models could potentially bridge the gap between categorical diagnoses and the complex, often overlapping presentations seen in clinical practice. As research in this area progresses, future editions of the DSM may incorporate more elements of clinical staging, particularly if evidence continues to support its utility in improving treatment selection and understanding patterns of illness progression.

PERSONALIZED DIAGNOSIS

Personalized diagnosis represents a shift away from the categorical approach used in the DSM-5-TR towards a more individualized understanding of mental health conditions [31]. While the DSM-5-TR provides standardized diagnostic criteria for mental disorders, personalized diagnosis aims to tailor the diagnostic process to everyone's unique biological, psychological, and social characteristics.

The DSM-5-TR relies on symptom-based criteria to categorize mental disorders, which allows for consistency in diagnosis across clinicians and settings. However, this approach has been criticized for not fully capturing the complexity and heterogeneity of mental health presentations. In contrast, personalized diagnosis incorporates a broader range of data, including genetic information, biomarkers, environmental factors, and individual life experiences. This approach often utilizes advanced technologies like machine learning to predict individual outcomes and treatment responses. While the DSM-5-TR has made some moves towards dimensionality, such as including severity specifiers and cross-cutting symptom measures, personalized diagnosis goes further by considering the unique combination of factors that contribute to an individual's mental health status. This approach aligns with the growing understanding that mental disorders are complex and multifaceted, influenced by a variety of interacting factors. However, while personalized diagnosis holds promise for improving treatment outcomes and understanding individual variations in mental health, it is still an evolving field. The DSM-5-TR remains the standard for clinical diagnosis in many settings due to its established reliability and utility in professional communication. As research in personalized diagnosis advances, it may increasingly complement and potentially reshape traditional diagnostic approaches in future iterations of diagnostic manuals.

CULTURAL FORMULATIONS

The DSM-5-TR continues and expands upon the emphasis on cultural considerations in psychiatric diagnosis introduced in previous editions. The manual includes a dedicated chapter titled "Culture and Psychiatric Diagnosis" in Section III, which provides comprehensive guidance on integrating cultural concepts into clinical practice. This chapter introduces the Cultural Formulation Interview (CFI), a semi-structured interview guide designed to help clinicians systematically assess cultural factors that may impact a patient's mental health presentation, diagnosis, and treatment.

The CFI consists of 16 questions that explore the patient's cultural identity, explanatory models of illness, psychosocial stressors, cultural features of the patient-clinician relationship, and overall cultural assessment. Additionally, the DSM-5-TR includes 12 supplementary modules to the CFI that allow for more in-depth exploration of specific cultural domains such as explanatory models, level of functioning, social network, and cultural identity. These tools aim to enhance cultural competence in clinical practice and improve the accuracy and relevance of psychiatric diagnoses across diverse populations.

Throughout the manual, each disorder includes sections on "Culture-Related Diagnostic Issues" and "Sex- and Gender-Related Diagnostic Issues," which have been updated to reflect current research and understanding of how cultural and gender factors may influence the presentation, prevalence, and course of mental disorders. The DSM-5-TR also emphasizes the importance of considering the impact of racism, discrimination, and other social determinants of mental health in assessment and diagnosis. This comprehensive approach to cultural formulation in the DSM-5-TR represents a significant step towards more culturally sensitive and accurate psychiatric diagnosis and treatment planning.

DSM-6: WHAT TO EXPECT

While the exact DSM-6 release date has not been officially announced, based on historical patterns, it is anticipated to be released sometime between 2023 and 2028. The development of a new DSM edition is a complex process involving extensive research, expert input, and rigorous review, which can impact the release timeline. The DSM-6 is expected to build upon the foundations laid by its predecessors, incorporating the latest research findings and clinical insights further to improve the diagnosis and treatment of mental disorders. Some potential areas of focus for updates and changes in the DSM-6 may include:

- Refinement of diagnostic criteria for existing disorders, aiming to enhance the validity and reliability of psychiatric diagnoses.
- Introducing new disorders or reclassification of existing ones based on emerging research and clinical evidence.
- Updates to reflect advancements in neuroscience and our understanding of the biological basis of mental disorders.
- Further emphasis on dimensional approaches to diagnosis, allowing for a more nuanced assessment of symptom severity and presentation.
- Incorporation of cultural and social factors in diagnostic criteria, recognizing the impact of diverse backgrounds on mental health.
- Potential revisions to specific disorder categories such as autism spectrum disorders, neurocognitive disorders, and substance use disorders.
- Integration of new technologies and digital health considerations in diagnostic processes.

The DSM-6 will likely continue aligning with the International Classification of Diseases (ICD) to ensure consistency in coding and diagnostic practices across different healthcare systems. This alignment facilitates effective communication between healthcare providers and supports research efforts globally. As with previous editions, the development of DSM-6 will involve collaboration among numerous experts and professionals in the field. The APA typically forms various work groups and task forces to review current literature, conduct field trials, and propose revisions. This process ensures a comprehensive and rigorous approach to updating the manual. It is important to note that while these potential changes are based on current trends and expectations in psychiatry, the specific details of DSM-6 revisions will only be confirmed upon its official release. Mental health professionals, researchers, and stakeholders in the field should stay informed about updates from the APA regarding the development and eventual release of DSM-6.

CONCLUSION

The DSM-5-TR represents a significant update to the DSM-5, incorporating new research findings and clinical insights accumulated since 2013. Fundamental changes include adding new diagnostic entities like prolonged grief disorder, clarifying existing diagnostic criteria for over 70 disorders, updating terminology, and comprehensive text revisions. The manual also introduced new symptom codes for suicidal behavior and nonsuicidal self-injury and placed increased emphasis on cultural sensitivity and addressing issues related to racism and discrimination.

In the future, the DSM is expected to continue evolving as a "living document" that can be updated on an ongoing basis rather than at set intervals. The APA has implemented a continuous improvement model, allowing for empirically driven changes as new research emerges. This approach keeps the manual current with the latest scientific understanding of mental disorders.

Future editions of the DSM may incorporate more dimensional approaches to diagnosis, further integration of biological and neuroscience findings, and potentially closer alignment with other frameworks like the RDoC project. There is also an ongoing effort to improve the manual's utility for clinicians and researchers while addressing concerns about heterogeneity within diagnoses and comorbidity.

As the field of psychiatry advances, the DSM will likely continue to face challenges in balancing categorical and dimensional approaches to mental disorders, incorporating new research findings, and maintaining clinical utility. The development of DSM-6, which may be a decade away, will involve extensive collaboration among experts and stakeholders to address these challenges and further refine the classification and diagnosis of mental disorders.

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