Clinical Update and History of *Diagnostic and Statistical Manual of Mental Disorders*

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The *DM-ID-2* is based upon *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5),* published in 2013. The American Psychiatric Association (APA) released a Text Revision of the *DSM-5* in 2022. This clinical update offers a brief overview of the history of *DSM* and an update on content in *DSM-5-TR* (APA, 2022). In this focus on diagnostic frameworks, we offer a second addendum that provides information about and a brief history of *International Classification of Diseases (ICD).* From these reviews, it should be clear that mental health diagnoses evolve, as does our understanding of the mechanisms that might contribute to mental health conditions. For more on the evolution of autism diagnosis, the interested reader is directed to the article by Rosen et al. (2021), which traces changes in the autism diagnosis from *DSM-III* to *DSM-5*.

Pre–World War II

In the United States, the initial stimulus for developing a classification of mental disorders was the need to collect statistical information. What might be considered the first official attempt to gather information about mental health in the United States was the recording of the frequency of "idiocy/ insanity" in the 1840 census. By the 1880 census, seven categories of mental health were distinguished: mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy (Suris et al., 2016).

In 1917, the American Medico-Psychological Association, the 19th-century precursor of the APA and the National Commission on Mental Hygiene, developed a plan for gathering uniform health statistics across mental hospitals. Adopted by the Bureau of the Census, this system devoted more attention to clinical usefulness than did previous systems but was still primarily an administrative classification. In 1921, the American Medico-Psychological Association changed its name to the American Psychiatric Association. It subsequently collaborated with the New York Academy of Medicine to develop a nationally acceptable psychiatric classification that would be incorporated within the first edition of the American Medical Association's Standard Classified Nomenclature of Disease. This system was designed primarily for diagnosing patients with severe psychiatric and neurological disorders.

Post–World War II

The first edition of *Diagnostic and Statistical Manual of Mental Disorders (DSM-I)* was published in 1952 by the APA. *DSM-I* was based on *International Classification of Diseases, Sixth Revision (ICD-6). DSM-I* was the first official manual of mental disorders to focus on clinical use. It contained a glossary of descriptions of the diagnostic categories. The *DSM-I* was based on theories of abnormal psychology and psychopathology prevalent at the time, which were heavily influenced by psychoanalytic thinking.

As had been the case for *DSM-I* and *DSM-II*, the development of the third edition (*DSM-III*) was coordinated with the development of the next version of *ICD—ICD-9*—which was published in 1975 and implemented in 1978. Work on *DSM-III* began in 1974, with publication in 1980. *DSM-III* introduced several important innovations, including explicit diagnostic criteria, a multiaxial diagnostic assessment system, and an approach that attempted to be neutral concerning the causes of mental disorders. This effort was aided by extensive work on constructing and validating the diagnostic criteria and developing psychiatric interviews for research and clinical uses. Considered a landmark change, *DSM-III* moved away from theoretical interpretations of mental disorders and adopted a more empirically based approach with clear diagnostic criteria, marking a significant shift in psychiatric diagnosis. *DSM-III* contained about 60 disorders.

User experience with *DSM-III* revealed inconsistencies in the system and instances in which the diagnostic criteria were not clear. Therefore, APA appointed a work group to revise *DSM-III*, which developed the revisions and corrections that led to the publication of *DSM-III-R* in 1987. This revision of *DSM-III* contained minor adjustments to diagnostic criteria and text clarifications.

DSM-IV was published in 1994. While this edition maintained consistency with its predecessor, it also contained refinements of diagnostic criteria based on ongoing research.

DSM-IV-TR (2000) updated the descriptive text from the 1994 edition to reflect new research findings since the initial publication of *DSM-IV*. Much of this revision effort involved conducting a comprehensive review of the literature to establish a firm empirical basis for making modifications. Numerous changes were made to the classification (e.g., disorders were added, deleted, and reorganized), to the diagnostic criteria sets, and to the descriptive text. Developers of *DSM-IV* and the 10th revision of *ICD* worked closely to coordinate their efforts, resulting in better alignment between the two systems and fewer differences in wording. *ICD-10* was published in 1992.

Published in 2013, *DSM-5* represented a major revision with significant changes, including the removal of some diagnoses, restructuring of diagnostic categories, and introduction of new disorders. The work on *DSM-5* began in 2000 with the formation of work groups. These work groups generated white papers, monographs, and journal articles, providing the field with a summary of the state of the science relevant to psychiatric diagnosis and identifying gaps in the current research, with the hope that more emphasis would be placed on research within those areas. In 2007, APA formed the *DSM-5* Task Force to begin revising the manual, as well as 13 work groups focusing on various disorders.

DSM-5-TR

DSM-5-TR was released in 2022 and updated the descriptive text from the 2013 edition of *DSM-5*. Work on the text revision began in Spring 2019 and involved more than 200 experts, the majority of whom were involved in the development of *DSM-5*. These experts conducted literature reviews and reviewed the text to identify out-of-date material. A work group was assigned to ensure appropriate attention was paid to factors such as racism and discrimination and the use of non-stigmatizing language. Although the text revision did not include conceptual changes to the criteria sets for mental health disorders, it did contain some necessary clarifications to certain diagnostic criteria. *DSM-5-TR's* structure and content

reflect advances in the understanding of mental health disorders and how to treat them. The revisions include one new diagnosis, the elimination of some older diagnoses, changes in the wording of criteria for certain mental health disorders, and changes in the language used to name certain conditions.

Why Publish a Revised Version of *DSM-5*?

If the reader looks at the table of contents of *DSM-5-TR*, it becomes evident that this text revision does not depart from the structure of *DSM-5*. *DSM-5-TR* lists the same 20 chapters dedicated to separate disorders or groups of disorders sequenced from childhood, beginning with the chapter on Neurodevelopmental Disorders and ending with Neurocognitive Disorders, which most commonly occur in older adulthood. The Revision Subcommittee Co-Chairs, Drs. First and Wang (*DSM-5-TR*, 2022) provided an overview of the purpose of the text revision in the Preface to *DSM-5-TR*. It is beyond the scope of this clinical update to comprehensively review all the text revisions that reflect advances in the pertinent literature on mental health disorders, changes in cultural norms pertinent to the description and recognition of mental health disorders, and changes in practice. The overall goal of revision is to provide the most up-to-date guidance to the clinician for diagnosing mental health disorders and provide a framework for research on mental health disorders. *DSM-5-TR* is not the first instance of text revisions. The APA issues text revisions when there is new scientific evidence pertinent to mental health conditions or when clinical experience results in the need to clarify or change diagnostic criteria for a significant number of mental disorders and/or the accompanying text to be accurate. The main goal of *DSM-5-TR* was to comprehensively update the descriptive text accompanying each disorder based on review of the literature that occurred in the nine years between the publication of *DSM-5* and *DSM-5-TR*.

DSM-5 represented the most significant structural change in the diagnostic system since *DSM-III*. Based upon the response to the *DSM-5*, it became evident that diagnostic criteria needed revision for clarity and accuracy (First et al., 2023). Since the publication of *DSM-5*, active research in biological, developmental, socioeconomic, and cultural aspects of mental disorders warranted updates to the descriptive text accompanying diagnostic categories. *DSM-5-TR* contains the *ICD-10-CM* codes approved through 2021.

What's New in *DSM-5-TR*?

- Adds one new disorder and removes older disorders and diagnoses
- Tightens criteria for clarification for diagnoses such as attention deficit hyperactivity disorder and autism spectrum disorder
- Adds new category for "Other Conditions That May Be a Focus of Clinical Attention"
- Adds codes for the sequence of encounters with an individual with suicidal ideation, attempts, or with a history of suicidal behaviors (but not current)
- Adds codes for current non-suicidal self-injury (NSSI) and for a history of NSSI

New Mental Health Disorder

Prolonged grief disorder (F43.8) (PGD). This diagnosis appears within Section II of the text revision as part of the chapter for "Trauma and Stressor-Related Disorders" (*DSM-5-TR*, pp. 322–327). PGD is also in the 11th revision of *International Classification of Diseases* (*ICD-11*), listed under code 6B42. Prolonged grief disorder is characterized by distressing symptoms of grief that continue for at least 12 months following the loss of a person who was close to the bereaved.

The grief response is characterized by intense longing for the deceased person and/or preoccupation with thoughts and memories of the lost person, along with other grief-related symptoms such as emotional numbness, intense emotional pain, and avoidance of reminders that the person is deceased. These symptoms are severe enough to cause impairment in daily functioning. The duration and severity of the bereavement reaction exceed expected social, cultural, or religious norms for the individual's culture and context. For children and adolescents, this preoccupation may focus on the circumstances of the death. Also, the symptoms are not better explained by another mental health disorder, such as major depressive disorder, posttraumatic stress disorder, etc. (Ault, 2022; Singer, 2022).

The symptoms associated with prolonged grief disorder have some overlap with those of major depressive disorder and posttraumatic stress disorder, so a careful differential diagnosis is essential. Both have symptoms that overlap with PGD but differ by lacking the intense yearning and preoccupation with the deceased. Several other *DSM* mental disorders develop after a stressor such as the death of a close other. For instance, uncomplicated bereavement (Z63.4), another focus of clinical attention (*DSM-5-TR*, p. 834), is a normal reaction to the loss of a loved one and includes symptoms like depression. An adjustment disorder, a time-limited maladaptive response occurring within three months of a stressor, could develop following the death of a close other.

Clarification or Revision of the Criteria Sets for Mental Health Conditions

DSM-5-TR contains updated or revised criteria for over 70 disorders.

Autism spectrum disorder: Criterion A is revised to require that all three types of deficits be present, stating "as manifested by all of the following." These deficits are A.1 deficits in social-emotional reciprocity, A.2 deficits in nonverbal communicative behaviors used for social interaction, and A.3 deficits in developing, maintaining, and understanding relationships (*DSM-5-TR*, p. 56).

Substance/medication-induced bipolar and related disorders: Criterion B.1 addresses when the Criterion A symptoms must develop. It now includes "after exposure to or withdrawal from a medication" (*DSM-5-TR*, p. 162).

Major depressive disorder: In *DSM-5*, Criterion D reads, "the occurrence of the major depressive episode (the current, presenting episode) is not better explained by a mental disorder… on the schizophrenia spectrum or other psychotic disorders." Criterion D is revised in *DSM-5-TR* to read, "at least one major depressive episode is not better explained by a mental disorder… on the schizophrenia spectrum or other psychotic disorders" (p. 183). Clients may now be diagnosed with major depressive disorder, whether or not the current episode of depression includes symptoms of psychosis, if over their

lifetime they have had at least one major depressive episode without concurrent symptoms of another mental disorder.

Avoidant/restrictive food intake disorder: Criterion A in *DSM-5-TR* is revised to no longer require that the eating or feeding disturbance be "manifested by persistent failure to meet appropriate nutritional and/or energy needs." *DSM-5-TR* Criterion A (p. 376) states the eating or feeding disturbance must be associated with one or more of the four listed symptoms: significant weight loss, dependence on enteral feeding or oral supplements, significant nutritional deficiency, or marked interference with psycho-social functioning. Any one of these symptoms is sufficient for meeting Criterion A.

Coding within DSM-5-TR

The United States has used *International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)* as the basis for coding mental health disorders since 2015. *ICD-10-CM* is a version of the World Health Organization's *ICD-10*, which has been modified for clinical use by the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS). The codes that appear in *DSM* are the *ICD* codes that are equivalent to the *DSM* diagnoses. In *DSM-5*, both *ICD-9* and *ICD-10* codes were included because the *ICD-9-CM* system was still in use in the U.S. at the time of *DSM-5* publication. *DSM-5-TR*, however, includes only *ICD-10-CM* codes since they are currently the only official coding system in the United States. *ICD-11* was published in 2019 and has been adopted by 35 countries as of the writing of this clinical update. It is unclear when the U.S. will officially adopt the latest version of *ICD*. *ICD-11* represents a significant change in codes used to designate mental health disorders.

Codes are alphanumeric and appear before or after the name of the disorder. The code begins with a letter and is followed by a number assigned to that disorder, and may contain a specifier that denotes additional information about the disorder, such as level of severity, a description of the course of the disorder, or a feature of the disorder. In *DSM-5-TR*, the following letters are used: "F" is used to indicate mental health disorders, "T" signifies the encounter (initial or subsequent), "G" and" R" refer to conditions that may impact upon mental health diagnosis, and "Z" indicates a focus of clinical attention. The use of diagnostic codes is fundamental to medical recordkeeping. It facilitates data collection and retrieval and compilation of statistical information.

Other Conditions of Clinical Attention

Suicidal behavior and non-suicidal self-injury are additions in *DSM-5-TR* as conditions of clinical attention (*DSM-5-TR*, p. 822), with several *ICD-10* codes to indicate if the client is currently engaged in suicidal behavior or non-suicidal self-injury or has a history of such behavior. These additions, part of the symptoms in many diagnostic categories, will help the counselor document suicidal and non-suicidal self-injury behaviors as part of the client's *DSM* diagnosis list and treatment plan. A mental disorder is not required to list either condition.

Suicidal behavior is defined as "potentially self-injurious behavior with at least some intent to die as a result of the action" (*DSM-5-TR*, p. 822). Codes for suicidal behavior include:

- 91A - Suicidal behavior, initial encounter (At the intake session, the client has suicidal behavior.)
- 91D - Suicidal behavior, subsequent encounter (The client has previously received treatment while having suicidal behavior and now is presenting for treatment again while having suicidal behavior.)
- 51 - History of suicidal behavior (Suicidal behavior has occurred during the client's lifetime.) Note that this is a "lifetime" diagnosis that remains permanently listed as part of the client's diagnosis list.

Non-suicidal self-injury is the behavior of intentionally inflicting damage to one's body that will "likely induce bleeding, bruising, or pain" (*DSM-5-TR*, p. 822).

Codes for non-suicidal self-injury include:

- 88 - Current non-suicidal self-injury (Client is actively engaged in self-injury without being suicidal.)
- 52 - History of non-suicidal self-injury (Intentional self-injury has occurred during the client's lifetime.) This is a lifetime diagnosis.

Applicability to Individuals with IDD

When applying these criteria to people with intellectual developmental disorder (IDD), self-injury can ostensibly be coded without tying this to a mental health diagnosis. Also, it is questionable whether all individuals who engage in self-injury "intentionally" do so. Researchers have cited several reasons for self-injury, including distress, pain, and as a form of behavioral "communication" among individuals with communication limitations (Samways et al., 2022). Although there has been research linking NSSI to behavioral disorders, less is known about emotional distress as a possible driver of NSSI.

Renaming of Mental Health Conditions

The APA approved name changes for two *DSM-5* mental disorders to make the names identical to the comparable disorders listed in *ICD-11*.

Intellectual developmental disorder (*DSM-5-TR*, pp. 37–46), a disorder in the neurodevelopmental disorders category, replaces the *DSM-5* name "intellectual disability." Intellectual developmental disorder is a disorder of both "intellectual and adaptive functioning deficits with a failure to meet developmental and socio-cultural standards for personal independence and social responsibility" (*DSM-5-TR*, p. 37).

- 6A00.0 - Disorder of intellectual development
- 6A00.1 - Mild disorder of intellectual development
- 6A00.2 - Moderate disorder of intellectual development
- 6A00.3 - Severe disorder of intellectual development
- 6A00.4 - Profound disorder of intellectual development
- 6A00.Z - Provisional disorder of intellectual development, unspecified

Functional neurological symptom disorder (*DSM-5-TR*, pp. 360–364), a somatic symptom and related disorder, replaces the prior name "conversion disorder." Functional neurological symptom disorder requires one or more symptoms of altered voluntary motor or sensory functioning incompatible with known neurological or medical conditions (e.g., loss of hearing with no damage to nerves, blood circulation, or ear structures).

Addition or Revision of Specifiers

Many of the *DSM-5-TR* mental disorders (e.g., major depressive disorder) manifest in a variety of symptoms and symptom patterns. Specifiers are extensions to a diagnosis that further clarify the course, severity, or special features of the client's disorder or illness. Specifiers allow for a more specific diagnosis, which helps the counselor select more effective treatment for each client. In both *DSM-5-TR Manual* and *Desk Reference to the Diagnostic Criteria From DSM-5-TR*, the available specifiers and associated *ICD-10* codes follow the diagnostic criteria of each mental disorder except the specifiers for the mental disorders in the bipolar and related disorders and depressive disorders categories. Their specifiers are listed and defined at the end of each category in a separate section titled "Specifiers for Bipolar and Related Disorders" (*DSM-5-TR*, pp. 169–175) and "Specifiers for Depressive Disorders" (*DSM-5-TR*, pp. 210–214).

Revised Specifiers

Below are new or revised specifiers for mental disorders:

- **Bipolar I:** severity specifiers and *ICD-10* codes for a current manic episode
- **Bipolar II:** severity specifiers and *ICD-10* codes for a current hypomanic episode
- **Other specified obsessive-compulsive related disorder:** added specifier, "olfactory reference disorder"

Bipolar I: The specifiers mood-congruent psychotic features and mood-incongruent psychotic features are now further defined as current manic or current depressive episode definitions for the levels of severity, mild, moderate, and severe.

Bipolar I and Bipolar II: There are mood changes and sometimes psychotic features with bipolar disorder, but the *DSM-5* language made it difficult to distinguish these from the psychotic disorders, such as schizoaffective disorder. This has been clarified within the text revision.

The "mild" severity specifier for manic episode (few, if any, symptoms over required threshold; distressing but manageable symptoms, and the symptoms result in minor impairment in social or occupational functioning) was inconsistent with manic episode Criterion C, which requires that the mood disturbance be sufficiently severe to cause marked impairment in social or occupational functioning, necessitate hospitalization, or include psychotic features. The severity specifiers from *DSM-IV* have now been adopted: "mild" if only minimum symptom criteria are met; "moderate" if there is a very significant increase in activity or impairment in judgment, and "severe" if almost continual supervision is required.

Persistent depressive disorder: The available specifiers are "with anxious distress" and "atypical features;" the other five provided in the *DSM-5* were eliminated.

Gender dysphoria: Terminology in the specifiers is updated to use culturally sensitive and less stigmatizing language.

Persistent depressive disorder: The holdover term "dysthymia" from *DSM-IV's* dysthymic disorder has been removed; only two specifiers, "anxious distress" and "atypical," remain.

Social anxiety disorder: "Social phobia" has been removed, given that many clinicians have adopted the term "social anxiety disorder," so "social phobia" is no longer clinically useful.

Attenuated psychosis syndrome: *DSM-5* used to have the phrase "with relatively intact reality testing."

Removed Diagnoses

Several disorders that appeared in *DSM-5* were removed in the text revision to avoid overlap with other disorders:

- **Somatization disorder:** Removed to avoid overlap with other disorders
- **Hypochondriasis:** Removed to avoid overlap with other disorders
- **Pain disorder:** Removed to avoid overlap with other disorders
- **Undifferentiated somatoform disorder:** Removed to avoid overlap with other disorders
- **Sexual aversion disorder:** Removed due to lack of supporting research and rare use
- **Dyspareunia not due to a medical condition** merged with vaginismus not due to a medical condition to form genito-pelvic pain/penetration disorder

Revised Language

Gender

The terminology in the gender dysphoria chapter of the *DSM-5* was changed. This includes changing terms such as:

- "Natal sex" to "birth-assigned gender"
- "Natal male/female" to "individual assigned male/female at birth"
- "Gender reassignment treatments" to "gender-affirming treatments"
- "Cross-sex medical procedure" to "gender-affirming medical procedure"
- "Desired gender" to "experienced gender"

- The word “cisgender” wasn’t used in *DSM-5*. In *DSM-5-TR*, there has been a relatively sweeping move to include a definition of cisgender and a preference for the term “non-transgender” as a way of centering not cisgender folk, but transgender people. *DSM-5-TR* has a post-transition specifier for gender dysphoria.

Race

The reader will note that *DSM-5-TR* utilizes the term “racialized” instead of “race/racial” to highlight that race is considered a social construct. Following suit, the term “ethno-racial” is used in the text to denote categories, such as Hispanic, White, or African American, that combine ethnic and racialized identifiers. The terms “minority” and “non-White” are avoided. The term “Caucasian” is not used. Information is provided on variations in symptom expression, attributions for disorder causes or precipitants, and factors associated with differential prevalence across demographic groups. Cultural norms that may affect the level of perceived pathology are also reported. Attention was paid to the risk of misdiagnosis when evaluating individuals from socially oppressed ethno-racial groups.

The text revision emphasizes the role of race, ethnicity, culture, and social context as considerations in diagnosing disorders. Among the changes to *DSM-5-TR* consistent with this is a change in language and terminology:

- The term “Latinx” is used in place of Latino/Latina to promote gender-inclusive terminology.
- *DSM-5* terminology has been updated to conform to current preferred usage, and includes replacing “neuroleptic medications,” which emphasize side effects, with “antipsychotic medications or other dopamine receptor blocking agents;” replacing “intellectual disability” with “intellectual developmental disorder;” and changing “conversion disorder” to “functional neurological syndrome.” Reflecting the evolving terminology in the area of gender dysphoria, “desired gender” is replaced with “experienced gender;” “natal male/natal female” with “individual assigned male at birth” or “individual assigned female at birth;” and “cross-sex treatment regimen” with “gender-affirming treatment regimen.”

Clarifications of Criteria Sets

One of the main goals of the text revision was to bring clarification to the criteria sets of different diagnoses. This was based on feedback from the clinical community about areas of confusion or lack of clarity, which impacted the use of *DSM-5* for diagnoses (First et al., 2023). Since the publication of *DSM-5-TR*, significant advances in understanding mood disorders have focused on a more nuanced view of the spectrum nature of mood disorders, with greater emphasis on transdiagnostic specifiers like anxious distress and mixed features. This allows for a more comprehensive assessment of individual symptom presentation across different mood states, including both depression and mania, further research into the role of genetics and neurobiology in mood disorders, leading to potential new treatment targets, and a growing recognition of the importance of considering cultural and social factors in diagnosis and treatment planning.

DSM-5-TR includes new specifiers that potentially improve the diagnosis of mood disorders. These changes reflect a more nuanced understanding of mood disorders, which can lead to more precise and effective treatment. For example, recognizing anxious distress in a mood disorder may lead to different therapeutic approaches. *DSM-5-TR* introduces the concept of mixed features specifiers, allowing clinicians to capture presentations where symptoms of depression and mania co-occur within the same episode, highlighting the spectrum nature of mood disorders rather than viewing them as distinct entities.

- **Anxious distress:** A specifier that acknowledges the overlap between different mood disorders
- **Mixed features:** A specifier that acknowledges the overlap between different mood disorders
- **Unspecified mood disorder (F39):** A diagnosis for people who have symptoms of a mood disorder but don't meet the criteria for a specific diagnosis

Unspecified mood disorder is a newly added category. It applies to presentations in which symptoms characteristic of a mood disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate. However, at the time of the evaluation, they do not meet the full criteria for any of the disorders in either the bipolar or the depressive disorders diagnostic classes, and it is difficult to choose between unspecified bipolar and related disorders and unspecified depressive disorder.

Disruptive mood dysregulation disorder is listed in *DSM-5-TR* but not in *ICD-11*. The text in the "Development and Course" section describing the age range at which disruptive mood dysregulation disorder can be diagnosed and validity established was updated to "6–18 years," as noted in Criterion G.

Specifiers indicating the duration of symptoms in adjustment disorder were inadvertently left out of *DSM-5* and have now been reinstated: "acute" if symptoms have persisted for less than six months and "persistent" if symptoms have persisted for six months or longer after the termination of the stressor or its consequences.

Research indicates a significant link between unspecified mood disorder and intellectual developmental disorder, with studies showing that people with intellectual disability are at a higher risk of experiencing mood disorders, including those categorized as "unspecified." This is due to challenges in accurately diagnosing specific symptoms due to communication limitations and can manifest as behavioral changes like aggression or withdrawal, making proper assessment crucial.

Chapter 15: Trauma- and Stressor-Related Disorders

The description of posttraumatic stress disorder for children 6 years and younger was clarified by noting that "witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures" in Criterion A.2 was removed for its redundancy, given that it already indicates that the events occurring to others must be witnessed in person.

Chapter 25: Neurocognitive Disorders

The essential cognitive features in delirium are disturbances of attention and awareness of the environment. While the nature of the attentional disturbance—characterized in Criterion A as a reduced ability to direct, focus, sustain, and shift attention—is clear, the characterization of the awareness component as "reduced orientation to the environment" is confusing. This is because "disorientation" already appears as one of the "additional disturbances in cognition" listed in Criterion C. Consequently, Criterion A has been reformulated to avoid using "orientation," so that it now reads "A disturbance in attention (i.e., reduced ability to direct, focus, sustain, and shift attention) accompanied by reduced awareness of the environment."

The following conditions can be viewed as sources of cognitive impairment, although they differ from the cognitive deficits associated with IDD. These conditions may co-occur in people with IDD.

- **Methamphetamine dependence:** People with methamphetamine dependence may have persistent cognitive deficits, even after recovering from dopamine transporter deficiency.
- **Cocaine users:** Cognitive impairment can make cocaine users less able to benefit from behavioral treatment.
- **Cognitive deficits:** People with stimulant use disorders may have cognitive deficits in verbal memory, working memory, and executive functions.

DSM-5-TR Level 1 and Level 2 Emerging Measures

For further clinical evaluation and research, the APA is offering several "emerging measures" in Section III of *DSM-5-TR*. These patient assessment measures were developed to be administered at the initial patient interview and to monitor treatment progress. These serve to advance the use of initial symptomatic status and patient-reported outcome (PRO) information, as well as the use of "anchored" severity assessment instruments. Instructions, scoring information, and interpretation guidelines are included. Clinicians and researchers may provide APA with further data on the instruments' usefulness in characterizing patient status and improving patient care.

The APA is offering the Cultural Formulation Interview (including the Informant Version) and the Supplementary Modules to the Core Cultural Formulation Interview for further research and clinical evaluation. They should be used in research and clinical settings as potentially useful tools to enhance clinical understanding and decision-making, and not as the sole basis for making a clinical diagnosis. Additional information can be found in *DSM-5* in the Section III chapter "Cultural Formulation." The APA requests that clinicians and researchers provide further data on the usefulness of these cultural formulation interviews. The cultural context section provides a comprehensive review of the cultural context of mental disorders and the Cultural Formulation Interview (CFI) for clinical use. It includes basic information on integrating culture and social context in clinical diagnoses, as well as cultural

formulation and cultural concepts of distress. *DSM-5-TR* provides key terms that help to highlight the cultural context of illness experience. Understanding this context is essential for effective diagnostic assessment and clinical management. Definitions and clarifications are provided for terms such as culture, race, and ethnicity.

Appendix A

The APA published 25 *DSM-5-TR* Fact Sheets, which can be accessed and downloaded at: https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-tr-fact-sheets

These fact sheets highlight the differences between *DSM-5* and *DSM-5-TR*.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

American Psychiatric Association. (2022). *DSM-5-TR fact sheets*. https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-tr-fact-sheets

Ault, A. (2022). DSM update: What's new? *Medscape*. https://www.medscape.com/viewarticle/969662

First, M. B., Clarke, D. E., Yousif, L., Eng, A. M., Gogtay, N., & Appelbaum, P. S. (2023). *DSM-5-TR*: Rationale, process, and overview of changes. *Psychiatric Services, 74*(8), 869–875. https://doi.org/10.1176/appi.ps.20220334

Rosen, N. E., Lord, C., & Volkmar, F. R. (2021). The diagnosis of autism: From Kanner to DSM-III to DSM-5 and beyond. *Journal of Autism and Developmental Disorders, 51*(12), 4253–4270. https://doi.org/10.1007/s10803-021-04904-1

Samways, B., Heslop, P., & Dowling, S. (2022). Self-reported explanations for self-injury by people with intellectual disabilities: A systematic review of qualitative studies. *International Journal of Developmental Disabilities, 70*(3), 382–396. https://doi.org/10.1080/20473869.2022.2098665

Singer, J. (2022). Special report on DSM-5-TR – What social workers need to know. *The New Social Worker*. https://www.socialworker.com/feature-articles/practice/dsm-5-tr-what-social-workers-need-to-know/

Surís, A., Holliday, R., & North, C. S. (2016). The evolution of the classification of psychiatric disorders. *Behavioral Sciences, 6*(1), 5. https://doi.org/10.3390/bs6010005