



DSM-5-TR: WHAT YOU NEED TO KNOW

DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS

FIFTH EDITION
TEXT REVISION

DSM-5-TR™

AMERICAN PSYCHIATRIC ASSOCIATION

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DISCLOSURES FOR ALL PRESENTERS

- Nitin Gogtay, MD: *Nothing to disclose*

LEARNING OBJECTIVES

To

- Understand the DSM revision process, including DSM-5-TR
- Understand changes to criteria and text of select DSM disorders including serious mental illnesses
- Understand the rationale for including prolonged Grief Disorder (PGD) in the DSM
- Understand how to differentiate PGD from Depressive disorders
- Understand the inclusion of ICD-10-CM codes for Suicidal behavior and Nonsuicidal self-injury
- Understand how DSM-5-TR addressed issues related to culture, race and discrimination
- Identify issues not addressed in the DSM to date
- Understand the process of how to propose changes to the DSM

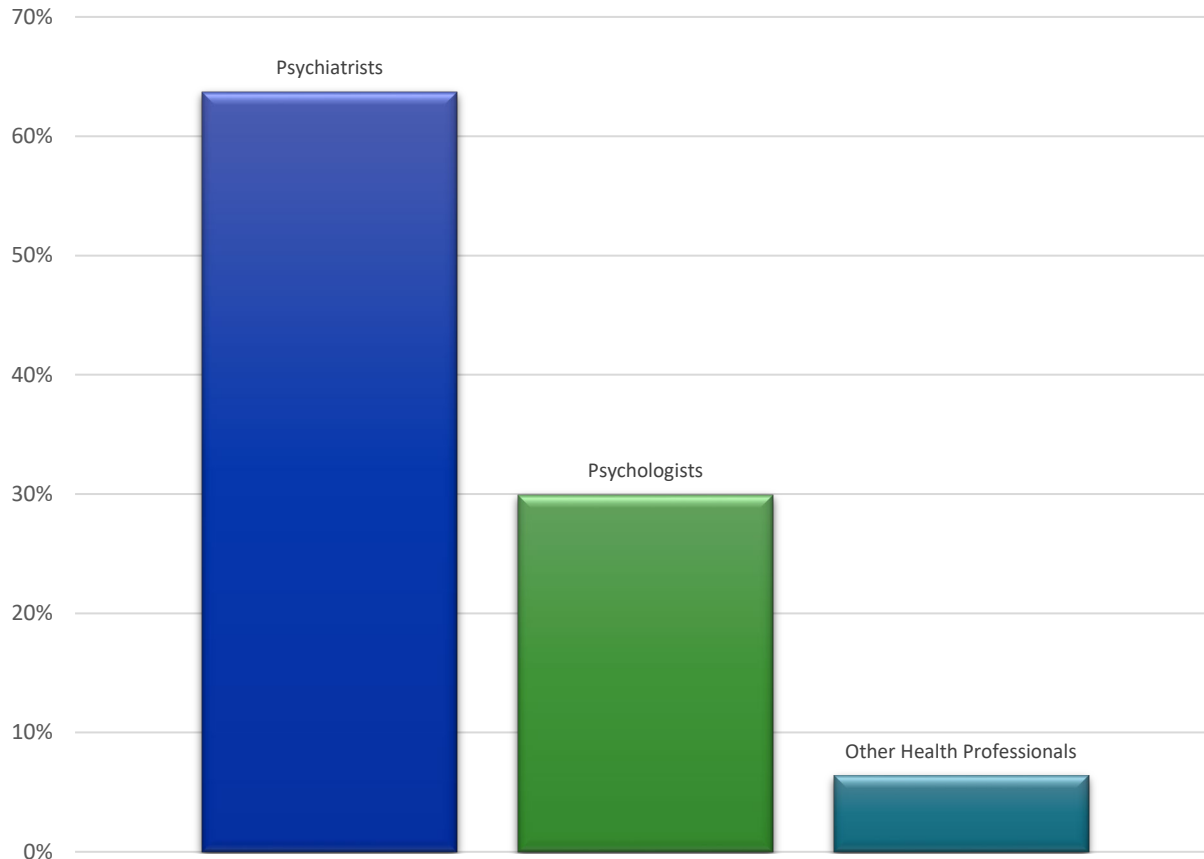
DEVELOPMENT OF DSM-5-TR

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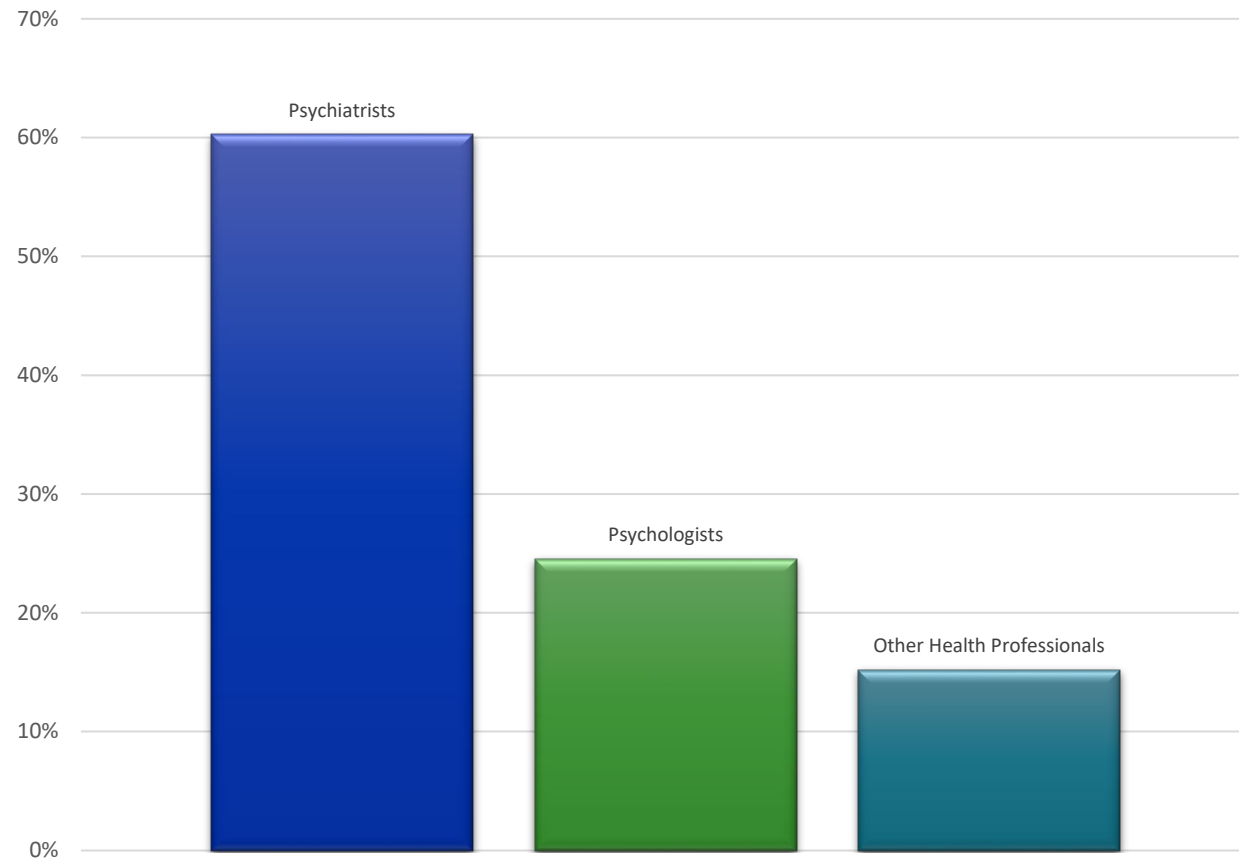
- The APA started work on DSM-5-TR in Spring 2019.
- DSM-5-TR development involved the work of over 200 subject matter experts.
- The subject matter experts comprise diverse, internationally recognized clinicians and scientific researchers with backgrounds in psychiatry, psychology, social work, pediatrics, neurology, nursing, epidemiology, and anthropology:
 - 20 Disorder Review Groups, each headed by a section editor
 - 4 cross-cutting review groups (Culture, Sex and Gender, Suicide, and Forensic)

DEVELOPMENT OF DSM-5-TR

DSM-5 Task Force and Work Group Members



DSM-5-TR Committee and Work Group Members



NEURODEVELOPMENTAL DISORDERS

AUTISM SPECTRUM DISORDER (ASD)

Changes to criterion A

- A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by **ALL the following**, currently or by history (examples are illustrative, not exhaustive; see text)
1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
 2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
 3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

AUTISM SPECTRUM DISORDER (ASD)

Change in “Associated with neurodevelopmental, mental, or behavioral disorder” specifier

Specifier text:

- Associated with a neurodevelopmental, mental, or behavioral **problem**
- In DSM-5-TR, the specifier was changed to what was originally intended in DSM-5, which is to allow for clinically relevant neurodevelopmental, mental, or behavioral **problems**, such as irritability to be indicated.

INTELLECTUAL DEVELOPMENTAL DISORDER (INTELLECTUAL DISABILITY)

DSM-5 Diagnostic Criteria:

- A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.
- B. Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.
- C. Onset of intellectual and adaptive deficits during the developmental period.

The phrase ~~“To meet diagnostic criteria for intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in Criterion A.”~~ in the text on p. 38 was removed from the *Diagnostic Features* section in DSM-5 since it inadvertently appeared to change the diagnostic criteria for Intellectual Disability to add a fourth criterion.

INTELLECTUAL DEVELOPMENTAL DISORDER (INTELLECTUAL DISABILITY)

- **In the text of DSM-5 (P.37):** “For example, a person with an IQ score above 70 may have such severe adaptive behavior problems in social judgment, social understanding, and other areas of adaptive functioning that the person’s actual functioning is comparable to that of individuals with a lower IQ score. Thus, clinical judgment is needed in interpreting the results of IQ tests.”
- **In the text of DSM-5-TR (P.42):** “For example, a person **with deficits in intellectual functioning whose IQ score is somewhat above 65–75** may nevertheless have such **substantial** adaptive behavior problems in **social judgment or other areas of adaptive functioning** that the person’s actual functioning is clinically comparable to that of individuals with a lower IQ score. Thus, clinical judgment is important in interpreting the results of IQ tests, and using them as the sole criteria for the diagnosis of an intellectual developmental disorder is insufficient.”
- *To communicate: the idea that although one should not be bound narrowly to the 65-75 IQ score range, that said, it also wants to emphasize that the diagnosis of IDD would not be appropriate for those with substantially higher IQ scores, so clinical judgment becomes very important.*



SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS

SUBSTANCE/MEDICATION-INDUCED PSYCHOTIC DISORDER

Criterion B.1 updates to add “or withdrawal from” medication

- B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
 1. The symptoms in Criterion A developed during or soon after substance intoxication- or withdrawal or after exposure to or withdrawal from a medication.
 2. The involved substance/medication is capable of producing the symptoms in Criterion A
- DSM-5 wording left out the fact that, as is the case with substances, symptoms can arise in the context of taking a medication either while the person is taking the medication or after stopping it, if the medication is prone to causing a withdrawal syndrome.
- **NOTE: This change has been made across all substance/medication-induced disorders across DSM-5-TR**

BIPOLAR AND RELATED DISORDERS

BIPOLAR I & BIPOLAR II DISORDERS

Changes to Criteria B and C for BPI and BPII

- DSM-IV: the criteria were intended to differentiate between mood episodes that were part of schizoaffective disorder (“**not better accounted for by**”) and those concurrent with other psychotic disorders (“**not superimposed on**”).
- DSM-5: it was less clear how to determine whether mood episodes are “better explained by” other psychotic disorders given that no psychotic disorder includes mood episodes in its definition (except for schizoaffective disorder).
- DSM-5-TR: A modified version of the DSM-IV criteria was implemented

Bipolar I disorder

- B. ~~The occurrence of the~~ At least one manic ~~and major depressive~~ episode(s) is not better explained by schizoaffective disorder, **and is not superimposed on** schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

Bipolar II Disorder

- C. ~~The occurrence of the~~ At least one hypomanic episode(s) and at least one major depressive episode(s) ~~is are~~ not better explained by schizoaffective disorder, **and are not superimposed on** schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

BIPOLAR I AND BIPOLAR II DISORDERS

Changes to mood- congruent/incongruent psychotic features specifiers

- Applying Mood-Congruent/Mood Incongruent Psychotic Features specifiers to BPI & BPII depends on whether the current (or most recent) episode is a manic or major depressive episode.

DSM-5 (p.152)

With mood-congruent psychotic features: During manic episodes, the content of all delusions and hallucinations is consistent with the typical manic themes of grandiosity, invulnerability, etc., but may also include themes of suspiciousness or paranoia, especially with respect to others' doubts about the individual's capacities, accomplishments, and so forth.

With mood-incongruent psychotic features: The content of delusions and hallucinations is inconsistent with the episode polarity themes as described above, or the content is a mixture of mood-incongruent and mood-congruent themes.

BIPOLAR I AND BIPOLAR II DISORDERS

When applied to current or most recent manic episode (in bipolar I disorder):

- *With mood-congruent psychotic features:* The content of all delusions and hallucinations is consistent with the typical manic themes of grandiosity, invulnerability, etc., but may also include themes of suspiciousness or paranoia, especially with respect to others' doubts about the individual's capacities, accomplishments, and so forth.
- *With mood-incongruent psychotic features:* The content of delusions and hallucinations does not involve typical manic themes as described above, or the content is a mixture of mood-incongruent and mood-congruent themes.

When applied to current or most recent major depressive episode (in bipolar I disorder or bipolar II disorder):

- *With mood-congruent psychotic features:* The content of all delusions and hallucinations is consistent with the typical **depressive themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment.**
- *With mood-incongruent psychotic features:* The content of the delusions or hallucinations does not involve typical **depressive themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment, or the content** is a mixture of mood-incongruent and mood-congruent themes.

BIPOLAR I AND BIPOLAR II DISORDERS

Changes to Severity Specifiers

In DSM-5, p.154

- **Mild:** Few, if any, symptoms in excess of those required to meet the diagnostic criteria are present, the intensity of the symptoms is distressing but manageable, and the symptoms result **in minor impairment in social or occupational functioning.**
- **Moderate:** The number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for “mild” and “severe.”
- **Severe:** The number of symptoms is substantially in excess of those required to make the diagnosis, the intensity of the symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning.
- **DSM-5-TR:** specifiers **applicable to a manic episode** have been added:
 - **Mild:** Minimum symptom criteria are met for a manic episode.
 - **Moderate:** Very significant increase in activity or impairment in judgment.
 - **Severe:** Almost continual supervision is required in order to prevent physical harm to self or others.

SUBSTANCE/MEDICATION-INDUCED BIPOLAR & RELATED DISORDER

Criterion A updated for clarity and harmonized across the Substance-induced and Due to Another Medical Condition categories as follows

- A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by abnormally elevated, expansive, or irritable mood and abnormally increased activity or energy. ~~with or without depressed mood, or markedly diminished interest or pleasure in all, or almost all, activities.~~

BIPOLAR & RELATED DISORDER DUE TO ANOTHER MEDICAL CONDITION

Criterion A updated for clarity as is harmonized across the Substance-induced and Due to Another Medical Condition categories as follows

- A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by ~~period of~~ abnormally elevated, expansive, or irritable mood and abnormally increased activity or energy, ~~that predominates in the clinical picture.~~

OTHER SPECIFIED BIPOLAR AND RELATED DISORDER

- Revision of example 3 “**hypomanic episode without prior major depressive episode**” to resolve a conflict with criterion E for persistent depressive disorder: “*E. There has never been a manic episode or a hypomanic episode.*”
 - Hypomanic episode without prior major depressive episode: One or more hypomanic episodes in an individual whose presentation has never met full criteria for a major depressive episode or a manic episode. ~~If this occurs in an individual with an established diagnosis of persistent depressive disorder (dysthymia), both diagnoses can be concurrently applied during the periods when the full criteria for a hypomanic episode are met.~~
- Addition of a fifth example “**Manic episode superimposed** on schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorder.”
 - This example applies when the individual has a manic episode that is superimposed on psychotic disorder (i.e., changes to Criteria B and C for BPI and BPII)

RESTORATION OF UNSPECIFIED MOOD DISORDER

- The removal of unspecified mood disorder from DSM-5 was an unintentional by-product of the division of the mood disorders chapter in DSM-IV into separate chapters for bipolar and depressive disorders.
- Unspecified mood disorder is now in the [depressive](#) and [bipolar disorders](#) chapters in DSM-5-TR.
 - Symptoms are characteristic of a depressive or bipolar disorder
 - Symptoms do not meet the full criteria for MDD, BPI, BPII, AD w/ depressed mood or mixed anxiety and depressed mood
 - Cause clinically significant distress or impairment in functioning.

DEPRESSIVE DISORDERS

MAJOR DEPRESSIVE DISORDER

- *Criterion D in MDD* (i.e., the relationship between the mood episode and psychotic disorders) was modified to reflect the DSM-IV wording.
 - Major mood disorders are typically characterized by multiple mood episodes. So, application of criterion D using DSM-5 was problematic when some of the mood episodes were better explained by a psychotic disorder, but others were not.
 - Equivalent in DSM-IV (Criterion B) indicated that the mood episodes being referred to by the exclusion were those that met the definitional requirements for the disorder thereby avoiding the problem.
- D. ~~The occurrence of the~~ **At least one** major depressive episode is not better explained by schizoaffective disorder, **and is not superimposed on** schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

PERSISTENT DEPRESSIVE DISORDER

Criteria

- The exclusion in criterion E for Persistent Depressive Disorder was changed to match its counterpart in MDD. Hence, the phrase “[criteria have been met for Cyclothymic Disorder](#)” was removed.
 - E. There has never been a manic episode or a hypomanic episode. ~~and criteria have never been met for cyclothymic disorder.~~

Name

- The parenthetical “dysthymia” was removed since dysthymic disorder in DSM-IV [imposed a limit on the severity of the depression](#) by requiring that the depression not meet the criteria for a major depressive episode at any time during the first two years.

Specifiers

- DSM-5: The criteria set for persistent depressive disorder listed seven out of the eight specifiers that apply to major depressive disorder.
- DSM-5-TR: Since only the [anxious distress specifier](#) and the [atypical features specifier](#) are explicitly applicable to persistent depressive disorder. They were the only ones kept.

OTHER SPECIFIED DEPRESSIVE DISORDER

- Addition of a fourth example “**Major depressive episode superimposed** on schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorder.”
 - This example applies when a major depressive episode occurs concurrently with a psychotic disorder that does not have mood episodes as part of its diagnostic criteria.



OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

OTHER SPECIFIED OBSESSIVE-COMPULSIVE AND RELATED DISORDER

Addition of olfactory reference disorder (olfactory reference syndrome) to the examples of presentations

- Olfactory reference disorder was included in DSM-5 under the term “*Jikoshu-kyofu*,” an older term that is used in traditional Japanese psychiatry.
 - That may incorrectly imply that the disorder is a culture-bound syndrome whereas it has been reported around the world.
- Olfactory reference disorder has been added as a separate disorder to ICD-11, in the chapter on obsessive-compulsive or related disorders.



TRAUMA- AND STRESSOR-RELATED DISORDERS

POSTTRAUMATIC STRESS DISORDER

Changes to criterion A.2 for posttraumatic stress disorder in children

- The note under criterion A.2 stating: “witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures” was removed for children 6 years and younger.
 - The decision was based on **its redundancy** given that criterion A.2 already indicates that the events occurring to others must be witnessed in person.
- A. In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
1. Directly experiencing the traumatic event(s).
 2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers.
~~Note: Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.~~
 3. Learning that the traumatic event(s) occurred to a parent or caregiving figure.

PROLONGED GRIEF DISORDER

- A new disorder in Section 2 of the DSM, under the **Trauma- and stressor-related disorders**. *p.* 322
- **Definition:** An intense yearning or longing for the deceased (often with intense sorrow and emotional pain), and preoccupation with thoughts or memories of the deceased (in children and adolescents, this preoccupation may focus on the circumstances of the death).

How to differentiate PGD from Depressive disorders?

- Prolonged grief disorder, major depressive disorder, and persistent depressive disorder share several symptoms, including *low mood, crying, and suicidal thinking*.
- In prolonged grief disorder **the distress is focused on feelings of loss and separation from a loved one** rather than reflecting generalized low mood.
- Major depressive disorder may also be preceded by the death of a loved one, **with or without comorbid prolonged grief disorder**.

FEEDING AND EATING DISORDERS

AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER

Changes to criterion A

- Criterion A was edited to eliminate the text “*as manifested by persistent failure to meet appropriate nutritional and/or energy needs.*”
 - A. “An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) ~~as manifested by persistent failure to meet appropriate nutritional and/or energy needs~~ associated with one (or more) of the following:
 1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
 2. Significant nutritional deficiency.
 3. Dependence on enteral feeding or oral nutritional supplements.
 4. Marked interference with psychosocial functioning.”
- The deleted text conflicted with criterion A.4 that allowed Criterion A to be met by “*marked interference with psychosocial functioning,*” thus not requiring a failure to meet nutritional needs.

OTHER SPECIFIED FEEDING OR EATING DISORDER

changes to the atypical anorexia nervosa example

- Added the sentence: *“individuals with atypical anorexia nervosa may experience many of the physiological complications associated with anorexia nervosa”* to the description of the atypical anorexia nervosa example
 - **Atypical anorexia nervosa:** All of the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual’s weight is within or above the normal range. [Individuals with atypical anorexia nervosa may experience many of the physiological complications associated with anorexia nervosa.](#)
 - The aim was to clarify that the presence of physiological consequences during presentation does not mean that the diagnosis is anorexia nervosa.

GENDER DYSPHORIA

GENDER DYSPHORIA

Updated terminology in the gender dysphoria Specifiers and text

- The text of gender dysphoria was updated to use culturally-sensitive language, e.g.:
- “desired gender” → “experienced gender”
- “cross-sex medical procedure” → “gender affirming medical procedure”
- “cross-sex hormone treatment” → “gender affirming hormone treatment”
- “natal male” → “individual assigned male at birth”
- “natal female” → “individual assigned female at birth”
- “differences in sex development” was noted to be an alternate term for “disorders of sex development”

NEUROCOGNITIVE DISORDERS

DELIRIUM

Changes to criterion A

- In DSM-5, criterion A for delirium: “A disturbance in attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced orientation to the environment)” could be unclear.
 - The criterion equated “awareness” to “reduced orientation to the environment”
 - It uses the term “disorientation” which already appears as one of the “additional disturbances in cognition” in criterion C
- To clarify the meaning, in DSM-5-TR, the parenthesized phrase “reduced orientation to the environment” was removed, and the second half of criterion A was changed
 - A. A disturbance in attention (i.e., reduced ability to direct, focus, sustain, and shift attention) ~~and~~ accompanied by reduced awareness of the environment. ~~(reduced orientation to the environment).~~
 - B. The disturbance develops over a short period of time (usually hours to a few days), represents a change from baseline attention and awareness, and tends to fluctuate in severity during the course of a day.
 - C. An additional disturbance in cognition (e.g., memory deficit, disorientation, language, visuospatial ability, or perception).

MAJOR OR MILD NEUROCOGNITIVE DISORDER DUE TO TBI

Changes to criterion B.4, neurological signs examples

- Removal of (“*a new onset of seizures; a marked worsening of a preexisting seizure disorder*”) that were incorrectly offered as examples of clinical signs/manifestations of TBI.
 - Their inclusion in DSM-5 made the definition of TBI inconsistent with the other prevailing definitions, including those of the American Congress of Rehabilitation Medicine; CDC; WHO; VA/DoD, among others
 - These two examples are not supported by literature on TBI
 - Replacing the removed examples with the more widely accepted evidence of TBI
- B.** There is evidence of a traumatic brain injury—that is, an impact to the head or other mechanisms of rapid movement or displacement of the brain within the skull, with one or more of the following:
1. Loss of consciousness.
 2. Posttraumatic amnesia.
 3. Disorientation and confusion.
 4. Neurological signs (e.g., neuroimaging demonstrating injury; ~~a new onset of seizures; a marked worsening of a preexisting seizure disorder~~; visual field cuts; anosmia; hemiparesis; hemisensory loss; cortical blindness; aphasia; apraxia; weakness; loss of balance; other sensory loss that cannot be accounted for by peripheral or other causes).

OTHER MENTAL DISORDERS AND ADDITIONAL CODES

NO DIAGNOSIS OR CONDITION

Addition of a code for No Diagnosis or Condition (Z03.89)

- This code applies to situations in which the person has been evaluated and it is determined that no mental disorder or condition is present.



OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION

SUICIDAL BEHAVIOR & ASSOCIATED ICD-10-CM CODE

Addition of codes for Suicidal Behavior and Nonsuicidal self-injury

Suicidal Behavior

- This category may be used for individuals who have engaged in potentially self-injurious behavior with **at least some intent to die** as a result of the act.
- Evidence of intent to die can be **explicit or inferred** from the behavior or circumstances.
- A suicide attempt **may or may not result in actual self-injury**.

Codes for Suicidal Behavior

- **T14.91XA** Initial encounter
- **T14.91XD** Subsequent encounter
- **Z91.51** History of Suicidal Behavior

NONSUICIDAL SELF-INJURY & ASSOCIATED ICD-10-CM CODE

Addition of codes for Suicidal Behavior and Nonsuicidal self-injury

Nonsuicidal Self-Injury

- This category may be used for individuals who have engaged in intentional self-inflicted damage to their body of a sort likely to induce bleeding, bruising, or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing) in the absence of suicidal intent.

Codes for Nonsuicidal Self-Injury

- R45.88 Current Nonsuicidal Self-Injury
- Z91.52 History of Nonsuicidal Self-Injury



ATTENTION TO CULTURE, RACISM, AND DISCRIMINATION IN DSM-5-TR

ETHNORACIAL EQUITY AND INCLUSION WORK GROUP

Name	Ethnoracial group	Expertise
Roberto Lewis-Fernández, M.D., Co-chair	LatinX	Cultural psychiatry
Danielle Hairston, M.D., Co-chair	African American	Health equity and structural racism in psychiatry
Renato D. Alarcón, M.D., M.P.H.	LatinX	Cultural psychiatry
Paul S. Appelbaum, M.D., ex officio	White	Forensic psychiatry
Diana E. Clarke, Ph.D., M.Sc.	African American/ Caribbean Black	Epidemiologist, health equity and structural racism in psychiatry
Constance E. Dunlap, M.D.	African American	Health equity and structural racism in psychiatry, psychoanalyst
Nitin Gogtay, M.D.	South Asian	Neuroscientist, brain development and psychosis researcher
Joseph P. Gone, Ph.D.	American Indian/Alaskan Native	Cultural psychology and Indigenous community well-being
Jessica E. Isom, M.D., M.P.H.	African American	Health equity and structural racism in psychiatry
Laurence J. Kirmayer, M.D.	White	Cultural psychiatry
Francis G. Lu, M.D.	Asian American	Cultural psychiatry
Dolores Malaspina, M.D., M.S., M.S.P.H.	White	Diversity, equity and inclusion in psychiatry
Altha J. Stewart, M.D.	African American	Health equity and structural racism in psychiatry
Lamyaa H. Yousif, M.D., Ph.D., M.Sc.	White Middle Eastern	Epidemiologist

ATTENTION TO CULTURE, RACISM, & DISCRIMINATION IN DSM-5-TR

Examples of strategies implemented to address concerns about race, ethnoracial differences, racism and discrimination in the DSM:

- Use of the term “**racialized**” instead of “**race/racial**” to highlight the socially constructed nature of race.
- Use of the term “**ethnoracial**” to denote the U.S. Census categories.
- Avoidance of terms such as “**minority**” and “**non-White**”.
- Use of the emerging term “**Latinx**” to promote gender-inclusive terminology.
- Inclusion of prevalence data on specific ethnoracial groups when existing research documented reliable estimates.
- Providing information on variations in symptom expression, attributions for disorder causes or precipitants, and factors associated with differential prevalence across demographic groups.

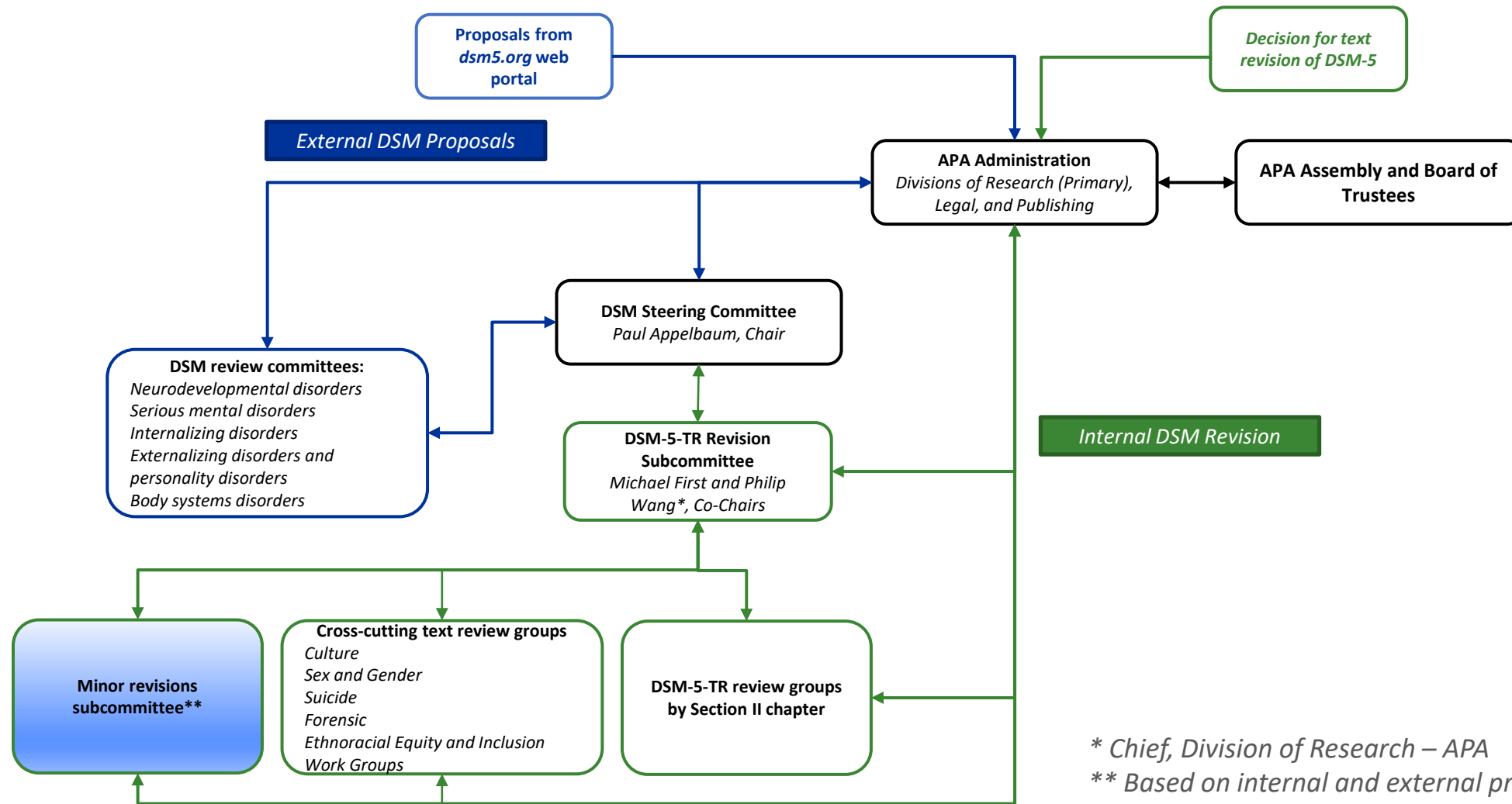
CODING AND RECORDING PROCEDURES

INTERNATIONAL CLASSIFICATION OF DISEASES CODES

- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) is a version of the World Health Organization's ICD-10 that has been modified for clinical use by the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS) and provides the only permissible billable diagnostic codes for mental disorders for clinical use in the United States.
- ICD-10-CM went into effect in the US on [October 1, 2015](#)
- Both [ICD-9-CM](#) and [ICD-10-CM](#) codes in DSM-5.
- Only [ICD-10-CM](#) codes in DSM-5-TR.

CHANGES TO THE DSM

DSM REVISION PROCESS



* Chief, Division of Research – APA
 ** Based on internal and external proposals

PROPOSALS FOR MAKING CHANGES TO DSM–5-TR

- An online system has been developed that allows the field to propose **new diagnoses, changes to existing diagnoses, deletions of existing diagnoses, revisions to the text** that may include **corrections or clarifications**, and other changes:
 - <https://www.psychiatry.org/psychiatrists/practice/dsm/submit-proposals>
- Proposals for making changes to the DSM go through **an extensive multi-stage review process** before final approval, which allows updates to diagnostic criteria and selected text without waiting for a new edition of the DSM.

Types of Proposals:

- Type 1: Proposals for making changes to an existing diagnostic criteria set
- Type 2: Proposals for addition of a new diagnostic category or specifier
- Type 3: Proposals for deletion of an existing diagnostic category or specifier/subtype
- Type 4: Proposals for corrections and clarifications (including changes to improve the understanding and application of an ambiguous diagnostic criterion, specifier, or text)
- Type 5: Proposals for changes to the text (not necessitated by changes to diagnostic criteria)
- Type 6: Proposals for additions to Section 3, Conditions for Further Study
- Type 7: Proposals for additions to Other Conditions that May Be a Focus of Clinical Attention