DSM-5-TR Updates: What Providers Need to Know

Friday, May 20, 2022
9AM- 2PM CT | 8AM- 1PM MT

Webinar Summary

- DSM-5-TR Organization Summary
- Wording and Coding
- Suicidal Behavior
- Diagnostic Changes
- 50 Coding Updates
- Updated Re-design
- Future Considerations

DSM-5-TR Organizational Summary

- Primary goals:
  - Help clinicians make more accurate and consistent diagnoses
  - Help researchers better study how disorders relate to one another, which can lead to better treatment for patients.
  - Lifespan approach in Section II
  - Section III now includes “Conditions for Further Study” section p. 20
  - Color organization of sections within section II

DSM-5-TR Organizational Summary

- Same Structure as the DSM-5
  - Neurodevelopmental Disorders
  - Schizophrenia Spectrum and Other Psychotic Disorders
  - Bipolar and Related Disorders
  - Depressive Disorders
  - Anxiety Disorders
  - Elimination Disorders
  - Other Mental Disorders and Additional Codes
  - Obsessive-Compulsive and Related Disorders
  - Trauma- and Stressor-Related Disorders
  - Dissociative Disorders

DSM-5-TR Updates: What Providers Need to Know

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DSM-5-TR Organizational Summary

- Somatic Symptom and Related Disorders
- Eating and Feeding Disorders
- Sleep/Wake Disorders
- Sexual Dysfunctions
- Gender Dysphoria
- Disruptive, Impulse-Control, and Conduct Disorders
- Substance-Related and Addictive Disorders
- Neurocognitive Disorders
- Personality Disorders
- Paraphilic Disorder
- Medication-Induced Movement Disorders and Other Adverse Effects of Medication
- Other Conditions That May Be a Focus of Clinical Attention
**History**

<table>
<thead>
<tr>
<th>DSM Edition</th>
<th>Year of Publication</th>
<th>Disorders Listed</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSM-I</td>
<td>1952</td>
<td>106 Disorders</td>
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<tr>
<td>DSM-II</td>
<td>1968</td>
<td>182 Disorders</td>
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<tr>
<td>DSM-III</td>
<td>1980</td>
<td>165 Disorders</td>
</tr>
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<td>DSM-III-TR</td>
<td>1987</td>
<td>232 Disorders</td>
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<td>DSM-IV-TR</td>
<td>2000</td>
<td>299 Disorders</td>
</tr>
<tr>
<td>DSM-5</td>
<td>2013</td>
<td>299 Disorders</td>
</tr>
<tr>
<td>DSM-5-TR</td>
<td>2022</td>
<td>299 Disorders</td>
</tr>
</tbody>
</table>

**Changes in Wording/Terminology**

- System rather than “exotica”
- Ethnological used to denote U.S. Census categories (i.e., Hispanic, White, or African American) that combine ethnic and racialized identities
- Removed terms “minority” and “non-white”
- Categorize
  - Now becoming larger population
  - Prevents term designating race or ethnicity
- Latinx used to promote gender-inclusive terminology rather than “Latino/a”
- Some information on suggesting not ALL or the cultural influence group or use of gender terms
- Some changes occur throughout the DSM manual, but in general, there are no overarching changes
- Note: There were different variations in different sections of the manual (e.g., DSM-5 vs. DSM-5-TR)

**Recognizing Cultural Differences**

- Added disclaimers to inform reader of higher incidence of diagnosis in certain cultural groups
- Attention to cultural norms
- Attention to risk of misdiagnosis when evaluating individuals from socially oppressed ethnic/racial groups
- Terms: “Cultural contexts” or “Cultural backgrounds” to avoid overgeneralization
- Identifies specific “Concepts of Distress”

**Cultural Context**

- Addresses cultural context of mental illness and the Cultural Formulation Interview (CFI) (p. 86-87)
- Addresses stigmatization or use of generalized language
- Revised examples of cultural concepts of distress and describes ways distress is expressed, reported, and interpreted (p. 87)
- Includes outline of systematic person-centered cultural assessment in cultural formulation section (p. 86-87)

**Cultural Concepts of Distress**

- Cultural Concepts of Distress
  - Refers to ways that individuals experience, understand, interpret, or act on experiences, behavioral problems, or troubling thoughts and emotions (p. 87)
- Cultural attributions
  - Refers to ways that individuals experience, understand, interpret, or act on experiences, behavioral problems, or troubling thoughts and emotions (p. 87)
- Cultural syndromes
  - Refers to ways that individuals experience, understand, interpret, or act on experiences, behavioral problems, or troubling thoughts and emotions (p. 87)
  - Cultural syndromes: clusters of symptoms and syndromes that occur to co-occur among individuals in specific cultural groups, communities or contexts and are recognized locally as coherent patterns of experience.
Cultural Concepts of Distress (DSM-5-TR, p. 871-872)

- Replaces former formulation Culture-bound Syndrome.
- Change made to clarify to emphasize clinically important cultural differences often involve explanations or experience of distress rather than culturally distinctive configurations of symptoms.
- Culture bound overemphasizes the extent to which cultural concepts of distress are characterized by highly idiosyncratic experiences that are restricted to specific geographic regions.

Examples of Cultural Concepts of Distress
- Attaque de nervios
- Dhat syndrome
- Hākikamūri
- Dhat syndrome
- Kufungisisa
- Maladi dyab
- Nervios
- Shenjing shuariruo
- Susto
- Taijin kyofusho

Sex / Gender Differences (DSM-5-TR, p. 19)

- Sex: “refers to factors attributable to an individual’s reproductive organs and XX or XY chromosomal implement”
- Gender: “is a result of reproductive organs as well as an individual’s self-representation and includes the psychological, behavioral, and social consequences of the individual’s perceived gender.”
- Common Terms: “gender differences” or “women/men” or “girls/boys” vs “sex differences” or “male/female”
- Exceptions: use sex (“male/female”) when information is pertinent to sex.
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Clinical Sequence: (p. 847-850)
- Level 1 cross-cutting/self informant-rated measures
- Level 2 cross-cutting/symptoms measures
- Clinician-Rated Dimensions of Psychosis Symptom Severity (p. 852)
- Measure for schizophrenia spectrum and other psychotic disorders
- Updated to keep with criteria (severity specifiers)
- World Health Organization Disability Assessment Schedule 2.0 (p. 856)
- Updated to include clarifications to instructions for calculating summary scores

Section III Assessments (DSM-5-TR, p. 847-857)

- Cross-cutting/Symptoms measures
- Clinician-Rated Dimensions of Psychosis Symptom Severity (p. 852)
- Measure for schizophrenia spectrum and other psychotic disorders
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Gender (DSM-5-TR, p. 511)

- Removed binary classifications of male/female
- Natal male/natal female is now individual “assigned male/female at birth” (“birth-assigned sex”)
- Desired gender is now “experienced gender”
- Cross-sex medical procedure is now “gender-affirming medical procedure”

Section III Assessments

Self-Rated Level 1... (DSM-5-TR, p. 847-853)

- Adult Online Version (23 Questions):
Suicidal and Nonsuicidal Self-Injury Behaviors

Suicidal Behavior
(DSM-5-TR, p. 81a)

ICD-10

Suicidal and Nonsuicidal Self-Injury Behaviors

Suicidal Behavior
(DSM-5-TR, p. 88a)

Coding
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 end one's life can be explicit or inferred from the behavior or circumstances. A suicide attempt may or may not result in actual self-injury. If the individual is discussed by another person or changes his or her mind before initiating the behavior, this category does not apply.

Current Suicidal Behavior
T49.91 A Initial encounter: if suicidal behavior is part of the initial encounter with the clinical presentation
T49.910 Subsequent encounter: if suicidal behavior is part of subsequent encounters with the clinical presentation
Z92.51 History of Suicidal Behavior
Disorders and Symptoms of Injuries

Grief Updates

Current: Proposed
Specify if
Current: Not more than 12 months since the last attempt.
In early remission: 12-24 months since the last attempt.

Pontified Diagnostic Criteria
A. 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.)

B. 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.

C. The diagnosis is not applied to suicidal ideation or to preparatory acts.

D. The act was not initiated during a state of delirium or confusion.

E. The act was not undertaken solely for a political or religious objective.

Proposed Diagnostic Criteria
A. Within the last 24 months, the individual has engaged in intentional self-inflicted damage to the surface of the or her body of a sort likely to induce bleeding, bruising, or pain, with the expectation that the injury will lead to only minor or moderate physical harm.

B. The individual engaged in the self-injective behavior with one or more of the following:

1. To achieve an interpersonal difficulty.
2. To achieve a positive feeling state.
3. The intentional self-injury is associated with one of the following:
   a. Emotional difficulty or negative feelings or thoughts, such as depression, anxiety, terror, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act.
   b. Resulting in the act, a period of preoccupation with the intended behavior that is difficult to control.
   c. Thinking about self-injury that occurs frequently, even when it is not acted upon.
   d. The behavior is not socially sanctioned and is not restricted to politing or self-hitting.
   e. The behavior or its consequences cause significant distress or interference in important areas of functioning.
   f. The behavior does not occur exclusively during psychotic episodes, delusions, substance intoxication, or substance withdrawal.

C. In individuals with neurodevelopmental disorder, the behavior associated with the individual's mental disorder is better explained by another mental disorder or medical condition.

Proposed Nonsuicidal Self-Injury Disorder

Diagnostic Changes

Prolonged Grief Disorder

Updated Diagnoses

Diagnostic Updates for Children

Timeline:

- DSM-5: Persistent Complicated Bereavement Disorder added to Section 3 (2013)
- Proposal submitted for Prolonged Grief Disorder to be included in Section II of the DSM (2018)
- Criteria finalized and approved by Steering Committee, and the APA's Assembly and Board of Trustees (2019)
- PGD added to "Trauma and Stress-Related Disorders" chapter in Section 2 of the DSM-5 (2022)
Prolonged Grief Disorder (DSM-5-TR, p. 322)

Defined as: “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)” (APA, 2013).

Prevalence:
- Prevalence in adults is unknown.
- Meta-analysis demonstrated a pooled prevalence of 9.8%.
- Substantial heterogeneity across the studies analyzed which affected findings (e.g., symptom definitions, measures, duration).

Diagnostic Criteria (cont.)
C. Since the death, at least three of the following symptoms have been present most days for at least the last month:
1. Identity disturbance (e.g., feeling as though part of oneself has died).
2. Marked sense of disbelief about the death.
3. Avoidance of reminders that the person is dead (in children and adolescents, may be characterized by efforts to avoid reminders).
4. Intense emotional pain (e.g., anger, bitterness, sorrow) related to death.
5. Difficulty re-integrating into one’s relationships and activities after the death (e.g., problems engaging with friends, pursuing interests, or planning for the future).
6. Emotional numbness (absence or marked reduction of emotional experience) as a result of the death.
7. Feeling that life is meaningless as a result of the death.
8. Intense loneliness as a result of the death.

Prolonged Grief Disorder (DSM-5-TR, p. 322)

Diagnostic Criteria (cont.)
D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
E. The duration and severity of the bereavement reaction clearly exceed expected social, cultural, or religious norms for the individual’s culture and context.
F. The symptoms are not better explained by another mental disorder, such as major depressive disorder or posttraumatic stress disorder, and are not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Prolonged Grief Disorder (DSM-5-TR, p. 322)

Considerations:
- Developmental
- Comorbidity with PTSD
- Environmental
- Cultural

Note:
25q.1 Uncomplicated Bereavement

*Used when focus of clinical attention is a normal reaction to the death of a loved one. As part of their reaction to such a loss, some grieving individuals present with symptoms characteristic of a major depressive episode. The bereaved individual typically regards the depressed mood as “normal” although the individual may seek professional help for relief of associated symptoms such as insomnia or anorexia. The duration and expression of “normal” bereavement vary considerably among different cultural groups. Further guidance in distinguishing grief from a major depressive episode and from prolonged grief disorder is provided in their respective texts (p. 322).

Differential Diagnosis:
- Normal Grief
- Depressive Disorders
- Posttraumatic Stress Disorder
- Separation Anxiety Disorder
- Psychotic Disorder

Most Common Comorbidity:
- Posttraumatic Stress Disorder
- Major Depressive Disorder
- Substance Use Disorders
Case Example

Sue, a 50-year-old woman, comes to your office stating she feels as if 50 days pass by while she waits until she can sleep at night. Sue reports feeling numb to almost everything around her in her day-to-day life. Sue’s youngest son died unexpectedly in a car accident almost two years ago. She reports that she can’t wait until she can finally go to sleep during the day because that is when she can experience some relief from the anguish of her loss. It is the one time she can relax her mind during the day. Sue reports she is currently taking prescribed sleeping medication to help her fall and stay asleep through the night. She was taking this medication prior to her son’s death.

Sue is retired and enjoys helping her other four adult children during the day. Sue states she relies on the phone call informing her of the accident daily. She describes feeling as if her life was placed on pause at that very moment. While she enjoys being with her children, Sue reports feeling preoccupied with how the accident occurred and is not able to fully enjoy these moments because she knows one piece of her family is missing. She feels as if her husband and children have been able to go back to their routines while she has not been able to. Sue visits the cemetery daily as a way to connect with her son and states those visits help tremendously.

Sue states that no one around her understands the pain she experiences daily. She states that while people tell her how strong she is, she does not feel that way and does not feel like she can show her true feelings. Sue has closed off many of her support systems, as a result to maintain a ‘strong’ exterior. She states while she has forgiven the person that caused the accident, she is still very angry and does not understand why bad things continue to happen to her family.

Updated Diagnoses

- Antidepressant Syndrome
- Autism Spectrum Disorder
- Avoidant Restrictive Food Intake
- Bipolar and Related Disorders Due to Medical Conditions
- Bipolar I
- Bipolar II
- Delirium
- Depressive Disorder Due to Another Medical Condition
- Functional Neurological Symptom Disorder
- Gender Dysphoria
- Intellectual Disability
- Major Depressive Disorder
- Nodularity
- Oppositional Defiant Disorder
- Other Specified Bipolar Related Disorder
- Other Specified Delirium Disorder
- Other Specified Feeding Disorder
- Other Specified Schizophrenia
- Persistent Depressive Disorder
- Prolonged Grief Disorder
- PTSD
- Social Anxiety Disorder
- Substance Medicated Induced Bipolar Disorder
- Unspecified Mood Disorder

Grief Assessments:
- PG-13 Revised Scale
- Inventory of Complicated Grief

Inventory of Complicated Grief

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>Bereavement-related symptoms of grief are more severe than symptoms of grief expected to occur in bereavement.</td>
</tr>
<tr>
<td>A2</td>
<td>Bereavement-related symptoms of grief are severe enough to cause significant distress or impairment in social, occupational, or other important areas of functioning.</td>
</tr>
<tr>
<td>A3</td>
<td>Bereavement-related symptoms of grief are not better accounted for by another mental disorder.</td>
</tr>
<tr>
<td>A4</td>
<td>Bereavement-related symptoms of grief are not due to bereavement.</td>
</tr>
<tr>
<td>A5</td>
<td>Bereavement-related symptoms of grief are not due to another prolonged grief disorder.</td>
</tr>
</tbody>
</table>

Updated Diagnoses for Children

- Autism Spectrum Disorder
- "As manifested by all of the following":
  - "all of the following"
  - "Lack of social reciprocal interaction"
  - "Failure to develop peer relationships" |
- Disruptive Mood Dysregulation Disorder
- Criterion G updated "6+ years"
- Posttraumatic Stress Disorder
- Criterion A removed to avoid repetitiveness
- "Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures"
- Prolonged Grief Disorder
- "Language added to differentiate between children and adolescents versus adults"
- "Highlights differences in reactions"

Bipolar I Disorder & Bipolar II Disorder

- Placed between Schizophrenia Spectrum/Other Psychotic Disorders and Depressive Disorders
- Recognition of Bipolar Disorders as a bridge between the two diagnostic classes regarding symptomatology, family history, and genetics.
- Note: Bipolar II Disorder-Not longer viewed as less severe than Bipolar I due to the burden of depressive symptoms and impairment in work and social functioning due to mood instability.
### Bipolar Disorder & Bipolar II Disorder

- Specifiers Changes
- Mood Congruent & Mood Incongruent Specifiers are dependent upon whether the current (most recent) episode is depressive or manic.
- Severity Specifiers for Depression:
  - 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.
- Severity Specifiers for Mania:
  - Mild: Minimum symptom criteria are met for a manic episode.
  - Moderate: Very significant increase in activity or impairment in judgment.
  - Severe: Almost constant supervision is required in order to prevent physical harm to self or others.

### Bipolar II Disorder

For Bipolar II Disorder

"C. At least one hypomanic episode and at least one major depressive episode are not better explained by:

- schizoaffective disorder
- not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder."

### Persistent Depressive Disorder

For Bipolar I Disorder

*B. At least one manic episode is not better explained by:

- schizoaffective disorder
- not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder."

### Attenuated Psychosis Syndrome (APS)

- Criterion A of attenuated psychosis syndrome (APS) was modified to enhance its clarity.
- The DSM-5 definition of the attenuated psychosis syndrome (APS) included the phrase "with relatively intact reality testing."
- This caused confusion and logical inconsistency in the criteria as it defined delusions and hallucinations, forms of reality distortion, with intact reality testing.
- To avoid such confusion, the phrase "with relatively intact reality testing" has been removed and the three symptoms (i.e., attenuated forms of delusion, hallucination, and disorganized speech) have been defined more accurately, using a "gatekeeper" to distinguish the attenuated from the non-attenuated form.

### Intellectual Developmental Disorder - (Intellectual Disability)

- The diagnosis of Intellectual Developmental Disorder (Intellectual Disability).
- The term "intellectual developmental disorder" is used to clarify the disorder’s relationship with the World Health Organization’s International Classification of Diseases, eleventh revision (ICD-11) Classification system, which uses the term “disorders of intellectual development.”
- The equivalent term "intellectual disability" is placed in parentheses for continued use.
Social Anxiety Disorder

- Social Anxiety Disorder
- Social Phobia is NO longer acceptable for use

Unspecified Mood Disorder

- Unspecified Mood Disorder reinstated in DSM-5-TR
- Located in both depressive and bipolar disorder chapters in Section II
- Applies to:
  - Symptoms that are characteristic of depressive disorder
  - Cause clinically significant distress or impairment in social, occupational, or other areas of functioning
  - Symptoms do NOT meet criteria for any disorders in depressive disorders, adjustment disorder with depressed mood, or adjustment disorder with mixed anxiety and depressed mood.
  - Intended to be used when the clinician chooses not to specify the reason that the criteria are not met for a specific depressive disorder and includes presentations where there is insufficient information to make a more specific diagnosis.

Unspecified Bipolar and Related Disorder (F32-35)

This category applies to presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the depressive disorders diagnostic class. The clinician chooses not to specify the reason that the criteria are not met for a specific bipolar and related disorder and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings). (p. 664)

Unspecified Depressive Disorder (F32-35)

This category applies to presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the depressive disorders diagnostic class and do not meet criteria for adjustment disorder with depressed mood or adjustment disorder with mixed anxiety and depressed mood. The unspecified depressive category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific depressive disorder and includes presentations for which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings). (p. 210)

Functional Neurological Symptom Disorder (Conversion Disorder)

- Conversion Disorder is NO longer used
- Replaced by Functional Neurological Symptoms Disorder

Coding Updates - 50

- Updates to ICD-10-CM Coding 2022
- ONLY ICD-10 Codes (Alphanumeric code): NO DSM Codes
- The American Psychological Association (APA) announced coding updates to its DSM-5 diagnostic list based on the Centers for Medicare and Medicaid Services (CMS) ICD-10 diagnostic coding updates for 2022.
- Healthcare providers worldwide use the ICD-10-CM as a standardized system to share and compare health information. Each year, the CMS reviews and approves changes to the ICD-10-CM. Several code changes for 2022 pertain to diagnoses listed in the APA's DSM-5. These coding changes went into effect on October 1, 2022 and are already live in Valen's system.
Updated Redesign

Future Considerations

Future ICD-11

Further Study

Enhancements in the DSM-5-TR Text

Coding Updates - 50

- Updated Codes - Examples
  - The updated codes break down several diagnoses into more specific subcategories.
  - Homelessness previously fell under the Z25.0 code, but has been subdivided into two categories: sheltered homelessness (Z25.01) for patients who have access to homeless shelters, domestic violence shelters, or other temporary relief measures, and unsheltered homelessness (Z25.02) for those who lack access to any adequate housing situation.
  - The new codes separate lack of access to adequate food and lack of access to safe drinking water. Previously grouped under Z34.4, they're now broken into the categories: food insecurity (Z34.41) and lack of safe drinking water (Z34.42).
  - For identifying a patient's personal history of self-harm, the codes now differentiate between personal history of suicidal behavior (Z32.51) vs. personal history of non-suicidal self-injury (Z32.52).
  - Other changes include a code change for unspecified depressive disorder (now F33.1) and the addition of non-suicidal self-injury (R65.4).

- Harmonization with ICD-11
  - Overarching goal to harmonize the DSM & ICD classification systems as much as possible for the following reasons:
    - Data Collection/Tracking
    - National health statistics
    - Designing clinical trials for new treatments
    - Improve global applicability of results by international regulatory agencies
    - Improve replication of scientific results across national boundaries
    - Significant complications/inconsistencies evident when attempting to identify identical populations when using the DSM-V and ICD-10

- Representation of developmental issues
- Integration of scientific findings from latest research in genetics and neuroimaging
- Consolidation of autistic disorder, Asperger's disorder, and pervasive developmental disorder into autism spectrum disorder
- Classification of bipolar and depressive disorders
- Restructuring of substance use disorders for consistency and clarity
- Enhanced specificity for major and mild neurocognitive disorders
- Transition in conceptualizing personality disorders
- Section III
- Online enhancements

- Attenuated Psychosis Syndrome
- Depressive Episodes with Short-Duration Hypomania
- Caffeine Use Disorder
- Internet Gaming
- Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure
- Suicidal Behavior Disorder
- Nonsuicidal Self-Injury Disorder
Resources

- DSM-5-TR Fact Sheets
- Facts About the DSM-5-TR
- DSM-5-TR Online Assessment Measures

Thank you!

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