Understanding the factors discussed above helps make sense of what, for many scientists and health professionals, is one of the most exasperating and difficult-to-understand features of the vaccination debate: facts are not enough. Merely repeating evidence has been a notoriously ineffective way of shifting attitudes among those who self-identify as anti-vaccination[8]. One reason for this is that people do not always behave like cognitive scientists, weighing up evidence before reaching a conclusion. Frequently, we behave more like cognitive lawyers, selectively exposing ourselves, critiquing, and remembering evidence that reinforces a conclusion that feels "right" for us. Successful communication requires deep listening and an attentiveness to the fears, worldviews and ideologies that might be motivating COVID-19 refusal[9]. Persuasion attempts that are responsive to these underlying "attitude roots" are more likely to be successful than those that sail above them with an exclusive focus on facts and data[3].

Finally, mental health professionals recognize as much as anyone the importance of communication that is non-stigmatizing and inclusive. Although the public face of the anti-vaccination movement sometimes seems strident and unworthy of empathy, community members who align with those views are frequently characterized by anxiety and uncertainty. There is the potential for negative feedback loops, where the vaccine hesitant feel misunderstood and stigmatized, reinforcing their worldview that the system is corrupted and lacking in humanity. Feeling socially isolated, vaccine refusers may be driven toward the online communities and misinformation echo chambers that reinforce their fears. Respectful and inclusive communication is not just the "nice" thing to do; on a pragmatic level, it is a pre-requisite for enabling positive change.

Matthew J. Hornsey
University of Queensland Business School, University of Queensland, St. Lucia, QLD, Australia

1. Wang Q, Xu R, Volkow NR. World Psychiatry 2021;20:124-30.
2. Slovic P, Finucane ML, Peters E et al. Risk Anal 2004;24:311-22.
3. Hornsey MJ, Fielding KS. Am Psychol 2017;72:459-73.
4. Hornsey MJ, Harris EA, Fielding KS. Health Psychol 2018;37:307-15.
5. Hornsey MJ, Finlayson M, Chatwood G et al. J Experiment Soc Psychol 2020; 88:103947.
6. UK Office for National Statistics. Coronavirus and vaccination rates in people aged 50 years and over by socio-demographic characteristic, England. London: UK Office for National Statistics, 2021.
7. Fridman A, Gershon R, Gneezy A. PLoS One 2021;16:e0250123.
8. Nyhan B, Reifler J, Richey S et al. Pediatrics 2014;133:e835-42.
9. Lewandowsky S, Cook J, Schmid P et al. The COVID-19 vaccine communication handbook. https://sks.to/c19vax.

DOI:10.1002/wps.20990

DSM-5-TR: overview of what's new and what's changed

The DSM-5 Text Revision (DSM-5-TR)[1] is the first published revision of DSM-5 since its original publication in 2013. Like the previous text revision (DSM-IV-TR), the main goal of DSM-5-TR is to comprehensively update the descriptive text that is provided for each DSM disorder based on reviews of the literature since the release of the prior version. However, in contrast to DSM-IV-TR, in which updates were confined almost exclusively to the text[2], there are a number of significant changes and improvements in DSM-5-TR that are of interest to practicing clinicians and researchers. These changes include the addition of diagnostic entities, and modifications and updated terminology in diagnostic criteria and specifier definitions.

The updates to the diagnostic criteria and text in DSM-5-TR are the product of two separate but concurrent processes: the iterative revision process that allows the addition or deletion of disorders and specifiers as well as changes in diagnostic criteria to be made on an ongoing basis[3], which commenced soon after the publication of DSM-5, and a complementary text revision process which began in 2019.

While most of the changes instituted since publication of DSM-5 and included in this text revision involve relatively minor changes and serve to correct errors, clarify ambiguities, or resolve inconsistencies between the diagnostic criteria and text, some are significant enough to have an impact on clinical practice[4]. Here we outline the main changes in DSM-5-TR, subdivided into four categories: addition of diagnostic entities and symptom codes; changes in diagnostic criteria or specifier definitions; updated terminology; and comprehensive text updates.

Diagnostic entities added to DSM-5-TR include Prolonged Grief Disorder, Unspecified Mood Disorder, and Stimulant-Induced Mild Neurocognitive Disorder.

Prolonged Grief Disorder is characterized by the continued presence, for at least 12 months after the death of a loved one, of intense yearning for the deceased and/or persistent preoccupation with thoughts of the deceased, along with other grief-related symptoms such as emotional numbness, intense emotional pain and avoidance of reminders that the person is deceased, that are sufficiently severe to cause impairment in functioning[5,6].

Unspecified Mood Disorder is a residual category for presentations of mood symptoms which do not meet the full criteria for any of the disorders in either the bipolar or the depressive disorders diagnostic classes, and for which it is difficult to choose between Unspecified Bipolar and Related Disorder and Unspecified Depressive Disorder (e.g., acute agitation).

Stimulant-Induced Mild Neurocognitive Disorder has been added to the existing types of substance-induced mild neurocognitive disorders (alcohol, inhalants, and sedative, hypnotics or anxiolytic substances), in recognition of the fact that neurocognitive symptoms, such as difficulties with learning and memory and executive function, can be associated with stimulant use[7].

Free-standing symptom codes have been added to the chapter Other Conditions that May Be a Focus of Clinical Attention, to indicate the presence (or history of) suicidal behavior ("potentially self-injurious behavior with at least some intent to die")

and nonsuicidal self-injury ("intentional self-inflicted damage to the body likely to induce bleeding, bruising, or pain in the absence of suicidal intent")[1]. These codes will allow the clinician to record these clinically important behaviors independent of any particular psychiatric diagnosis.

Changes in diagnostic criteria or specifier definitions have been implemented for more than 70 disorders. While most of these changes are relatively minor, a number are more significant, and address identified problems that could lead to misdiagnosis. Diagnostic criteria sets or specifier definitions with more significant changes include those to criterion A for Autism Spectrum Disorder; changes in severity specifiers for Manic Episode; addition of course specifiers to Adjustment Disorder; and changes to criterion A for Delirium.

Autism Spectrum Disorder is defined by persistent difficulties in the social use of verbal and nonverbal communication (criterion A) along with restricted repetitive patterns of behavior (criterion B). While the minimum threshold for the restricted repetitive behavior component was straightforward (at least two of four), the minimum required number of types of deficits in social communication was ambiguous. Specifically, the criterion A phrase "as manifested by the following" could be interpreted to mean "*any* of the following" (one of three) or "*all* of the following" (three of three). Since the intention of the DSM-5 Work Group was always to maintain a high diagnostic threshold by requiring all three, criterion A was revised to be clearer: "as manifested by all of the following".

The "mild" severity specifier for Manic Episode (few, if any, symptoms in excess of 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.

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 6 months, and "persistent" if symptoms have persisted for 6 months or longer after the termination of the stressor or its consequences.

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, given that "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".

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".

The updates to the text were the result of a three-year process involving over 200 experts, most of whom had participated in the development of DSM-5. There were 20 Review Groups to cover the Section II chapters, each headed by a Section Editor. Experts were asked to review the text to identify material that was out-of-date. This was supplemented by literature reviews that covered the period of the prior 10 years.

Three cross-cutting Review Groups (Sex and Gender, Culture, Suicide) reviewed every chapter, focusing on material involving their specific expertise. Revisions to the text also underwent a forensic review. Finally, an Ethnoracial Equity and Inclusion Work Group reviewed the entire text to ensure among other things that explanations of ethno-racial and cultural differences in symptomatic presentations and prevalence took into consideration the impact of experiences such as racism and discrimination.

Most disorder texts had at least some revisions, with the overwhelming majority having significant revisions. Text sections most extensively updated were Prevalence, Risk and Prognostic Factors, Culture-Related Diagnostic Features, Sex- and Gender-Related Diagnostic Features, Association with Suicidal Thoughts and Behaviors, and Comorbidity. The text sections with the fewest updates were Diagnostic Features and Differential Diagnosis.

The American Psychiatric Association continues to welcome empirically-grounded proposals for change. Guidelines for submitting such proposals can be found at www.dsm5.org.

Michael B. First[1], Lamyaa H. Yousif[2], Diana E. Clarke[2], Philip S. Wang[3], Nitin Gogtay[2], Paul S. Appelbaum[1]

[1]Department of Psychiatry, Columbia University, New York, NY, USA; [2]American Psychiatric Association, Washington, DC, USA; [3]Cambridge Health Alliance, Cambridge, MA, USA

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, fifth edition, text revision. Washington: American Psychiatric Association, 2022.
2. First MB, Pincus HA. Psychiatr Serv 2002;53:288-92.
3. First MB. World Psychiatry 2016;15:223-4.
4. Appelbaum PS, Leibenluft E, Kendler KS. Psychiatr Serv 2021;72:1348-9.
5. Prigerson HG, Boelen PA, Xu J et al. World Psychiatry 2021;20:96-106.
6. Szuhany KL, Malgaroli M, Miron CD et al. Focus (Am Psychiatr Publ) 2021; 19:161-72.
7. Spronk DB, van Wel JHP, Ramaekers JG et al. Neurosci Biobehav Rev 2013; 37:1838-59.

DOI:10.1002/wps.20989