Psychological Medicine

cambridge.org/psm

The DSM-5 Clinical and Public Health Committee (CPHC): operations, mechanics, controversies and recommendations

John S. McIntyre[1], Joel Yager[2], Anita Everett[3], Cathryn A. Galanter[4], Jeffrey M. Lyness[5], James Nininger[6], Victor I. Reus[7] and Michael Vergare[8]

[1]Department of Psychiatry, University of Rochester Medical Center, Rochester, NY, USA; [2]Department of Psychiatry, University of Colorado School of Medicine, Denver, CO, USA; [3]Department of Psychiatry and Behavioral Sciences, Johns Hopkins Bayview Medical Center, Baltimore, MD, USA; [4]Department of Psychiatry, State University of New York Downstate, Kings County Hospital Center, New York, NY, USA; [5]Department of Psychiatry, University of Rochester Medical Center, Rochester, NY, USA; [6]Department of Psychiatry, Weill Cornell Medical College, New York, NY, USA; [7]Department of Psychiatry and Behavioral Sciences, University of California, San Francisco School of Medicine, San Francisco, CA, USA and [8]Department of Psychiatry and Human Behavior, Thomas Jefferson University Hospitals, Philadelphia, PA, USA

Original Article

Cite this article: McIntyre JS, Yager J, Everett A, Galanter CA, Lyness JM, Nininger J, Reus VI, Vergare M (2021). The DSM-5 Clinical and Public Health Committee (CPHC): operations, mechanics, controversies and recommendations. *Psychological Medicine* **51**, 2493–2500. https://doi.org/10.1017/S0033291720001415

Received: 4 January 2015
Revised: 21 January 2016
Accepted: 5 May 2020
First published online: 25 August 2020

Key words:
Clinical and Public Health Committee; DSM-5; nosology

Author for correspondence:
John S. McIntyre, E-mail: jack.mcintyre@rochesterregional.org

Abstract

Background. For DSM – 5, the American Psychiatric Association Board of Trustees established a robust vetting and review process that included two review committees that did not exist in the development of prior DSMs, the Scientific Review Committee (SRC) and the Clinical and Public Health Committee (CPHC). The CPHC was created as a body that could independently review the clinical and public health merits of various proposals that would fall outside of the strictly defined scientific process.

Methods. This article describes the principles and issues which led to the creation of the CPHC, the composition and vetting of the committee, and the processes developed by the committee – including the use of external reviewers.

Results. Outcomes of some of the more involved CPHC deliberations, specifically, decisions concerning elements of diagnoses for major depressive disorder, autism spectrum disorder, catatonia, and substance use disorders, are described. The Committee's extensive reviews and its recommendations regarding Personality Disorders are also discussed.

Conclusions. On the basis of our experiences, the CPHC membership unanimously believes that external review processes to evaluate and respond to Work Group proposals is essential for future DSM efforts. The Committee also recommends that separate SRC and CPHC committees be appointed to assess proposals for scientific merit and for clinical and public health utility and impact.

Introduction

In the long tradition of the American Psychiatric Association's focus on nosological and diagnostic issues leading to DSMI (1952), DSM II (1968), DSM III (1980) and DSM IV (1994), work on DSM 5 began in 1999 (Spitzer, Endicott, & Robins (1978), (Fischer, 2012), (Regier, Kuhl, & Kupfer, 2013) As noted in the Introduction to DSM -5, four basic principles were enunciated to guide the draft revisions: '(1) DSM -5 is primarily intended to be a manual to be used by clinicians, and revisions must be feasible for routine clinical practice; (2) recommendations for revisions should be guided by research evidence; (3) where possible, continuity should be maintained with previous editions of DSM: and (4) no a priori constraints should be placed on the degree of change between DSMIV and DSM -5.' (American Psychiatric Association, 2013). Furthermore, considerable attention was given to minimizing the potential impact of industry-related conflicts of interest on decisions regarding changes in diagnostic criteria to be included in DSM-5.

The second of these principles led the Board of Trustees to establish in late 2010 a Scientific Review Committee (SRC) with Kenneth Kendler, M.D. as Chair and Robert Freedman, M.D. as Co-Chair. The charge for the SRC was "to review the empirical soundness of all proposed changes to DSM IV and as a result of this review to make recommendations to the American Psychiatric Association's Board of Trustees (BOT) about the advisability of adopting the proposed changes in DSM-5. Such recommendations should focus primarily on scientific evidence in support of the proposed changes." Furthermore, the BOT requested that the SRC should provide 'an independent scientific review process similar to that which is done by NIH Study Sections or Scientific Review Groups, or by peer reviewers for refereed journals.' Details of the establishment and functioning of the SRC can be found in Kendler's article in Psychological Medicine. (Kendler, 2013)

CAMBRIDGE UNIVERSITY PRESS

During 2011, because the Scientific Review Group's efforts were devoted predominantly to examining the scientific evidence supporting the validity of proposed changes, and since one of the long-standing motivations of the DSM-5 Work Groups was to improve the clinical utility of the DSM, APA and DSM leadership thought that additional evaluation by a separate group established primarily to review clinical utility and logical inconsistencies would be a useful addition to the process. In some cases, only limited scientific evidence was available to support proposed changes. Regardless of whether or not strong scientific evidence existed to support the proposed changes, many carried future clinical and public health ramifications, some of which were attracting considerable publicity and in some cases heated discussion and debate in some professional communities and in public groups as well (Nemeroff et al., 2013).

Consistent with principle (1) as stated above ('DSM-5 is primarily intended to be a manual used by clinicians, and revisions must be feasible for routine clinical practice'), the Board of Trustees in December of 2011 established the Clinical and Public Health Committee (CPHC) to 'consider clinical utility and public health issues of work group proposals that are not being reviewed by the SRC. In addition, issues of logical inconsistencies of DSM- IV can be considered by CPHC. The CPHC will also review proposals that do not meet the evidence level required by the SRC and for which the Work Group and/or the SRC feel that additional review is warranted.'

This paper describes the establishment, operations, and mechanics of CPHC, illustrates and discusses some of the controversies faced, and based on our experiences offers recommendations for future DSM-5 development processes.

Establishment of the CPHC

The committee was charged with reviewing a large number of detailed proposals within a relatively modest timeframe and established its membership and procedures accordingly. APA President Dr John Oldham appointed Jack McIntyre, M.D. as Chair and Joel Yager, M.D. as Co-Chair of CPHC. Six other members, all co-authors of this paper, were appointed, and all were vetted to assure no industry-related conflicts of interest concerning any diagnostic issues. In accord with the wide range of clinical and public health issues to be considered, the committee was broadly composed and included two members in full-time private practice with clinical appointments at a medical school (JM and JN), and six with full-time academic appointments. Three committee members were trained in Geriatric Psychiatry (VR, JL, MV); one in Child and Adolescent Psychiatry (CG), and one member had extensive involvement in Community Psychiatry and Public Health (AE). The Co-Chair of the Committee (JY) also served on the SRC and two committee members were members of the APA Board of Trustees (AE and JN.) All CPHC members were chosen on the basis of wide clinical interests, to cover broad swaths of psychiatric diagnostic areas of experience, and, anticipating how contentious some of the group discussions might become, for having reputations for being able to 'play well with others' – that is, to be constructive small group members. All potential CPHC members were carefully vetted for conflicts of interest using the same criteria established for members of the DSM-5 Task Force.

Material available for CPHC members

For each submitted proposal, the Work Group serving under the Task Force, prepared a Memo Outlining the Evidence for Change (MOEC). The MOECs ranged from 28 to 420 pages. An initial MOEC was submitted to the SRC and, if the proposal was subsequently referred to the CPHC, the original MOEC and revisions and additions the Workgroup thought might benefit the CPHC's review process accompanied the referral. The CPHC's request for information differed slightly from that of the SRC, in line with the committee's increased attention to clinical, public health, and logical consistency issues. The outline for the MOEC requested by the CPHC (which is in practice was variably adhered to by DSM Work Groups in preparing their arguments to support changes) modeled that of the SRC and also requested information about clinical and public health impact. In addition to the MOEC, CPHC received the completed review by the SRC and information from the Field Trials (when available.) For proposals that generated significant controversy in the professional and/or lay literature, articles concerning this controversy were also included. These materials were sent to committee members soon after the proposal was referred to the Committee in order to expedite reviews.

External expert reviewers

The Committee knew in advance that given the nature of the task, the time-frames, and the information available that its determinations would be based largely on collective knowledge and experience filtered through group-process influenced decision-making, inevitably resting on collective knowledge, experiences, and opinions. With the given constraints, no other feasible and reasonable methods seemed possible. In such processes, measurements and rating scales are inescapably inexact, and although personal opinions are unavoidable the process attempts to solicit sufficiently varied input to evoke the 'wisdom of crowds' and avoid small-subgroup hegemony. To assure that input was not limited to voices of CPHC members, the Committee developed a review process modeled on procedures utilized by peer-reviewed journals to include the use of external reviewers.

The Chair and Co-Chair recruited the expert reviewers, but, in order to encourage frankness by the external reviewers, the reviewers' identities were blind to all other committee members. Some of the reviewers were well-known experts with extensive publications in the areas covered by the proposals and others, many internationally, were identified as active in those areas by literature reviews using PubMed. Members and advisors of existing DSM-5Work Groups could serve as experts, but not on proposals they were worked on or voted on. Each potential expert reviewer was alerted in the initial invitation that we would not use individuals who had potential industry-related conflicts of interest concerning the diagnoses they were to review; those who agreed to serve were further vetted by DSM administrators for potential conflicts of interest using the same guidelines as for members of the CPHC. Reviewers were assured that their reviews would be confidential and were told that they would be acknowledged and listed in DSM-5 as reviewers, but not identified as to which specific proposal they reviewed. In total, 482 experts were initially approached and 130 individuals accepted, were ultimately vetted, and conducted 138 reviews (a small number reviewed two proposals.) Generally, three–five external experts reviewed each proposal, but on a few occasions, there were more (eight for one proposal); for one proposal only two external reviews were received.

Each external reviewer received the MOEC, field-trial information if available, and in cases where significant public controversy (Narrow et al., 2013) had been generated in the professional and

https://doi.org/10.1017/S0033291720001415 Published online by Cambridge University Press

lay media, articles concerning this controversy were included in the packet. The CPHC review template, approved by the Task Force, modeled on the information requested in the MOECs, is shown in Table 1. In addition to completing the template, reviewers were invited to offer additional observations; many reviewers provided additional comments, some quite extensive, often very helpful and illuminating. CPHC primary and secondary reviewers also completed the review templates in advance of discussions.

Operations of the CPHC

The DSM-5 Task Force decided on which of the hundreds of diagnostic changes considered for DSM-5 to refer to CPHC for review. Submissions to CPHC were prioritized based on the amount of controversy proposals had stirred up in professional and lay media (high visibility issues were inevitably referred), their prevalence and public health importance, and when certain Work Groups and/or the SRC specifically requested CPHC review. Ultimately, a total of 40 proposals were reviewed, some of which consisted of large topic areas that included several individual diagnoses. Proposals reviewed by CPHC are shown in Table 2.

Mechanics of the CPHC review process

Briefly, completed proposals were assigned to a designated primary and secondary CPHC reviewer, and were also distributed to all CPHC members and 4–5 assigned vetted external reviewers who were known only to the CPHC chair and co-chair. Prior to group discussions, CPHC members received blinded reviews from external reviewers. At the start of the discussion for each proposal, similar to procedures in many NIH study sections CPHC members were queried for their preliminary votes of a global rating of the proposal on a 4 point scale (similar but not identical to the scale used by the SRC): (1) Excellent (strong support) (2) Good (moderate support, acceptable) (3) Fair (limited support) and (4) Poor (probably not-justified; do not include). Although all committee members were responsible for reviewing all proposals and individually rating each proposal (or section), each proposal's discussion was led by the primary and secondary reviewers, each of whom independently prepared a review following the CPHC's template. After group discussion, members provided their final numeric votes orally and in writing. For the final reports, primary and secondary receivers prepared summaries of the CPHC discussions and recommendations to accompany the final average tallied scores.

To conduct its business, the CPHC held 24 conference calls throughout 2012, each ranging from 1 to 3 h. On each conference call, up to three proposals were discussed, but some proposals were discussed a second and in one instance a third time. Occasionally, a second or third review resulted following additional input from the Work Group and/or Task Force based on concerns expressed by the SRC and/or CPHC. Also, for a small number of proposals, the CPHC Chair and/or Vice-Chair clarified some issues 'off line', between the committee's conference calls, with the Work Group Chair.

Final reports were sent to the President of APA, Dr Dilip Jeste and were used to provide input into the DSM-5 Summit Group's discussions, and subsequently to the BOT.

Results of CPHC reviews

The committee voted on a total of 102 issues, but this reflected separating parts of the proposals and then considering the proposals as a whole when single overall recommendations were submitted. For the 57 recommendations, 7 scored between 1 (excellent) and 2 (good), 26 between 2 (good) and 2.5, 7 between 2.5 and 3 (fair), 17 scored between 3 (fair) and 4 (poor).

Controversial issues in CPHC reviews

Proposals that had clear support from SRC were generally not referred to CPHC for consideration, although there were a few notable exceptions; one of which is noted below. Although the fundamental principle behind creating CPHC for DSM-5 was that any proposed revision must be feasible for routine clinical practice, we were fully aware early in the process our work was limited and challenged by the fact that little or no robust evidence generally existed to guide the committee in making determinations as to clinical utility or feasibility. As a rule of thumb, although CPHC did not independently rate the strength of scientific evidence supporting each proposal, CPHC members gave considerable attention and respect to how the SRC rated scientific merit. Unless clear overriding clinical utility, public health issues or logical inconsistencies were identified, CPHC was swayed by the principle that revisions should be guided by research evidence, and proposals lacking such supporting evidence generally received low scores from CPHC.

Although the Committee is bound to honor agreements concerning the confidentiality of the discussions, and space does not permit review of how each proposal was deliberated, the following examples will illustrate some of the major challenges the Committee faced in attempting to determine the clinical utility and public health merit in what was often and largely a 'data-free' zone of operations.

One proposal that received strong support from the SRC, the elimination of the bereavement exclusion for major depressive disorder, was nevertheless referred to the CPHC for review as well because considerable controversy existed in the medical and lay press. A prevalent argument was that by eliminating this exclusion the American Psychiatric Association would be pathologizing normal bereavement. While appreciating these concerns, CPHC (and the external reviewers) agreed that the supporting evidence for the proposal was quite strong and that this change would be clinically beneficial without generating untoward public health consequences. Accordingly, approval was recommended (although CPHC also recommended clarifying language in the accompanying text, which was, in fact, adopted in the final publication.)

A complex set of proposals were submitted to SRC and CPHC regarding changes for Autism Spectrum Disorder. A proposal for collapsing Asperger's Disorder as well as Pervasive Development Disorder NOS, Childhood Disintegrative Disorder, and Autism into one category to be called Autism Spectrum Disorder was assessed as having good scientific merit, and accordingly, this aspect of the ASD proposal received good support from the SRC. However, considerable concerns had been raised in the lay community that eliminating Asperger's Disorder would result in deleterious public health consequences regarding benefits and services for individuals previously diagnosed with Asperger's Disorder, and that elimination of this diagnosis would also disadvantage them socially, removing what for some, had become a meaningful identifying label. The proposal was therefore referred to CPHC for review. Although we generally concurred with SRCs assessments based on scientific evidence, nevertheless, considerations of clinical and public health issues led CPHC to recommend

https://doi.org/10.1017/S0033291720001415 Published online by Cambridge University Press

Table 1. CPHC Reviewer recommendation report

Proposal Title: Click here to enter text.
Proposed change: Click here to enter text.
Reviewer: Click here to enter text.
Date: Click here to enter a date.
Part 1 – Magnitude of the change:
Criterion/criteria clarification
PLEASE CHECK ONE (if you are reviewing a complex proposal where several criteria are involved that differ in magnitude, please provide explanations in the 'comments' box below)
☐ Modest change: Includes changes to a specifier, to the examples provided in a NOS category description, or to subtype criteria OR Includes the addition of a new specifier or subtype to a diagnosis that has not been widely studied or well-validated
☐ Substantial change: Refers to meaningful changes to the DSM-IV criteria of a diagnosis that has not been widely studied or well-validated. Includes the addition of a new specifier or subtype to a well-validated diagnosis
☐ Major change: Refers to meaningful changes to the DSM-IV criteria of a widely studied and well-validated diagnosis. Includes the addition of a new diagnosis to DSM-5
☐ N/A
Comments (optional): Click here to enter text.
Part 2 – Evidence for the change:
NOTE: In most cases, changes should be proposed primarily when not doing so could result in significant harm (*e.g. from under-detection of an existing condition, from sustaining culturally insensitive or stigmatizing language, etc.*).
Are the arguments for making the proposed changes based on scholarly work/publications from more than one academic author or single academic group? Yes___ No___
Comments: Click here to enter text.
Were field trial data available to inform these recommendations? Yes___ No___
If so, do field trial data adequately support these recommendations? Yes___ No___
Comments: Click here to enter text.
Is objective evidence presented to justify the proposed changes regarding the harms imposed by DSM IV criteria and the severity of those harms (e.g. citations of published articles in peer-reviewed journals, other psychiatric publications and/or comments on the DSM-5 website)? Yes_ No__N/A__
In instances where the DSM IV criteria are not clearly harmful, does the Work Group make a very strong case for the fact that that the proposed DSM5 changes will nevertheless result in overwhelming improvements? Yes__No ___
Is this evidence sufficient to substantiate the claim? Yes___ No___
Comments (required): Click here to enter text.
Part 3- Reasons for and consequences of the proposed change:
Reasons for the change
Clinical utility: Yes___ No___
Is this DSM-5 diagnosis likely to:
Increase diagnoses of this condition by replacing an alternative DSM IV diagnosis considered too restrictive? Yes__ No____
Decrease diagnosis of this condition by replacing an alternative DSM IV diagnosis considered too diffuse and over-inclusive (e.g. this proposal will reduce the use of a NOS category)? Yes___ No____
Be clearer, less internally contradictory, and less confusing to clinicians in psychiatry and other health professions than the DSM IV nomenclature, leading to greater clarity and diagnostic precision? Yes___ No____
Draw attention to an important clinical condition that may currently go unrecognized, undiagnosed or un-coded (e.g. suicidal behavior)? Yes___ No____
Be more culturally sensitive and inclusive and/or less stigmatizing than DSM IV criteria, thereby correcting significant harms previously noted? Yes___ No____
Other (specify)? Yes___ No____
Comment on any of these issues:: Click here to enter text.
Public health concerns: Yes___ No___
Is this DSM-5 diagnosis likely to:
Increase the detection of previously unrecognized clinically significant problems? Yes___ No___.

(*Continued*)

https://doi.org/10.1017/S0033291720001415 Published online by Cambridge University Press

Table 1. (*Continued.*)

Decrease erroneous diagnoses that have led to overdiagnosis, overtreatment or inappropriate treatment of significant numbers of cases? Yes___ No___
Comments: Click here to enter text.
Logical Consistency: Yes_ No___
Are the proposed changes in wording and/or placement likely to resolve concerns about observed discrepancies with regard to language or specific DSMIV criteria where previous wording/placement has resulted in confusion? Yes___ No___
Are the proposed changes in placement of diagnoses within a broad category likely to better harmonize, simplify and make more rational the placement of the involved diagnoses than is the case in DSM-IV? Yes__ No__
Do all stakeholder Work Group parties (i.e. WG members addressing each separate diagnosis) agree that the changes make significant improvements in the proposed format? Yes__ No___
Comments: Click here to enter text.
Estimation of changes in caseness:
Are quantitative estimates in anticipated changes in caseness presented? Yes___ No___
If yes, please indicate the percentage of estimated change: a. Modest (e.g. less than 5%) ___ b. Moderate (e.g. 6- 10% shifts)___ c. Significant (e.g. 11–25% shifts)____ d. Substantial (26% or greater shifts)____
Comments: Click here to enter text.
Discussion of possible negative consequences of the proposed change
Please list the major concerns and objections to the proposed changes of which you are aware that have appeared in the press or have been posted on the DSM 5 website (including issues such as unintended consequences of increasing or decreasing diagnostic and treatment rates, increasing stigma, public health concerns, forensic concerns, administrative concerns (e.g. funding for care):
Comments REQUIRED: Click here to enter text.
To what extent have these concerns and objections been acknowledged and discussed in the proposal (if several concerns/objections are noted, please rate each one separately)?
☐ Adequately considered and addressed
☐ Considerations addressed in less than a direct or unsatisfactory manner
☐ Considerations are neither acknowledged nor addressed
Comments REQUIRED: Click here to enter text.
(*For Parts 4 and 5 below check whether the element is addressed and all that apply*)
Part 4 - For New Diagnostic Category:
Are these addressed?
☐ A need for the category
☐ Relationship with other DSM categories
☐ Potential harm in adopting the category
☐ Potential harm in not adopting the category
☐ Available treatments for diagnoses in the category
☐ Diagnosis meets the criteria for a mental disorder
☐ N/A
Comments (optional): Click here to enter text.
Part 5 - Deletion of Existing Diagnosis:
Are these addressed?
☐ Magnitude of adverse effects on our patients that would arise from the deletion of the syndrome

(*Continued*)

https://doi.org/10.1017/S0033291720001415 Published online by Cambridge University Press

Table 1. (*Continued.*)

☐ Extent to which practitioners have avoided the DSM IV diagnosis due to stigma and/or because the concepts are confusing.
☐ Extent to which the DSM IV diagnosis has stifled advances in clinical research or program development
☐ Extent to which the DSM IV diagnosis has resulted in harmful treatment decisions.
☐ N/A
☐ Comments (optional): Click here to enter text.
Part 6 - PROPOSED CPH RECOMMENDATION:
PLEASE KEEP IN MIND that the strength of the arguments presented should commensurate with the magnitude of change. If a minor change is unlikely to change caseness, the evidence may be less stringent. But any substantial or major changes must be well buttressed by strong arguments that a major problem with DSM-IV has been identified and that the proposed changes will directly and satisfactorily address these problems.
☐ Strong support 1) moderate support (acceptable) 2) modest support (questionable) 3) limited support (probably not-justified). Suggest revision and resubmission 4) poor support (do not include in the main text; suitable for research appendix for further study) 5) poor support (do not include) 6) insufficient data – Request clarification and resubmission
Additional Comments (required for a rating of 4–6):
Click here to enter text.

the addition of explicit specifiers that would retain the uniqueness of each subgroup, e.g. Autism Spectrum Disorder '…predominantly XX type'. Ultimately, this recommendation was not incorporated into the published DSM-5.

More difficult were the considerations of proposals that received 'borderline' support or frankly unfavorable ratings from the SRC because that committee's review concluded that scientific evidence was lacking to support the magnitude of proposed changes in diagnostic criteria.

One example of where CPHC differed from SRC was in evaluating a proposal for Catatonia NEC. The SRC voted unfavorably on this proposal due to lack of scientific validators. In contrast, CPHC saw little in the way of the clinical downside and thought that this category could be clinically useful as a residual or working diagnosis, and rated this proposal as 'good'. Similarly, in consideration of adding 'craving' as a criterion for the diagnosis of Substance Use Disorders, in contrast to the SRC rating of limited-poor support, CPHC found this addition to be clinically meaningful and voted 'good to excellent' support.

Perhaps the most difficult assignment for CPHC concerned proposals for a complete restructuring in the way that personality disorders might be diagnosed. To briefly put this story in context, before the CPHC was ever involved, the Personality Disorder Work Group had set out a complex and constantly evolving series of proposals for overhauling the diagnostic approach to personality disorders. Initially based predominantly on replacing traditional categorical DSM criteria with a predominantly dimensional system based on temperament-associated traits and excluding the typological thinking usually practiced by clinicians, the Work Group's initial presentations were not well received by the DSM Task Force. In addition, a number of outspoken and well-reputed psychiatric and psychologist personality disorders experts objected to the new model as well as to the fact that their views were not represented in the composition or negotiations of the Work Group. After the Work Group leadership compromised by devising a 'hybrid' model that fused typological and trait-based approaches, two Work Group members who advocated for trait-based methods were so displeased that apparently, they resigned. The Work Group's initial MOEC proposals to the SRC focused primarily on deficiencies in the DSM-IV diagnostic approaches; it also offered some evidence-based justification for their new models. However, given the magnitude of the proposed changes, the SRCs judged the MOEC to provide insufficient evidence for scientific validation for the new diagnostic schemes. Even after the Work Group revised the MOEC, the SRC again judged the Work Group's revision to inadequately support claims that the new diagnostic scheme was sufficiently superior to merit discarding the DSM IV criteria in favor of the new proposal. At that point, the Work Group requested CPHC review(Zachar, Krueger, & Kendler, 2016)

Aware of these controversies and of the significant impact on clinical practice that would follow the adoption of the proposed hybrid criteria; the CPHC planned a more elaborate than usual review process for the personality disorders proposal. Instead of the usual 4–5 external reviewers,

CPHC recruited eight outside reviewers. Given the CPHC's charge to focus on clinical utility, the external reviewers included a mix of academic personality disorder researchers, academic researchers whose work focused on clinical problems noted for substantial comorbidities involving personality disorders, and several highly experienced practitioner-scholars whose clinical areas abutted personality disorder areas. None of the well-known psychiatrists or psychologists who had most publically and prominently opposed the changes was among the external reviewers. In addition to completing the review checklist, most of the external reviewers wrote detailed comments. Within the CPHC, in contrast to a single primary and secondary reviewer, four primary reviewers were assigned, each of whom was obliged to provide a

https://doi.org/10.1017/S0033291720001415 Published online by Cambridge University Press

Table 2. Diagnoses considered by CPHC and their scores

Proposal	CPH Score	Proposal	CPH Score
ADHD	2	Neurobehavioral disorder associated with prenatal alcohol exposure (ND-PAE)	4
Adjustment disorders	−2	Neurocognitive disorder types	4
Anxious depression	3.64	Nightmare disorder	2.93
ARFID	3	Non-suicidal self-injury	3.25/2.17/2.42
Autism spectrum disorder	2.42	Obsessive compulsive disorder (OCD)	3.33
Catatonia	1.93	Olfactory reference syndrome (ORS)	3.9
Communication disorders	3	Paraphilic disorders	
Conduct disorder	1.14	Pedophilic disorder	2
Conversion disorder	3.15	Personality disorder	4
Dissociative identity disorder	2.56	Post-traumatic stress disorder (PTSD)	2.6
Disruptive mood Dysregulation Disorder (DMDD)	2.38	Premenstrual dysphoric disorder (PMDD)	2.2
Gender Dysphoria	2	Schizoaffective disorder	Crit. B 2.4
GPPPD	2.1	Schizophrenia	2.5
Hypersexual disorder	3.92	Sensory processing disorder	3.57
Hypersomnolence disorder		Sexual dysfunctions	2
Insomnia disorder	2	Somatic symptom disorder/illness anxiety	2.2
Intellectual disability	2	Stimulant-related disorders	2.36
Intermittent explosive disorder	2.56	Substance use disorder	1.61
Major and mild neurocognitive disorder	2	Suicidal behavior disorder	1.83
MDD Bereavement exclusion	2	Tic disorders	1.5

written analysis prior to discussion. All of the reviewers and CPHC members appreciated how much in the way of time, energy, talent, and good intentions the Personality Disorders Work Group had devoted to these efforts. Nevertheless, only one of the external reviewers was favorable about the proposal (an academic whose career focus was on personality trait research); one had positive reactions to parts of the proposal and all the other reviewers were not at all favorable. CPHC members judged the proposal unfavorably, concluding that although elements of the proposed new scheme were probably clinically useful, the package as a whole was not and that imposing these changes would unduly burden clinicians without convincing evidence of substantial benefit over the DSM IV system. An 11th-hour revision of the proposal by the Work Group was received and reviewed by CPHC – bending its own procedural rules in so doing – and was still judged to be too clinically difficult to implement to justify replacing DSM IV criteria.

Accordingly, after final SRC, CPHC, Summit Group and Board of Trustees review, the Work Group was invited to write a section on 'Alternative DSM-5 Model for Personality Disorders' in Section III, Emerging Measures and Models. Since a major concern of the CPHC was clinician burden with the proposed new model, members of CPHC felt that placing the model in Section III of DSM-5 was a good solution, giving clinicians the option of using the new model if they were comfortable in doing so. Also, as experience with the new model grows it may become clear that its use is indeed feasible and it will be considered for a future DSM.

Comments and recommendations for future DSM efforts

Our experiences conducting the CPHC lead us to several reflections and recommendations for future DSM-related efforts by the American Psychiatric Association:

- Overall, we believe that having external review processes to evaluate and respond to Work Group proposals is essential and that such processes should be built into future efforts from their start.
- We also see value in having different groups assess proposals for scientific merit and separately for clinical and public health utility and impact. We believe that the mindsets, experience, and expertise of individuals focusing on these different facets of proposals differ sufficiently to merit distinct committees.
- Given the amount of work entailed in the reviews, as per grant proposals in the NIH, we suggest that future proposals be written in as succinct a manner as possible, directly addressing the parameters requested by review committees. The burden on committee members and external reviewers of being expected to thoroughly review hundreds of pages in some single proposals is unreasonable. Although appendices and supplementary material might be offered as optional reading for reviewers, basic proposals should be concisely written.
- Similar to the SRC, CPHC did not do 'blinded' voting. Generally, although not always, the range of votes among CPHC members was narrow, most coming within a point of one another (e.g. 2s and 3s). This degree of convergence

https://doi.org/10.1017/S0033291720001415 Published online by Cambridge University Press

undoubtedly resulted from group discussion, group attunement, and group process. In contrast, votes from external reviewers who saw only the written material and who did not have opportunities to interact with one another or with the committee showed a wider range (e.g. on some proposals votes ranged from 1 to 4). Given how personal beliefs, values, and opinions form these ratings and the imprecision of our rating scales, no method will approach perfection. However, experimenting with the use of anonymous Delphi surveys for voting on proposals might prove worthwhile.

We were privileged to participate in the development of DSM-5 and trust that our input and that of the many external reviewers who contributed to this process added to the quality of the final document. We hope that our experience-based recommendations will assist in future DSM-related planning efforts.

Acknowledgements. We thank Ann Miller and Jenny Shupinka for excellent, devoted staff support throughout the work of the CPHC.

Conflict of interest. No conflicts of interest for any of the authors

References

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed., pp. 7). Arlington, VA: American Psychiatric Association.

Fischer, B. (2012). A review of American psychiatry through Its diagnoses. *Journal of Nervous and Mental Disease*, *200*, 1022–1030.

Kendler, K. (2013). A history of the DSM-5 scientific review committee. *Psychological Medicine*, *43*, 1793–1800.

Narrow, W., Clarke, D., Kuramoto, S., Kraemer, H., Kupfer, D., Greomer, L., & Regier, D. (2013). DSM-5 Field trials in the United State and Canada, part III: Development and reliability testing of a cross-cutting symptom assessment for DSM-5. *American Journal of Psychiatry*, *170*, 71–82.

Nemeroff, C., Weinberger, D., Rutter, M., MacMillan, H., Bryant, R., Wessely, S., … Lysaker, P. (2013). DSM-5: A collection of psychiatrist views on the changes, controversies, and future direction. *BioMed Central Medicine*, *11*, 202.

Regier, D., Kuhl, E., & Kupfer, D. (2013). The DSM-5: Classification and criteria changes. *World Psychiatry*, *12*, 92–98.

Spitzer, R., Endicott, J., & Robins, E. (1978). Research diagnostic criteria: Rationale and reliability. *Archives of General Psychiatry*, *35*, 773–782.

Zachar, P., Krueger, R. F., & Kendler K. S. (2016). Personality disorder in DSM-5: An oral history. *Psychological Medicine*, *46*, 1–10.

https://doi.org/10.1017/S0033291720001415 Published online by Cambridge University Press