



American Psychiatric Nurses Association
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American Psychiatric Association
DSM-5 Development
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Dear Sir:

APNA is pleased to share its responses regarding the proposed criteria for the Diagnostic and Statistical Manual of Mental Disorders, 5th edition. This document reflects a summary of our comments which were submitted to the DSM-V Task Force via the APA website.

Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V) organizational response – APNA has charged the institute with compiling member responses to a call from APA for comments regarding proposed criteria for the new manual. This work will commence after April 2 (APNA's deadline for responses) and will be completed by April 14 in order to be reviewed and submitted by the April 20, 2010 APA deadline.

APNA supports the rationale for collapsing Axis I, II, and III into a single Axis. Also, APNA wholly supports the use of the International Classification of Functioning (ICF) to reflect the level of functioning and disability that one with mental illness exhibits. Also this system takes into account environmental and social factors that influence the patient. ICD Codes allow greater alignment between psychiatric diagnostic methods with medical diagnostic methods.

Any approach that would capture the objective assessment of disability would be greatly welcomed. While it appears thorough, there are some concerns whether this can be carried out in the practice setting given the usual time constraints of most employment settings.

One of the biggest changes under consideration is collapsing the DOs first beginning in childhood and assigning those DOs to the appropriate broad category such as separation anxiety DO to anxiety DO. I lean to including those disorders with the broader categories.

I particularly like the cross-cutting assessment. Our members have been asking for the "best" "most useful" "widely used" measures. The PROMIS look good to me and I am thrilled to see--anger (although I think it could be irritability) included.

Disorders Usually First Diagnosed in Infancy, etc.

Child/Adolescent Temper Dysregulation

This should be called a mood disorder and classified as such. The criteria sound much like kids with bipolar features. Temper dysregulation implies that this more a behavioral issue rather than a brain disorder and schools may deny services because it is only a behavior rather than a medical issue. It is also thought that the negative connotation of the word "temper" may confuse non-clinical colleagues and consumers.

PTSD in preschool children

Kids who are taken into state custody often act out and likely have PTSD due to the various disruptions in their lives. Kids would easily meet criteria in D & E; however, criteria in B may be difficult to ascertain particularly if there is no one available who knows the child or if the child is unable to express himself. The descriptors help portray an accurate developmental description.

Learning Disabilities: good changes

Rhett's Disorder: agree, drop dx

Non Suicidal Self Injury - APNA supports the inclusion of the Non Suicidal Self Injury diagnosis including the description and criteria.

Separation Anxiety - question why this would be added to the Adult Diagnosis. Should be maintained as a Childhood Disorder

ASD- agree with elimination of PDD, NOS. Asperger's should stay since we have moved to an era when this better understood and addressed. It is part of ASD but speaks to these high functioning children and adults in a term they have grown to accept.

ODD- the Severity Index will be helpful. Stay with the term 'often.'

ADHD - add a category of ADD because parents and kids with this subset of symptoms never see themselves as ADHD. Support age of onset at 12.

Add the symptoms of low frustration tolerance and sleep disturbance to the criteria.

Tic - support the language that people can have a prolonged tic-free interval and still have the disorder. Tourette's should stay with Childhood Disorders and not with OCD.

Delirium, Dementia, Amnestic and other Cognitive disorders

The proposed changes would subsume the above into three areas to be listed in DSM-V. They are Major Neurocognitive Disorders, Minor Neurocognitive disorders, and Delirium.

First, replacing dementia is fine since the term adds nothing diagnostically about specific impairment and or functional limits. Adding specific indicators of cognitive decline as well as functional decline puts less emphasis on memory and considers the importance of other domains such as language and executive function. Also, the focus on performance may assist in determining the safety of patients. The objective measures that would assist the clinician to clearly delineate between major and minor domains, as well as, delirium are well supported in the literature. The proposed emphasis on loss of independence will be useful in making diagnostic and or clinical decisions. Furthermore, APNA supports the addition of Minor Neurocognitive Disorder as it recognizes the need for patients to receive care and that the impairment may be related to a syndrome. Responses are mixed regarding the use of the term "Minor."

Mental Disorders Affecting Medical Condition

I don't understand any of this:

Proposed not to include Psychological conditions..... To include a severity score Personality traits affecting a medical condition DSMV Proposed not to include 1. Rename Somatoform disorder to somatic symptoms disorder and combine with PFAMC and Factitious. The Rationale- common clinical feature is the clinical

presentation of physical symptoms and or concern about medical illness. 2. De-emphasizes medically unexplained symptoms. Maladaptive Health Behaviors affecting medical condition Work Group Proposed not to include and used above rationalizations. Stress Related.... Workgroup recommended not to include same as above other or unspecified..... Work Group proposed not to include and used above rationalizations.

Substance-Related Disorders

Pleased to see the **Cannabis Withdrawal** was added to the DSM V. I work in dual diagnosis unit and witness first hand withdrawal symptoms related to heavy cannabis use. With this edition, patients experiencing cannabis withdrawal may receive the appropriate treatment in crisis centers and emergency treatment centers.

APNA supports the categorization of all substance abuse/dependence under the heading of disorders as it is more succinct. The distinction between abuse and dependence is not clinically significant in this population. Some patients are dependent on substances (i.e. for pain control) but do not necessarily abuse those substances. Additionally, they do not meet the criteria for a substance use disorder and are incorrectly viewed as having a substance ‘problem’ when the diagnosis of Substance Dependence is used. Clarifying tolerance/withdrawal will help to decrease the stigmatization that people with pain or anxiety disorders experience.

APNA supports the addition of Gambling Disorder in the category of addiction.

Mood Disorders

Replacing Dysthymic Disorder with Chronic Depressive Disorder is not supported by APNA as the word chronic would decrease hope in those who have this disorder. Language is powerful and can be used to increase one’s sense of hope or increase a sense of victimization and/or stigmatization.

The proposed recommendation to eliminate the diagnosis of ‘Mixed Episode’ to the creation of the specifier ‘Mixed Features’ to each mood disorder is supported by APNA.

What is the rationale for the proposed reintroduction of the diagnosis Melancholia? Also, APNA would like more information about the proposed diagnosis of Apathy Syndrome.

Anxiety Disorders

Clinical Anxiety Scale located in the anxiety dimension.

Clinicians at APNA are considering a simple method by which anxiety severity may be rated on a single dimension. This would be useful for both mixed anxiety depression and major depression accompanied by anxiety:

Anxious Symptoms:

- A. describes (irrational) worries
- B. feeling uneasy
- C. feeling nervous
- D. motor tension
- E. feels something awful may happen

Anxious Distress- defined as 3 or more of the above anxious symptoms.

0. Not anxious
1. Mildly anxious
2. Moderate Anxiety??? 2 symptoms
3. Severely Anxious 3-5 symptoms
4. Severely anxious with motor agitation

I currently use a scale of 0-10 in my own practice. 0 represents "cool as a cucumber" and 10 representing "unbearable anxiety". I am happy to see that this scale may be a uniform quick clinic tool to utilize to address anxiety distress found in a large portion of my patient population

Somatoform Disorders

Rename Somatoform disorder to somatic symptoms disorder and combine with PFAMC and Factitious. The common clinical feature is the presentation of physical symptoms and or concern about medical illness.

Factitious Disorders

Dissociative Disorders

Dissociative Fugue fits well as a sub category of Dissociative Amnesia.

Sexual and Gender Identity Disorders

Eating Disorders--Rename this disorder to be more inclusive -- "Eating and Feeding Disorders"-- include a definition of each term.

Binge Eating Disorders (BED) APNA supports the addition of this diagnosis. The diagnostic criteria are clear and distinct from anorexia nervosa and bulimia. The diagnostic criteria would indicate that the binge eating occurs, on average, at least once a week for three months. It is important to clarify "three consecutive months" or "three months in the past year".

Anorexia Nervosa The changes recommended enhances our ability to use the criteria to include persons who had this disorder but did not meet all the diagnostic criteria. It removes pejorative language such as "refusal" and inserts nonjudgmental words such as "restriction of food intake." Changes in criterion B expand inclusivity from just those with intense "fear of gaining weight or becoming fat" to those who may not express fear, but their "behavior" suggests they are avoiding weight gain, even though they are underweight. The removal of Criterion D is also supported as there are other factors that influence the onset and/or presence of menarche. Males with this disorder can now be appropriately placed here instead of in Eating Disorder NOS. The provision of two subtypes-restricting and binge-eating/purging-is a more descriptive picture of the actual disorder and may help to dispel some of the common misconceptions regarding this disorder.

Bulimia Nervosa The recommended revisions are modest and remove the specific type (purging and nonpurging)--mostly because nonpurging type more closely resembles BED thus these patients would receive the new diagnosis of BED. The only other recommended change is that the binge eating occurs at least once a week for three months rather than previously twice a week--again, clarification whether the three months are consecutive or during a year might be useful.

Eating Disorder NOS the only relevant comment is that adding BED might decrease the need for this category.

The proposed inclusion of the Avoidant/Restrictive Food Intake Disorder is also supported. The recognition of the proposed criteria within the older adult has been recognized by NANDA International as 'Adult Failure to Thrive' (1998) and 'Inadequate Nutritional Intake: Eating Less Than Body Requirements' (1975/2000).

Sleep Disorders

The proposed revisions include the addition of 10 sleep disorders that are not currently listed in the DSM-IV-TR. The addition of these diagnoses brings the DSM in line with the current ICD and ICSD (International Classification of Sleep Disorders, 2nd edition). These changes will strengthen the DSM nomenclature from a number of positions, one of the most salient being that the range of sleep disorders pertinent to psychiatric disease are brought into perspective for the psychiatric/mental health clinician. The inclusion of these diagnoses will strengthen specificity of diagnostic options for psychiatric and mental health practice across disciplines.

Three current DSM IV-TR diagnoses are slated for possible removal. The rationale behind the removal is based on evolving evidence in science which facilitates greater specificity and precision in the diagnoses proposed in their stead. These are excellent proposals, given the evolution of the state of the science in sleep and wakefulness.

The proposed changes to the insomnia and hypersomnia diagnoses are really refreshing to see. The previous iterations of the disorders separated the diagnoses into etiological categories, e.g., related to medical or psychiatric conditions whereas the proposed newer diagnoses approach these conditions globally with specific subtypes to specify medical or psychiatric etiologies. The same reasoning is followed with a number of the primary sleep disorders which consolidates the diagnoses and I expect will make the use of the diagnosis easier for clinicians.

As a clinician who works in the area of sleep and psychiatric illness, I have no criticisms to make. The changes are really important to clinical work and will facilitate the application of these diagnostic categories to the treatment of persons with psychiatric illnesses.

APNA supports the proposed addition of Parental Alienation Disorder. While there is ongoing debate in the literature regarding the validity of this diagnosis, this phenomenon has been recognized by the NANDA International since 1994 as 'Risk for Impaired Parental/Infant/Child Attachment'.

Adjustment Disorder

1. By changing the criteria from "either" to "both" there is synchronicity to other mental disorders.
2. The other language changes appear to be a directed change to use a person-centered treatment philosophy as is being promoted by the Institute of Medicine and is a beneficial change to add this language.
3. We support the elimination of the acute and chronic specifiers.
4. Concerned that this diagnosis will be used improperly when a patient is underreporting a stress reaction or the clinical evaluation is insufficient to determine that symptoms meet criteria for the PTSD or ASD. Support modifications to the PTSD and ASD criteria and allow this diagnosis to remain more general than specific. .

The proposed changes in this category will be useful--the proposal would recommend including AD in grouping of Trauma and Stress-Related Disorders--the recommendations would further distinguish this diagnosis from a diagnosis caused by trauma--moreover, it also adds a useful specification which is "With PTSD-Like or ASD-Like symptoms but these symptoms or stressors do not meet criteria for PTSD or ASD"--this particular sub-type is being considered and strongly recommend its inclusion.

Personality Disorder

Personality Assessment Formats: I prefer Option 2

Type and Trait Cross-Walk: the table is useful as a reference for the trait/disorder changes Borderline

Personality Disorder name change to Borderline Type.

With the elimination of PD NOS, then will Deferred be used for a much longer period? This would result in underpresenting to non-psychiatric clinicians the opinion that significant traits do exist, however, the determination of exact category cannot be definitively made until a later date. I would prefer the continuation of PD NOS. Much education and practice will be needed to correctly understand and implement the categories. Will the APA be offering free educational opportunities to clinicians to reinforce the new information? Overall DSM5 changes: will the World Health Organization at the same time adopt changes concurrent with DSM publication, so that ICD codes will change worldwide allowing for accurate billing?

APNA supports the significant revisions for Personality Disorders as proposed in the DSM-5 draft. It is thought that these proposed changes may allow the clinician to provide nonjudgmental and unstigmatized care.—APA may consider realigning Borderline Personality Disorder to Axis I in the category of Bipolar Disorders (e.g., Bipolar Spectrum Disorder) Patients with Borderline Personality Disorder experience similar yet less severe emotional dysregulation as that of patients with bipolar disorder This realignment may help with decreasing the social and behavioral stigma associated with the Borderline Personality Disorder label.

[George comments: I have concerns with the accuracy of this proposal. Personality Disorder or separate from Bipolar Disorders based on science. I understand the issue and even agree with the statements just not in the context of the DSM V.]

The proposed changes from ten to five personality disorder types are well articulated and are based on sound science. The five proposed diagnostic groups to Personality Disorders--Antisocial/Psychopathic Type, Avoidant Type, Borderline Type, Obsessive-Compulsive Type, and Schizotypal Type—include comprehensive specific personality trait profiles and scales which provide better clinical guidance for diagnosing and treatment. —The APNA supports the elimination of Personality Disorders-Not Otherwise Specified in order to provide clarity in the diagnostic selection. The inclusion of the six personality traits (negative emotionality, introversion, antagonism, disinhibition, compulsivity, and schizotypy) with the defined domains and facets proposed will assist clinicians in better diagnosing and treating these disorders.

Antisocial Personality Disorder APNA supports the recommendation to change Antisocial Personality Disorder to Antisocial/Psychopathic Type. Clinicians will benefit from the inclusion of the 5-point likert-type scale which measures nine specific personality traits The scale may enable clinicians to measure the severity of the patient's disorder.

Borderline Personality Disorder —APNA supports the inclusion of the ten traits with ratings which provide categories reflective of clinical practice. The scale's ability to distinguish the functioning level of a patient will be useful in the diagnosing and treatment of Borderline Personality Disorder.

Depressive Disorder Not Otherwise Specified - The NOS category is often over used for various reasons (lack of clinician time, lack of education or experience, limiting stigma, billing concerns).

I see depressive disorder NOS and Mood disorder NOS all too often in community psychiatry and feel the category should be limited and concise in content to avoid overuse and thus under diagnosing. The group working on the DSM-V seems to be considering this problem and I feel this may lead to more precise diagnostic evaluation.

Our organization has been honored to take part in this historic process by providing you with our feedback.

Sincerely,

A handwritten signature in black ink that reads "Mary D. Moller". The signature is written in a cursive, flowing style.

Mary D. Moller, DNP, APRN, PMHCNS-BC, CPRP, FAAN
President
American Psychiatric Nurses Association