Most students enter introductory or abnormal psychology courses with a naively realist concept of what constitutes mental illness, and most textbooks do little to complicate this understanding. The tendency to reify the various diagnostic categories of the mental health disciplines into stable and independent illnesses is ever present. A critical review of the development of successive versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) can help instructors demonstrate the evolving ways in which mental health and illness are conceptualized and reveal the cultural, political, and economic forces that shape this process. This article provides a brief general review of this history, along with useful pedagogical questions and suggestions for integrating this material into the classroom.

Keywords: mental health, mental illness, dsm, history, teaching
The History

American psychiatric classification describes a kind of arc—beginning with something like a mental disease census, then moving, around the time of World War II, toward a dynamic (and largely psychodynamic) characterization of psychopathological “reactions,” and ultimately, from the 1970s to the present, returning again to a medical disease classification model, with an additional and increasing emphasis on theory-neutral and empirically validated diagnostic taxonomies.

The first standardized classification manual, the *Statistical Manual for the Use of Institutions for the Insane* (National Committee for Mental Hygiene, 1918) included instructions for institutions about how to prepare uniform “statistical data cards” for each patient, including mostly demographic information (age, ethnicity, occupations, etc.) along with some basic information about the presenting “psychosis.” The bulk of the manual described 22 major diagnostic categories along with their most common manifestations. About half of the diagnoses dealt with symptoms of a presumed biological origin (brain trauma, alcohol use, disease, etc.), and nearly every diagnosis involved some biological component. Of the 22 categories, only one, “psychoneuroses and neuroses,” was directly acknowledged as “essentially psychogenic in nature” (p. 26). Ten revisions followed this original 1918 manual, and these included some significant changes, but the essentially biological and medical orientation toward the classification of mental illness remained consistent into the 1940s.

Around the time of World War II, the American approach to psychiatric diagnosis changed radically. Grob (1991) argued that a large number of psychiatrists involved in treating war-related psychological trauma found success in applying psychodynamic therapies to psychogenic disorders and, as a result, these clinicians became dissatisfied with the existing biologically oriented, symptom-based classification system. One expression of this disaffection was the formation of a committee from the Office of the Surgeon General, Army Service Forces, 1946/2000), adopted a new way of classifying psychopathology. The term *disorder* was used to refer to a “generic group” (p. 925), whereas specific diagnoses were always referred to as “reactions.” The term *reaction*, inspired by the work of Adolf Mayer (Houts, 2000), reflected the way *Medical 203* conceptualized psychopathology as a dynamic response to various distressing circumstances, as opposed to the more stable, biological, and hereditarian notions visible in the previous statistical manuals. The specific language of the document also explicitly invoked the psychodynamic theory that had risen to prominence in the war. Throughout this short document, psychiatric disorder was characterized in primarily psychological, rather than biological, language. Of the 10 basic diagnostic categories, only “disorders of intelligence” and “organic psychoses” mentioned any biological or hereditary origins for psychopathology, a radical break from the statistical manuals of the first half of the 20th century.

In the forward to *DSM–I* (American Psychiatric Association, 1952), George Raines indicated that the impetus for the development of the *DSM* was the consolidation of the many existing diagnostic nomenclatures, including those in use at the Veterans Administration and the Army, both based on *Medical 203*. Raines indicated that *DSM–I* was considered the successor to the *Statistical Manual*, but the content and underlying philosophy of the manual more clearly indicate its provenance from *Medical 203*. *DSM–I* maintained the psychodynamic language and the basic terminology of the generic “disorder” and the more specific “reaction,” and many of the passages in the manual were virtually identical to those in *Medical 203*. The basic diagnostic categories were also decidedly similar to those in *Medical 203*, some, such as psychoneurotic or psychotic disorders, bearing the same title and others simply renamed.

*DSM–II* (American Psychiatric Association, 1968) appeared partly as a response to the “success of the World Health Organization in promoting its uniform International Classification of Diseases (ICD)” (p. vii) and so represented an attempt to create more uniformity across these two classification systems. The account of this process, as well as *DSM–II* itself, makes it clear, however, that the ICD was changed much
more than was the DSM. In the introduction to DSM–II, Morton Kramer, a member of the Committee on Nomenclature and Statistics, which was responsible for drafting the manual, lauded this achievement and the U.S. influence: “The U.S. recommendations presented by Dr. Henry Brill in Geneva had considerable impact on the form and content of the final classification” (p. xv). Although the diagnostic logic of the DSM prevailed over that of the ICD, there were some significant changes in DSM–II from DSM–I—for example, DSM–II dropped most of the “reaction” language, although some diagnoses continued to use that terminology. There were also some changes in the names of diagnostic categories and descriptions, as well as the addition of new categories, most notably the addition of a special section for childhood disorders. The basic psychodynamic roots of diagnosis, however, remained unchanged in DSM–II.

Although the changes from the first to the second edition of the DSM were fairly minor, the philosophy of DSM–III (American Psychiatric Association, 1980) represented a profound break from these previous classification systems. The ancestors to the DSMs emphasized the continuity of medicine and psychiatry, but the first two editions of the DSM represented a “drift of American psychiatry away from its medical base” (Guze, 1982, p. 7). DSM–III, however, followed a broader development in American psychiatry that, according to Guze, advocated “committing itself anew to that quintessential medical activity: diagnosing illness” (Guze, 1982, p. 7).

This remedicalization of the DSM through the emphasis on diagnosis formed a core guiding principle for DSM–III, as Robert Spitzer, the chair of the Task Force on Nomenclature and Statistics that framed DSM–III, indicated, “the approach that was adopted by the DSM–III Task Force, from Robins and Guze’s recommendations, was the use of specified diagnostic criteria for virtually all of the disorders—the major innovation of DSM–III” (Spitzer, 1991, p. 294). Contrary to the more dimensional approach characteristic of the first two DSMs, these diagnostic criteria framed mental disorders in much more categorical terms, implying the possibility that the named disorders might be discrete and bounded entities. Of course, DSM–III (American Psychiatric Association, 1980) itself cautioned against such thinking: “In DSM–III there is no assumption that each mental disorder is a discrete entity with sharp boundaries (discontinuity) between it and other mental disorders, as well as between it and No Mental Disorder” (p. 6)—but the manual still disavowed the notion of disorder as a continuum of reactions (as in earlier manuals) and instead asserted that what are being classified are disorders that individuals have. For this reason, the text of DSM–III avoids the use of such phrases as “a schizophrenic” or “an alcoholic,” and instead uses the more accurate, but admittedly more wordy “an individual with Schizophrenia” or “an individual with Alcohol Dependence.” (p. 6)

Disorders, in DSM–III, were entities that individuals “have” rather than a spectrum of responses that individuals perform.

DSM–III also explicitly attempted to remove all evidence of earlier psychodynamic explanations for disorders and, instead, reframed diagnostic categories according to symptom clusters or patterns. This move to atheoretical and symptom-based language was partly justified by the lack of useful etiological knowledge (the same argument used to justify the symptom-based approaches in the manuals preceding DSM–I), but such language was also intended to make the manual accessible to clinicians of differing theoretical commitments: The major justification for the generally atheoretical approach taken in DSM–III with regard to etiology is that the inclusion of etiological theories would be an obstacle to use of the manual by clinicians of varying theoretical orientations” (American Psychiatric Association, 1980, p. 7). The removal of explicitly theoretical descriptions left DSM–III without any clear basis for the diagnostic categories provided, other than the consensus of clinical judgment, but the framers of the manual considered empirical evidence to be the appropriate check on the idiosyncrasies of personal judgment: “In attempting to resolve various diagnostic issues, the Task Force relied, as much as possible, on research evidence relevant to various kinds of diagnostic validity” (p. 3). This assertion reflected the growing belief that the diagnosis and treatment of mental disorders would have to be based on “data,” as Spitzer explicitly avowed when he indicated his membership in a group of intellectuals “harmoniously committed to the pursuit of data that will help us understand the multiple determinants of mental illness and the relative effec-
tiveness of various biological, psychological, and social treatments” (Spitzer, 1982, p. 592).

Subsequent revisions of the DSM have been less radical than were the shifts in the third edition. Work on DSM–III–R (American Psychiatric Association, 1987) began in 1983, only 3 years after the publication of DSM–III. This new revision was partly a response to requests for recommendations from the framers of ICD-10, but the revision was also motivated by the fact that “data were emerging from new studies that were inconsistent with some of the diagnostic criteria” (American Psychiatric Association, 1987, p. xvii). Revisions included renaming and reorganizing some categories (perhaps the most significant of these changes being the addition of the new category “developmental disorders”), removing and adding a small number of categories, and changing some of the diagnostic criteria for various disorders.

Work on DSM–IV (American Psychiatric Association, 1994) began in 1987 so that “development could be coordinated with the ongoing development of the 10th revision of the International Classification of Diseases” (First & Pincus, 2002, p. 288). As in DSM–III–R, changes in DSM–IV focused primarily on the reorganization of categories and criteria, rather than on any major theoretical shifts. Among the most significant changes in the manual were a greater emphasis on culture-specific aspects of diagnosis—including new discussions of “cultural variations,” “culture-bound syndromes,” and ways of reporting “cultural context” (American Psychiatric Association, 1994, p. xxiv), all based on the assumption that “the DSM–IV must not be culture specific but instead be applicable cross culturally” (Frances et al., 1991, p. 409)—and an explicit endorsement of a biopsychosocial model of disease—that is, a model in which the very notion of “mental” disorder is “a reductionistic anachronism of mind/body dualism” (p. xxi) and “most, if not all, mental disorders result from a complex and varying interplay of biological, psychological, and environmental risk factors” (Frances et al., 1991, p. 409).

Perhaps the most significant changes in DSM–IV (American Psychiatric Association, 1994) were in the revision process itself, an assertion endorsed in the manual: “it is our belief that the major innovation of DSM–IV lies not in any of its specific content changes but rather in the systematic and explicit process by which it was constructed and documented” (p. xvi). This process was, indeed, more systematic than in previous revisions, “obtaining and reviewing empirical input through three distinct, but interactive, stages, namely, literature reviews, data reanalyses, and field trials” (Widiger, Frances, Pincus, Davis, & First, 1991, p. 282). Perhaps more important, these review stages involved input “solicited especially from those persons likely to be critical of the conclusions of the review” (American Psychiatric Association, 1994, p. xix). The avowed purpose of this new revision process was “to develop methods of reviewing literature and doing data reanalyses and field trials so that decisions are based on evidence, not individual opinion” (Frances et al., 1991, p. 409). The degree to which decisions were based on evidence as opposed to opinion, however, is uncertain. As Robert Spitzer, the primary architect of DSM–III and III–R and an influential advisor in the creation of DSM–IV, stated during the DSM–IV revision process, “My own prediction is that when final decisions are made about DSM–IV, they will still be based primarily on expert consensus, rather than on data, as was the case with the DSM–III and DSM–III–R” (Spitzer, 1991, p. 294).

The current version of the DSM, DSM–IV–TR (American Psychiatric Association, 2000), made no changes to the diagnostic categories and made very few changes to the specific diagnostic criteria and diagnostic codes in DSM–IV. Work on DSM–V began shortly after the release of DSM–IV–TR, and it is poised to be published in 2012.

Discussion of the Pedagogical Questions

Why Did the Framers of the Modern DSMs Attempt to Create a “Theory-Neutral” System of Classification?

Around the time of the transition between DSM–II and DSM–III, the mental health professions faced a number of serious challenges to their legitimacy. The antipsychiatry movement (Szasz, 1960), including challenges from both professionals and patient advocacy groups, had gathered momentum, the psychodynamic approach at the root of the early DSMs was in
decline (Galatzer-Levy & Galatzer-Levy, 2007), and the manual itself was under attack, both in terms of its lack of empirical validation (Mayes & Horowitz, 2005) and because of certain controversial diagnostic categories (e.g., homosexuality).

These challenges presented a very particular problem: How could a diagnostic manual, like the DSM, become a pluralistic diagnostic tool, one amenable to the multiplicity of therapeutic and political contexts reflected in the American mental health professions? The earlier diagnostic schemes, based as they were on what were considered unverifiable psychodynamic explanatory mechanisms, seemed unsuitable. Other available theories, however, could claim no more empirical or political support and so, in DSM–III (American Psychiatric Association, 1980), the decision was made to construct a diagnostic system “atheoretical with regard to etiology or pathophysiological process” (p. 7) and so return to the symptom-based form of diagnosis employed in the pre-DSM classification schemes. DSM–III itself acknowledged that for most disorders “the etiology is unknown” (p. 6), and so a theoretical form of classification was unwarranted in any case. Many have since argued that theoretical neutrality is an impossibility (Halling & Goldfarb, 1996), and that the pretence of theory neutrality has only served to obscure the particular assumptions about mental illness and its treatment that undergird the DSMs.

What Assumptions About Mental Illness Are Reflected in the Different Classification Schemes Employed in the DSMs?

The model of mental illness undergirding DSM–I and DSM–II is obviously more explicit than the models guiding subsequent revisions, given that these early DSMs attempted to produce a theoretically integrated model of psychic functioning. These manuals depicted mental illnesses as essentially maladaptive reactions definable along various continua but not identifiable as discrete entities. Beginning in DSM–III, however, mental illness was explicitly separated from the murky realm of actions and reactions and was instead granted an independent ontological status. Mental illness shifted from something that you did, or perhaps were, to something that you had. In this classification scheme, the goal now became identifying as precisely as possible a distinguishable set of syndromes or illnesses. Of course, DSM–III (American Psychiatric Association, 1980) does disavow the notion that “each mental disorder is a discrete entity with sharp boundaries” (p. 6), but the manual belies this disavowal in two important ways—first, DSM–III grants mental illnesses the status of entities, even if we are told that these entities are not sharply defined, and, second, naming distinct disorders and providing specific criteria for them institutionalizes a diagnostic and research praxis in which categories of mental illness are functionally distinct, an essentially irresistible force in normalizing the notion of discrete disease entities.

This emphasis on discrete and definable illnesses coincided with, and helped to reinforce, at least two additional assumptions about mental illness. The first of these was a return to the medicalized, symptom-based approach to diagnosis characteristic of pre-DSM classification and the second was a renewed emphasis on empirical validation for diagnostic categories and criteria. This move toward discretely definable, symptom-based, empirically validated diagnostic categories defined mental illness in a very particular way, separating it from its earlier humanistic, socially embedded context and moving it toward the more objectivist, positivistic, and scientistic psychology of the second half of the 20th century.

What Role Did Personal, Social, and Political Concerns Play in the Development of the DSMs and of the Diagnostic Criteria Now Used to Define Mental Health and Illness?

There are undoubtedly many reasons for the shifts in diagnostic philosophy described here, but perhaps the most compelling are the personal, social, and political ones. If one were to ask what person, more than any other, has influenced our conception of mental illness, we would likely hear names such as Freud, Rogers, or perhaps Ellis. We would likely not hear names such as Robert Spitzer or William Menninger, but such names may very well be more historically accurate answers to this question. In their respective eras, both of these men led movements intended to reform American psychiatry and, ultimately, their particular visions
of mental illness determined, to a significant degree, the limits of officially sanctioned diagnosis for generations of mental health professionals.

In 1946, Menninger, along with a group of like-minded professionals, formed the Group for the Advancement of Psychiatry (GAP), whose “social activism and emphasis on a psychodynamic social psychiatry” (Grob, 1991, p. 428) had a tremendous influence on American psychiatry. The psychodynamic and socially embedded focus promoted by Menninger and other GAP members was obvious, explicit, and central, first, in Medical 203, authored by a Menninger-led task force, and, later, in the first two editions of the DSM, both of which were based on Medical 203.

In a later era, Robert Spitzer was also prominent in a reform movement sometimes (following Klerman’s, 1978, book chapter) called the neo-Kraepelinian school. According to Blashfield (1982), this movement “strongly advocated a scientific approach to classification, supported the medical model, engaged in biological research, and eschewed the psychoanalytic perspective” (p. 4). Unlike GAP, this group was not a formal one, and Spitzer (1982) himself disavowed any membership in a “neo-Kraepelinian college” (p. 592), insisting instead that his only allegiance was to “data-oriented” (p. 592) psychiatry. Nevertheless, there is no question that, along with others, Spitzer’s work successfully advocated for a return to the symptom-based, medically oriented, and empirically justified form of psychiatric diagnosis. Spitzer himself participated in the revision of DSM–II, led the revolutionary revision that became DSM–III, and performed an important advisory role in subsequent revisions, work that ensured the institutionalization of a new form of classification.

Of course, political considerations also transcend individual interests. At least part of why the change in the modern DSMs gained traction was due to the way that they addressed other social and political pressures. The case of homosexuality as a diagnostic category is a good example. The presence of this disease classification in DSM–II produced public protests and private lobbying that eventually led to its removal in the seventh printing of DSM–II, essentially on the basis of an American Psychiatric Association vote (Mayes & Horowitz, 2005). Likely even more influential than particular social movements were the political and economic pressures brought to bear by the role that the diagnosis of mental illness plays in the insurance industry and in funded research. Many authors (e.g., Galatzer-Levy & Galatzer-Levy, 2007; Mayes & Horowitz, 2005; Pilecki, Clegg, & McKay, 2011; Rogler, 1997) have argued that the rise in drug-based therapies, the need to secure government funding for research, and the need to define mental illness in the third-party payer system all necessitated the very changes that the modern DSMs instituted—namely, discretely definable, symptom-based illnesses amenable to “objective” (and thus fundable) empirical validation and to the standardized treatments, and especially category-specific drug treatments, necessary for determining insurance coverage.

It should not be surprising that such personal, social, and political concerns play so important a role in the DSM revision process because the manual has always been produced by committee and so also by consensus. As such, the final product of any revision process will reflect the assumptions, interests, and commitments of those who occupy the seats of influence—that is, it will be at least as much a political product as it will be a scholarly one. Even with the significantly increased transparency of the DSM–IV revision process, the political wrangling involved led Caplan (1991), an invited advisor to the revision task force, to decry the process as “highly political” and “plagued by various issues of bias and arbitrariness” (p. 162).

**What Is the Relationship Between Mental Illness and the Diagnostic System We Use to Identify, Study, and Treat Mental Illness?**

It is always tempting to see a category such as “schizophrenia” or “bipolar disorder” as something discrete, as a clearly definable biological entity, but the history of the DSMs makes it clear that whatever “mental illness” is, it is not as easily definable as some obvious organic dysfunction. Just as it was in the early 20th century, it remains the case that we know of no clearly definable biological etiologies for our categories of mental illness. Indeed, the ways that mental illnesses are defined have always been, and continue to be, principally by consensus rather than in terms of organic pathology.
Mental illnesses are fundamentally socially embedded categories, and so subject to fad, to politics, and to economic pressures. There is little sense, then, in thinking about diagnosis as the act of properly identifying independent disease entities. Whatever mental illness is, it has not remained a static backdrop for increasing diagnostic sophistication. As the DSMs have changed, so also has mental illness itself.

References


Received July 28, 2011
Revision received July 28, 2011
Accepted January 6, 2012