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Volume 4 | Article 12

Fall 2003

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Jackson, E. D. (2003). Organizing Madness: Psychiatric Nosology in Historical Perspective. *Inquiry: The University of Arkansas Undergraduate Research Journal, 4*(1). Retrieved from https://scholarworks.uark.edu/inquiry/vol4/iss1/12

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ORGANIZING MADNESS:

PSYCHIATRIC NOSOLOGY IN HISTORICAL PERSPECTIVE

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Abstract:

This paper traces the history of psychiatric nosology in the US from its origins in the early 19th century through the most recent revision of the standardized classification, DSM-IV TR. The evolution of nosology is found to be shaped not only by advances in knowledge, but also by socio-historic and professional trends. The initial impetus for systematic classification came from outside the mental health profession, but later revisions reflected intraprofessional struggles and experiences. Future revisions will almost certainly be prone to these same intra- and extraprofessional influences, and may see a dramatic shift away from symptomatology and towards an etiological focus.

Editor's note: Space limitations precluded publication of the entire thesis. The complete paper, including the following omitted sections can be found on the Inquiry website: Early Classification Systems and the Rise of American Psychiatry, Kraepelin and the Movement to Classify, Creating a Standardized Nosology, the Experiences of World War II, *DSM-III* and the Next Nosological Revolution, and *DSM-IV*: A Significant Change.

Introduction

In a back page essay that appeared in Time late in 2002, Walter Kim (2002) commented on the ever-increasing number of mental disorders that were recognized by the American Psychiatric Association (APA).[1] "Given so many maladies to choose from," he said, "a person who can't find at least one of his problems covered in DSM-TV must have something really wrong with him" (p. 92).

The *Diagnostic and Statistical Manual of Mental Disorders (DSM),* now in its fourth edition *(DSM-IV)* is a mental health clinician's primary tool for identifying and categorizing mental disorder in the United States. It contains a list of all mental illnesses currently recognized by the APA along with detailed descriptions of each disorder and a set of criteria that aid in identification and diagnosis. *DSM*'s influence, however, extends beyond diagnostic boundaries: it guides research into psychoactive pharmaceuticals, it is used by insurance companies to authorize reimbursement for mental health services, and its definitions and disorders often play a role in legal decisions of sanity and culpability. Fundamentally, *DSM* delineates in our society which behaviors are reasonable and expected in the course of a normal lifestyle and which behaviors constitute the presence (if mental illness.

As mentioned, *DSM* is currently in its fourth edition, indicating that it has not remained the same throughout its existence. In fact, it has at times undergone massive reorganizations and if the first version of *DSM* were placed next to the most recent edition the two books would scarcely seem related. Revisions and reprinting are not uncommon events in and of themselves; many documents, from textbooks to tax codes to college guides,go through multiple editions over the course of time. There is no reason to expect that classification schemes for mental illness would be any different, for as Grob (1991) noted, "Nosologies[2] - psychiatric or otherwise - are rarely etched permanently in stone" (p. 430).

Bearing this impermanence in mind, the purpose of this paper will be to explore the reasons behind change in psychiatric nosology, and particularly *DSM*, throughout the history of American mental health care. If *DSM* is simply a compendium of science based knowledge regarding mental illness, accruing more knowledge and drawing closer to a definitive system with each edition, then this would simply be a history of the accumulation of formal psychiatric knowledge. As it would happen, this is not the case. As Bayer and Spitzer (1985) explained:

> For many years, philosophers concerned with the explication of the logic of scientific inquiry portrayed an image of scientific progress that disregarded the extent to which social and professional interests came into play Scientific activity and controversy are now understood to be affected in important ways by intraprofessional interests, as well as by broad historical and social trends (p. 195).

Consideration of these professional interests and socio-historical trends place the DSM into a much broader focus, illustrating the various events and transactions - both inside and outside of psychiatry - that have motivated revisions of psychiatric nosology and revealing some of the implications these alterations had, and continue to have, on the process of understanding and diagnosing mental illness.

The Creation of *DSM*

Grinker and Spiegel's sentiments, written in 1944, were shared by a great many of WW II's returning psychiatric professionals and would ultimately shape the construction of a revised clinical nosology. As previously mentioned, these returning individuals constituted nearly half of the total number of psychiatrists in America, and they were a group eager to apply the psychiatric lessons they had learned in war to mental health practices at home. This "group" of like-minded practitioners, however, was at the moment informal; they were not unified under any common heading. Without some sort of organization, it is unlikely that such a diverse population could have enacted a lasting change in the profession of psychiatry.

An organization did emerge, though, under the leadership and influence of William Menninger. In 1946, the Group for the Advancement of Psychiatry (GAP) was founded at a meeting of the APA, the organization that the GAP was determined to reshape. Grob (1991) summarized the thrust of the movement well in saying, "The new organization [GAP] was based on the presumption that psychiatry's responsibilities and functions transcended institutional care and treatment of the mentally ill. 'I do feel,' Menninger told a colleague in early 1947, 'that American psychiatry needs renovation in the sense of consideration of social problems and social needs' " (p. 428).

Though it cannot be said with certainty, one can conceive that Menninger called it a "renovation" and not a "revolution" out of hesitance to invoke such language in the wake of a World War, rather than as the most adequate portrayal of the circumstances surrounding the creation of the GAP. Menninger envisioned a sweeping change in the aim of professional psychiatry, much more than a simple retooling of what was already present. From the rhetoric of visionary mental health professionals of this era, a sense of far-reaching social activism emerges, and that is exactly what Menninger and the GAP were advocating.

Little time was wasted in beginning the nosological revision: in 1948 the APA Committee on Nomenclature and Statistics opted to postpone changes in its current manual (i.e. *Statistical Manual for the Use of Institutions for the Insane*) and instead sought suggestions for a major change. By 1950 the Committee had prepared a draft of the new psychiatric nosology, an amalgam of three nomenclatures in use by the close of WWII: the APA's Standard Classified Nomenclature of Disease (the *Statistical Manual*), the Armed Forces Nomenclature (*War Department Technical Bulletin, Medical 203*), and the Veterans Administration Nomenclature (only slightly different from *Medical 203*) (Hours, 2000, p. 945).

The process of revision took only two years. The 1950 draft of the new manual, titled the *Diagnostic and Statistical Manual: Mental Disease (DSM)*, was circulated to various individuals and organizations within the psychiatric profession and also to a sample of 10% of the APA membership (selected to represent a cross-section of geographic locations, occupational settings, and organizational memberships). Of that ten percent, 46% returned the 9-page questionnaire accompanying the draft, and 93% of these respondents were said to have approved the initial draft (Houts, 2000, p. 945). A second draft was prepared utilizing this first set of revisions, and this draft was approved by the APA membership and its governing body in 1951; the manual was published and distributed by the APA the following year.

In *DSM*, mental illness was divided into three broad, logical categories: organic brain syndromes, functional disorders, and mental deficiency (retardation). Comparatively, the *Statistical Manual* had twenty-two, rather specific categories. Additionally, *DSM* was much less dominated by psychoses and contained greatly expanded sections on psychoneurotic reactions, personality disorders, and transient situational personality disorders. Finally, as the name of the new manual suggested, it was not only oriented toward the facilitation of gathering statistical information but also towards professional diagnosis. George Raines (1953), chair of the committee responsible for *DSM*, explained why:

> It has become popular to decry diagnosis of psychiatric illness with the contention that each patient is an individual so different that standard labels cannot be applied. Without sound diagnosis, statistics are inaccurate and misleading, or unavailable; factual data cannot be accumulated from past experience to guide the future; and accumulated knowledge is transmitted with great difficulty, if at all (Raines, 1953, p. 548).

Ultimately, and in contrast to the *governmental* influences behind the previous standard nosology, *DSM* is best seen as a document influenced by sweeping changes in both the professional and social ideology of psychiatric *practitioners* in the years after WWH. Professionally, practitioners switched from a primarily medical, biological orientation to a chiefly psychoanalytic view as a result of their experiences in WWII; this change is mirrored in the greatly increased prominence of psychodynamics in *DSM*. In terms of social ideology, psychiatrists became much more interested in applying mental health practices to non-institutional populations as a result of growing social activism and prevailing post-war ideas of social betterment. William Menninger (1947/1967) explained this social activism by saying:

> Psychiatry should place high priority on its efforts to provide the "average" person with psychiatric information he can apply to his own problems. The public wants this education, Very possibly it may increase the number of patients who seek help from a psychiatrist, just as a campaign about cancer or tuberculosis increases the number of patients who go to doctors about these problems (p. 579).

Menninger's last sentence, in particular, highlights one of two caveats to the seemingly altruistic social activism proposed by post-war psychiatric professionals. This "possible increase in the number of patients" seeking psychiatric services was not only an off-handed coincidence of an increase in education, but also a professional necessity if the huge number of psychiatrists returning from the war were to have any hope of working. A doubling of active practitioners in psychiatry, which WWII generated, would need (at least) a doubling of patients in order to sustain that many professionals.

Secondly, the years after WWU saw a huge rise in the amount of federal funding available for training and research in psychiatry and clinical psychology. For example, as a result of the National Mental Health Act of 1946, the amount of fund dispersed by the NTMH between 1948 and 1962 for research and training grants rose from $374,000 to $42.6 million and from $1.1 million to $38.6 million, respectively (Starr, 1982, p. 346). Clearly there was a lot of money available within various areas of mental health care, creating strong incentives to remain in a profession that previously had been in the doldrums of the medical world.

DSM-II: The First Revision

In contrast to *DSM*, the first official revision of this manual, *DSM-II*, was not accompanied by the broad social and professional changes that shaped *DSM*. As Kutchins and Kirk (1997) explain, "making *DSM-II* was a relatively private and simple process, more like changing rules and regulations within one organization than negotiating treaties among many rivals factions, each with a very different objective" (p. 40). The rather modest goal of the work, according to two of its consultants, Spitzer and Wilson (1968), "is the improvement in treatment and prevention that will evolve with better communication among psychiatrists of all nations" (p. 1929).

Assisting international communication, in fact, was the main motivation for changing *DSM*. The *International Classification of Diseases (ICD)* had long been published by the World Health Organization (WHO) to facilitate the collection of disease statistics, including those on mental illness around the world. In 1965, asked its Committee on Nomenclature and Statistics to revise *DSM* in order to make it compatible with *ICD-8*. The new diagnostic manual would also include changes in professional concepts of mental disorder that had occurred since 1952, namely the inclusion of new disorders and the exclusion of unused ones. Gerald Raines, chair of the committee that produced *DSM*, had anticipated such revisions:

> Sound diagnosis is possible only with a nomenclature in keeping with current concepts of psychiatric illness, and sufficiently flexible and inclusive to permit the introduction of new ideas. It is therefore necessary that psychiatric nomenclature, as well as other medical nomenclature, be revised from time to time to keep it in step with the moving body of psychiatric knowledge (Raines, 1953, p. 548).

The actual process of revising and changing *DSM* was quite simple, and relatively isolated from outside influence. Whereas *DSM* organized mental disorders in to three categories, *DSM-II* contained ten such categories.[7] The categorical increase was chiefly the result of the reclassification of six of the mental illness clusters collected under a single *DSM* heading ("functional disorders") as individual categories to indicate how mental disorder was often viewed in America. *DSM-II* also included a new section on childhood disorders ("behavior disorders of childhood and adolescence") that did not appear in *DSM*. All told, fifty-four diagnoses were added to *DSM-II*, raising the total from 108 in *DSM* to 162 in *DSM-II*, beginning a trend of increasing the number of diagnoses that has continued through the most recent edition (Houts, 2002, p. 20).

Perhaps the most notable occurrence in *DSM-II*, in that it foreshadowed greater changes to come in later revisions, was the elimination of the term "reaction" from the text. "Schizophrenic reaction," for example, became simply "schizophrenia." According to the Committee on Nomenclature and Statistics, this was done in order:

> ... to avoid terms which carry with them implications regarding either the nature of a disorder or its causes ... In the case of diagnostic categories about which there is current controversy concerning the disorder's nature or cause, the Committee has attempted to select terms which it thought would least bind the judgment of the user (APA, 1968, emphasis in original).

This move towards an atheoretical perspective was for the time being incomplete, as several diagnoses still retained the label of "reaction" ("psychotic depressive reaction," for example). Curiously, the category on childhood and adolescent disorders - the only entirely new set of diagnoses in *DSM-II* - was composed entirely of "reactions."

Taken as a whole, *DSM-II* was only subtly different from *DSM*. The major factors that had influenced the creation of *DSM* (i.e. psychodynamics and shift in focus away from practice in mental hospitals) remained intact in its first major revision. There were hints in its production, however, of greater changes to come. Spitzer and Wilson (1969), replying to various criticisms of *DSM-II*, suggested that future revisions involve various subcommittees to supplement the actions of the small committee

charged with producing the next edition. In the same article, Spitzer and Wilson again noted, perhaps most presciently of all, that, "McCall and Jackson [two who critiqued the volume] make strong cases for considering the neuroses to be essentially symptom complexes devoid of any independent existence as nosological entities. Although we believe these ideas have considerable merit, they will have to convince the profession of their approach before they can be incorporated into an official classification system" (p. 424).

DSM-IV-TR and Beyond

DSM-IV was released in May 1994, amid much coverage in the national media. Receiving far less attention nationally was the release two years later of a *DSM-IV Coding Update* that included numerous modifications in the code numbers assigned to particular mental disorders. Within this slim coding volume was an announcement of intentions to release a text revision of *DSM-IV* in 1999 or 2000, to include no alterations in diagnoses or criteria sets, but instead to make simple additions to sections providing information on course, prevalence, etc. Kutchins and Kirk (1997) recalled with suspicion that, "Very shortly after publication of *DSM-III*, a revision was announced and users were assured that it was to be a minor midcourse correction to incorporate new findings and rectify errors. When *DSM-III-R* appeared, most of the diagnoses had been changed, new ones had been added, and other substantial alterations had been adopted" (p. 265).

The revision of *DSM-IV (DSM-IV-TR)* was released in 2000 to little fanfare. In contrast to the liberties taken by the Work Group to Revise *DSM-III*, the group in charge of *DSM-IV-TR* stayed within the boundaries of a minor text alteration, adding only 50 pages to the manual and no new diagnoses. Its goal was simply to facilitate early inclusion of growth in research knowledge that had occurred, because *DSM-V* was not scheduled for print until at least 2010.

This timeline for *DSM-V* is still intact, with no hints of any changes in the schedule of release. The greater psychiatric profession, however, is already preparing for the next revising process, and a current search for "*DSM-V*" in PsycINFO yields over 35 hits for articles containing both suggestions for the manual and predictions of *DSM- V's* outcome. Barring any major paradigm shifts in the psychiatric profession, *DSM-V* will likely build on the evidence-based tradition that Frances firmly established in the creation of *DSM-IV*. In fact, it is likely that until research psychiatrists lose the hold on the profession that they gained in the 1970's with the fall of the psychodynamic orientation, future revisions will continue to parallel the current research-oriented trends of the mental health care world.

Ultimately, as psychiatry begins to uncover more and more of the "biological abnormalities" to which Kendell (1991) referred, a major shift in psychiatric nosology is liable to occur. This move will be to a diagnostic system that moves away from the current emphasis on symptom-based diagnostic criteria and towards etiological descriptions of mental disorders (Schaffner, 2002). As Kilhstrom (2002) entreats:

> For Kraepelin, diagnosis by symptoms was a temporary fall back, to be used only because diagnosis by pathology and etiology was not possible. This "fallback" has dominated our thinking for more than a century, and it is time to press forward, with all deliberate speed (p. 297).

Such a perspective is not only advocated by Kihlstronn (2002) and Schaffner (2002) but also, more subtly, by those producing each *DSM* edition, who hail each subsequent version as more efficacious and more valuable than the last. Grob (1991) addressed the idea of progress in nosology in the conclusion of his essay on the history of *DSM*:

> To contemporary psychiatrists the history of nosology represents aversion of the idea of progress; advances in knowledge supposedly lay the foundation for the creation of new categories that describe reality in better and more accurate terms. Within such a perspective, the history of psychiatry is moving on an upward gradient toward an ideal end. In this specific instance, the final goal is a definitive and presumably unchanging nosology of mental illnesses (p. 430).

It is difficult to argue with the desire for such an outcome, where all issues of etiology, diagnosis, and treatment can be comprehensively addressed with the publication of a single volume, however unwieldy. However, the want for such an outcome precludes an understanding of the history and development of psychiatry and psychiatric nosology; insights provided by this professional meta-narrative illuminate the danger in considering the eventuality of an ideal, unchanging psychiatric nosology.

There is the fallacy, often implicit in the claims of any profession (not just psychiatry), assuming that all progress is progress towards something better - in the case of psychiatric classification, an ideal, static nosology. In the case of psychiatry, this is not truly a fallacy, because it is relatively unarguable that the profession's nosology has progressed since Greek humeral theory and even since the first official nosology, *DSM*. However, one must take care not to equate *progress* within the limitations of the surrounding professional environment with *advancement* towards an ideal end. This is a mistake often made in the appraisal of biological evolution, where natural selection can easily be misconstrued (with only a small touch of anthropocentrism) as the means directed at achieving an "optimal" end.

Beutler and Malik (2002) applied this idea to *DSM's* using the evolutionary arguments of R.A. Fisher and Sewall Wright (see Provine, 1986), who argued back and forth regarding

whether or not the majority of current species had reached their full evolutionary potential. Fisher asserted that species were mostly optimalized, residing upon what could be imagined as the highest peak, surrounded by valleys of lower evolutionary fitness. Wright countered this by proposing that the peak on which most species resided is not likely the highest peak in all the landscape but rather what he termed a "local optimum." This would represent the highest point that a species could see from where they were now, though not necessarily the highest point possible. Psychiatric nosology, Beutler and Malik (2002) asserted, is likely subject to the same shaping forces and the same tendency to reside on a local optimum.

As this thesis has examined, the profession of mental health and its practitioners have been prone to fluctuations throughout their history, exposed to numerous shifts in the loci of power, social and technological experience, theoretical orientation, and financial resources - the shaping forces that Beutler and Malik (2002) referred to. These professional alterations affected not just the day-to-day activities of mental health practitioners but also the predominant psychiatric nosology, resulting in the substantial changes in classification that have been discussed throughout this paper.

If this history of change affords us any glimpse of the forthcoming, then the profession of psychiatry is unlikely to exist as a static entity future. Additionally, based on historic trends, it is just as unlikely that future shifts in the psychiatric profession will be unaccompanied by alterations in the nosology of mental illness. The idea of progression towards a definitive, unchanging nosology seems a tenuous outlook to endorse.

Much less unreasonable is the belief, outlined earlier, that nosology will eventually move towards a focus less on symptomology and more on etiology and ultimate causation. As research into mental disorders progresses and knowledge of genetic and environmental contributions to psychopathology accumulates, it is hypothetically possible that later *DSM* editions could ultimately become objective, irrefutable sources of knowledge on classification and diagnosis, a sort of Periodic Table of mental illness. The notion of a *DSM* Task Force setting out to revolutionize the classification of mental illness could be laid to rest, for the only changes possible in a definitive nosology would be the expansion of descriptive research literature and the accumulation of necessary terminological or statistical updates (similar to the mission of the text revision of *DSM-IV*).

The ultimate feasibility of this outcome for psychiatric nosology is highly and, for the moment, irresolutely debatable. What should be emphasized, however, is that psychiatric nosology does not emerge simply as the result of "advances of knowledge" (Grob, 1991, p. 430). Rather, systems of classification are born of a myriad of issues and influences that circumscribe the knowledge itself: whose knowledge is paid attention to (professional prominence), changes in where the knowledge comes from (locus of professional power), who has the funds to produce the knowledge (financial resources), how the knowledge is interpreted (theoretical conceptions), and the environment of knowledge application (social/technological surroundings). In this light, even the presence of a complete, objective knowledge base regarding mental disorders may not guarantee a definitive, unchanging nosology. As Grob (1991) noted, perhaps, "the only constant is the process of change itself. The search for a definitive nosology, therefore, may simply be an expression of the perennial human yearning for omniscience - an attribute eagerly sought by many but never yet found" (p. 430).

End Notes:

[1]Bearing in mind that there are two prominent APA's in the realm of behavioral science (American Psychiatric Association and American Psychological Association), it will be used in this paper only to refer to the American Psychiatric Association.

[2] "Nosology," a term frequently used in this paper, is a classification or list of diseases

[7]The ten categories in
DSM-II are: mental retardation (all causes), organic brain syndromes, psychoses not attributed to physical conditions listed previously, neuroses, personality disorders and certain other non- psychotic mental disorders, psychophysiologic disorders, special symptoms, transient situational disturbances, behavior disorders of childhood and adolescence, and conditions without manifest psychiatric disorder.

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Faculty mentor comment:

Dr. David Schroeder, in his letter to the Inquiry Publication Board, made the following remarks about Mr. Jackson's work:

> Eric Jackson's paper, "Organizing Madness: Psychiatric Nosology in Historical Perspective," is based on Eric's Honor's thesis and provides a unique review of the multiple influences that have shaped psychiatric classification schemes, including the most recent edition of the *Diagnostic and Statistical Manual. Mental Disorders (4" Edition, 1994)*. Eric traces the evolution of diagnostic manuals from the earliest attempts of psychiatry and psychology to model medicine's diagnostic systems for physical diseases for the creation of a similar nosological scheme for mental diseases. While benefits for patients were undoubtedly realized by these classificatory advances, Eric explores other factors that are largely unrelated to treatment per se (e.g., professional authority, financial consideration) as important roles played in the development of diagnostic manuals. While these factors certainly continued to impact revisions of early manuals, and ultimately the *DSM*, and the continuing series of revisions, Eric also integrates the influences of changes in the dominant psychiatric and psychological orientations (e.g., the shift from a Freudian psychodynamic view that held sway in the early part of the 20th century to more objective and behavioral-based views of abnormal behavior that emerged with the "cognitive revolution" that began in the 1960's and continues today). These changes not only led to changes in terminology (e.g., the elimination of the term "neurosis" from the psychiatric lexicon) but also to the explicit specification of defining an empirically validated symptom pattern for each diagnostic category.
>
> Eric has offered a masterful integration that brings together works form psychiatry, psychology, medical anthropology, and the history of medicine to provide the context for his review. He provides a glimpse "behind the scenes" at how the most important reference for psychiatry, clinical psychology, and other mental health professions has been shaped. His submission is extremely well written, and he presents his analysis without bias or preconception. This paper is a strong piece of scholarship that does not lose the reader in professional jargon. It should be an interesting and enjoyable "read" for people from a wide range of backgrounds.

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The *Diagnostic and Statistical Manual of Mental Disorders (DSM),* now in its fourth edition *(DSM-IV)* is a mental health clinician's primary tool for identifying and categorizing mental disorder in the United States. It contains a list of all mental illnesses currently recognized by the APA along with detailed descriptions of each disorder and a set of criteria that aid in identification and diagnosis. *DSM'*s influence, however, extends beyond diagnostic boundaries: it guides research into psychoactive pharmaceuticals, it is used by insurance companies to authorize reimbursement for mental health services, and its definitions and disorders often play a role in legal decisions of sanity and culpability. Fundamentally, *DSM* delineates in our society which behaviors are reasonable and expected in the course of a normal lifestyle and which behaviors constitute the presence (if mental illness.

As mentioned, *DSM* is currently in its fourth edition, indicating that it has not remained the same throughout its existence. In fact, it has at times undergone massive reorganizations and if the first version of *DSM* were placed next to the most recent edition the two books would scarcely seem related. Revisions and reprinting are not uncommon events in and of themselves; many documents, from textbooks to tax codes to college guides, go through multiple editions over the course of time. There is no reason to expect that classification schemes for mental illness would be any different, for as Grob (1991) noted, "Nosologies[2] - psychiatric or otherwise - are rarely etched permanently in stone" (p. 430).

Bearing this impermanence in mind, the purpose of this paper will be to explore the reasons behind change in psychiatric nosology, and particularly *DSM*, throughout the history of American mental health care. If *DSM* is simply a compendium of science based knowledge regarding mental illness, accruing more knowledge and drawing closer to a definitive system with each edition, then this would simply be a history of the accumulation of formal psychiatric knowledge. As it would happen, this is not the case. As Bayer and Spitzer (1985) explained:

> For many years, philosophers concerned with the explication of the logic of scientific inquiry portrayed an image of scientific progress that disregarded the extent to which social and professional interests came into play Scientific activity and controversy are now understood to be affected in important ways by intraprofessional interests, as well as by broad historical and social trends (p. 195).

Consideration of these professional interests and socio-historical trends place the *DSM* into a much broader focus, illustrating the various events and transactions - both inside and outside of psychiatry - that have motivated

revisions of psychiatric nosology and revealing some of the implications these alterations had, and continue to have, on the process of understanding and diagnosing mental illness.

Early Classification Systems and the Rise of American Psychiatry

Broad, informal classification systems for mental illness stretch far back into human civilization. Numerous Greek and Roman thinkers, in fact, were speculating about the nature and causes of mental disorder over two thousand years before the APA published the first version of the *DSM*, a trend that continued through the Middle Ages. After the Middle Ages, from around 1500 until the early part of the 18th century, classification of mental disorders in Europe developed in the context of changing social concepts of acceptable behavior. During this period, mental illness transitioned from its previous distinction as a medical syndrome to a new classification as a non-medical lack of human reason. What Foucault (1965) called "The Great Confinement," or the period of incarcerating individuals deemed as mad in the same facilities as common criminals, followed this denotation as unreasonable.

Classification of madness would shift again two centuries later, when mental disorder regained a therapeutic perspective and the status of sickness. Foucault (1965) linked this transition to the actions of William Tuke and Philippe Pinel in the mid- to late18'h century. Take founded the Retreat at York in 1729 as an institution for treatment of insane relatives and friends of Quakers, with far different intentions than the predominant institutions of the era. Highly critical of the existing conduct towards the mentally disordered, Tuke encouraged the much more germane behavior of warm baths and humane treatment. Pinel encouraged similar attitudes in Paris near the turn of the 19" century, and is credited as the founder of the modem asylum movement. He, like Tuke, emphasized that incarceration of the insane was not only misguided but also harmful. Pinel promoted methods of humaneness and regularity similar to Tuke's, "suggesting that just as the politician manages the body politic, so the physician should concern himself with the regulation of the insane through a system of moral constraint and education" (Turner, 1987, p. 66).

This shift in classifying exactly what mentally deviant behavior was (a medically treatable illness versus an untreatable state of unreason) led to a need for new locations to house those formerly incarcerated with criminals or placed in undifferentiated welfare institutions such as poorhouses. This need was filled by the modem asylum, which rapidly increased in number across both the United Kingdom and the United States in the 19th century. The asylum movement in America began initially in the Northeast at the turn of the 19th century, where affluent members of large, urban communities (Boston, New York City, etc.) began to endow private mental institutions, and the movement had spread to the South within the next several decades as public institutions began to appear in areas with less independent wealth (Grob, 1994). By the second half of the 19th century, almost every state had at least one asylum, and many had several, all generally confronted with more admissions than beds. It was from these asylums that American psychiatry and therein modem psychiatric nosology would emerge.

The profession of psychiatry enjoyed a great many successes (including high remuneration and increased professional authority) in the period immediately following the rise of the asylum; nosology, in contrast, progressed comparatively little. The few classification systems that existed were very simplistic and included such historically familiar categories as mania, melancholia, monomania, dementia, idiocy, and epilepsy. Beyond that, the vague nosological systems that did exist aroused little interest in psychiatric professionals of the time. Samuel B. Woodward, elected to the presidency of the Association of Medical Superintendents of American Institutions for the Insane (AMSAII, which would ultimately become the APA) during its 1844 founding, noted in 1842 that insanity was a "unit, indefinable ... easily recognized ... [but] not always easily classified" (Grob, 1994, p. 59).

Insofar as therapeutic measures are related to accurate diagnosis, a reliable nosology is crucial. If, however, treatment is unrelated to diagnosis, then a comprehensive nosology becomes much less important, and perhaps even useless. So to what degree was treatment differentiated based on diagnosis in the early years of psychiatry? The answer is very little. Gerald Grob noted that, "Indeed, nomenclature and classification aroused little enthusiasm among mid-nineteenth-century American psychiatrists, if only because diagnosis was not relate to specific therapies" (Grob, 1994, p. 59). Additionally, as the above quote from Woodward noted, insanity was "easily recognized," further implying that the process of diagnosis was simple enough to eliminate the need for a reliable or differential nosology. These two factors (ease of diagnosis and undifferentiation of treatment) each contributed to the early disdain for nosological systems.

Kraepelin and the Movement to Classify

Despite its initial high regard, AMSAII faced mounting criticism in the later decades of the 19th century, and by the last decade of the 1800's winds of change were moving through the organization. Assaults by neurologists such as Edward C. Spitzka had opened the association to public question, and as part of the process of rebuilding professional authority the organization was formally renamed in 1892, becoming the American Medico-Psychological Organization (ANIPA). One of the keys to ANIPA's trouble at this time was a lack of legitimacy. For the general medical establishment, professional currency in the late 19th century was coming by way of a growing body of scientific medical knowledge; physicians who acquired this knowledge were legitimized by their possession of a unique source of wisdom.[3] Psychiatric professionals and superintendents of the same era, however, had no such unifying body of knowledge. If psychiatry was to reassume its initial position as an esteemed medical specialty, the profession needed a legitimizing body of psychiatric knowledge akin to the scientific medical knowledge that general practitioners were utilizing in their professional sphere.

At roughly this same point in time, as the professional status of American psychiatry was rapidly declining, an interest in psychiatric nosology was beginning to grow. At the forefront of the reemergence of classification was a German clinician named Emil Kraepelin, a man who would eventually lay the theoretical framework for modern psychiatric nosology in the Western world. Kraepelin recognized the limitations of classification systems based on etiology and anatomy. He admitted that his own ideas on etiology were speculative and realized that anatomical knowledge at the time was not equipped to probe the mechanisms of mental disease. This ultimately led Kraepelin to a classification scheme built on symptomology, justified by the following statement in his 1904 textbook *Clinical Psychiatry*:

> there is a fair assumption that similar disease processes will produce identical symptom pictures, identical pathological anatomy, and an identical etiology. If, therefore, we possessed a comprehensive knowledge of any one of these three fields - pathological anatomy, symptomatology, or etiology - we would at once have a uniform and standard classification of mental diseases. Cases of mental disease originating in the same causes must also present the same symptoms, and the same pathological findings (p. 117).

With this in mind, Kraepelin studied thousands of mentally ill patients at his clinic in Heidelberg, sifting through large tracts of data to uncover the underlying commonalities within a disorder. In the end, Kraepelin and his co-researcher A-R. Dielendorf placed mental disorders into fifteen categories, many of which are recognizable today, such as manic-depressive insanity (now bipolar and unipolar affective disorder), paranoia, psychogenic neuroses, psychopathic personality, and syndromes associated with improper mental development (mental retardation) (Kihlstrom, 2002). Despite the fact that the Kraepelinian focus on symptomological classification would eventually come to enjoy a position of absolute authority in the field of psychiatry, nosological traditions were not immediately welcomed. The long-standing aversion to classifying schemes was not going to crumble overnight, or even over the course of several years. But the seeds had been sown, and at the time the grounds of psychiatry were once again a fertile bed of transformation.

Creating a Standardized Nosology

There was little doubt among mental health professionals that a standardized nosology would facilitate better communication among members of the psychiatric community (a metric system of sorts for mental illness), but skepticism about the efficacy of a symptom-based system of classification persisted. Some practitioners insisted such a nosology would be unsatisfactory, as the symptoms would overlap so frequently as to be useless. Others, as Stewart Paton noted in a 1905 textbook, argued that psychiatry does not handle "definite disease entities, such as typhoid fever or pneumonia," raising the issue of deficient knowledge of psychopathology (Grob, 1991, p. 423-424). Particularly enlightening are the words of Charles G, Hill in his 1907 presidential address to the AMPA, where he said that there is little room in psychiatry for new classifications "unless we add 'the classifying mania of medical authors... (Hill, 1907, p. 3).

If individuals within psychiatry were not motivated to create a standardized nosology, then where did the motivation for change arise? Kraepelin's classifying legacy and the changing attitudes in general medicine were powerful factors, but could not overcome the internal resistance in psychiatry by themselves; another source of influence must have existed. Gerald Grob's (1991) examination of psychiatric nosology moved the search for motivation outside the realm of professional mental health:

> The impetus to create a psychiatric nosology came largely from outside of psychiatry or medicine. By the end of the nineteenth century, a number of new social science disciplines had come into existence. Many of the individuals associated with these new disciplines were concerned not only with developing a scientific understanding of individual and social behavior but also with applying this understanding to a series of pressing social problems that seemed to threaten the very fabric of society (Grob, 199 1, p. 424).

Chief among those concerned with such social problems - of which mental hygiene was a prime example - was the United States Government, a body understandably concerned with maintaining "the very fabric of society."

As far back as 1840, the census attempted to catalog the insane, and by 1880 the U.S. census had created seven official categories of disease: mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy (Grob, 1991; Kutchins & Kirk, 1997). Further, special censuses in 1904 and 1910 dealt specifically with mental disorder in the institutionalized insane and marked an even greater government interest in the mentally ill. By 1908, only a year after Hill's unflattering remarks regarding classification, the Bureau of the Census appealed to the AWA to assist in the collection of data by appointing a special committee on nomenclature. The initial request was not honored, but after five years, the Census Bureau succeeded, marked in 1913 by the founding of a Committee on Statistics of AMPA (Grob, 1991).

Once the Committee on Statistics was created, the formation of a standardized nosology quickly gathered momentum. Within four years of the committee's founding, unambiguous support emerged for a standardized system of classification to guide the census' data collection. In 1917, the Committee on Statistics reported that:

> "such data, if collected in a uniform and systematic manner, 'would serve as the basis for constructive work in raising the standard of care of the insane, as a guide for preventative effort, and as an aid to the progress of psychiatry.' They [the Committee on Statistics of the AMPA] added, 'the present condition with respect to the classification of mental diseases is chaotic. This condition of affairs discredits the science of psychiatry and reflects unfavorably upon our Association'" (Grob, 1991, p. 425).

This endorsement by the AMPA, along with the previously mentioned growth in scientific and classifying traditions in medicine as a whole, made a standard nosology all but inevitable. In 1918, that inevitability became a reality when the Committee on Statistics of the AMPA, with the cooperation of the National Committee for Mental Hygiene, released the first standardized psychiatric classification system: *Statistical Manual for the Use of Institutions for the Insane*.[4] Two aspects of this manual bear particular mention in regards to a study of the doctrine's influences.

First, the *Statistical Manual* was biologically oriented. As Grob (199 1) elaborated, this was quite understandable given the nature of psychiatry at the time. The vast majority of psychiatric specialists in 1918 were employed by mental institutions, and the patient population of these institutions generally presented not only severe mental problems but also substantial physical issues as well. In 1922, for example, the U.S. Census Bureau reported that 33.4% of all first admissions were cases of psychoses of known somatic origin (Grob, 1991, p. 426). The somatic trends of the Statistical Manual, then, reflected the nature of psychiatric practice.

Second, and perhaps more importantly, the Statistical Manual was not oriented towards diagnosis. Ultimately, this meant that it was of only marginal utility to practitioners despite its accurate representation the nature of psychiatric practice at the time it was published. It is not unreasonable to ask why a nosology that strongly reflected the practice of psychiatry was not also designed to facilitate and possibly ease the day-today work of these same practitioners. The answer lies mainly in the prior discussion of document's initial motivation: the needs of the government, not of the psychiatric professional. As Kutchins and Kirk (1997) noted, summarizing the previous discussion, "the struggles for to develop a systematic nomenclature, from the earliest decades of the 19th century, were motivated by administrative and governmental needs, not by demands from practitioners" (p. 39).

The *Statistical Manual* would act as the definitive nosology for both the Bureau of the Census and for the APA (which the AWA became in 1921) for over thirty years. The Bureau of the Census continued utilizing the information to collect data, and the APA updated the manual no fewer that ten times prior to the Second World War, with each edition bearing the same insignificant benefit to psychiatric professionals. For the time being, practitioners were still relatively disinterested in the construction of a nosology that was geared at providing reliable and valid diagnoses. Lack of concern in the 1940's arose from the same source that it did in the W century:

irrelevance of diagnosis to treatment. "Psychiatric therapies between the two World Wars," Grob (1991) explains, "were for the most part eclectic and nonspecific; diagnosis was of only marginal significance" (p. 427). The events and aftermath of World War II, however, would once again set the stage for transformation. The impetus for nosological change this time, however, would not be administrative or governmental. Rather, it would emerge from the group that had historically been the least interested in standardized classification: mental health practitioners.

The Experiences of World War II

The *Statistical Manual for the Use of Institutions for the Insane* was revised for the final time by the APA in 1942 and, by chance, occurred at roughly the same time as the event that would re-shape American psychiatry: the entrance of the United States into WWII. Flouts (2000) noted that, "In the pre-World War 11 era ... organized psychiatry was not in the business of conducting outpatient psychotherapy with the ordinary person with problems of anxiety and depression, and clinical psychology was not in business at all. Instead, psychiatry was much as it had been at the end of the 19" century, a limited profession dealing chiefly with the severely mentally ill populations of large state hospitals" (p. 940).

Psychiatry in the armed forces was equally limited, but during VTWH the ranks mental health practitioners swelled considerably, growing from 35 neuropsychiatric assignments in 1941 to 2,400 by the end of the war (in comparison, the APA only had 2,295 members in 1940) (Grob, 1991, p. 427). According to those figures, the rise in psychiatry in the military during WWR effectively doubled the number of psychiatric specialists in the United States.[5] An explosion like this in a field with such a marginal professional status - the state of both civilian and professional psychiatry at the time (Grob, 1991) - could have only occurred with the help of the military, where practitioners were assigned to specialties rather than having the freedom to individually choose.

Military psychiatrists experienced a new sort of mental health care during the war, a brand quite distinct from that which had shaped the nosologies and nomenclatures that they were attempting to employ, such as the Statistical Manual for the Use of Institutions for the Insane. That document, as the name implies, was created for the use of mental hospitals, which until then were the primary locus of treating mental illness. The illnesses manifested in an institutionalized population were generally quite severe, and the Statistical Manual placed heavy emphasis on these grossly debilitating disorders. These severe mental illnesses were not, however, those with which military psychiatrists were commonly confronted on the battlefield. Grob (1991) illuminated the problem, noting that "Military and Veterans Administration psychiatrists found themselves using a nomenclature ill-adapted for 90% of their patients. Minor personality disturbances - many of which were of importance only because they occurred within a military context - were placed in the 'psychopathic personality' category" (p. 428).

It was exactly these minor personality disturbances with which military psychiatrists were being flooded, in the form of soldiers showing adverse behavioral reactions to the horrors of life on the front lines. These were not chronically disordered individuals, military psychiatrists came to realize, but instead persons who were otherwise mentally sound that had been exposed to severe personal stress and subsequently developed mental health issues. This realization, while not entirely new to the world of psychiatry[6], had not yet taken hold in the greater professional community, but the experiences of military psychiatrists - who would ultimately compose half of America's psychiatric specialists -would cause an ideological shift. "Rather than being confined to severe forms of mental illness," Houts (2000) noted, "mental-disorder problems were viewed as arising from life circumstances, especially stressful events, and such problems could persist into the future once they were produced in otherwise 'normal' individuals" (p. 940). The shift from treating psychopathology in severely disordered persons to "normal" individuals without chronic disorders was emerging.

Also rising in the United States at this juncture, despite having been present long before, was the psychodynamic method of appraising mental illness. In part, this was a result of an influx in European psychiatric professionals - most of whom were psychoanalytically oriented - seeking refuge from their war-tom continent (Kutchins & Kirk, 1997). Mainly, however, it was the result of the previously discussed experiences of military psychiatrists. Grob (1991) elaborated:

> During that conflict [WWHI, psychiatrists made major contributions in developing simple but effective means of dealing with large numbers of neuropsychiatric casualties. They found that support forms of psychotherapy, when combined with rest, sleep, and food, produced almost instantaneous results. More than any other element, the success in returning to active duty servicemen who experienced psychological

> problems renewed a spirit of therapeutic optimism and activism, which was carried back into civilian life after the war. 'Our experiences with therapy in war neuroses have left us with an optimistic attitude,' Roy R. Grinker and John P. Spiegel reported in a chapter for a manual of military psychiatry. 'The lessons we have learned in the combat zone can well be applied in rehabilitation at home' (p. 427).

The Creation of *DSM*

Grinker and Spiegel's sentiments, written in 1944, were shared by a great many of WW II's returning psychiatric professionals and would ultimately shape the construction of a revised clinical nosology. As previously mentioned, these returning individuals constituted nearly half of the total number of psychiatrists in America, and they were a group eager to apply the psychiatric lessons they had learned in war to mental health practices at home. This "group" of like-minded practitioners, however, was at the moment informal; they were not unified under any common heading. Without some sort of organization, it is unlikely that such a diverse population could have enacted a lasting change in the profession of psychiatry.

An organization did emerge, though, under the leadership and influence of William Menninger. In 1946, the Group for the Advancement of Psychiatry (GAP) was founded at a meeting of the APA, the organization that the GAP was determined to reshape. Grob (1991) summarized the thrust of the movement well in saying, "The new organization [GAP] was based on the presumption that psychiatry's responsibilities and functions transcended institutional care and treatment of the mentally ill. 'I do feel,' Menninger told a colleague in early 1947, 'that American psychiatry needs renovation in the sense of consideration of social problems and social needs' " (p. 428).

Though it cannot be said with certainty, one can conceive that Menninger called it a "renovation" and not a "revolution" out of hesitance to invoke such language in the wake of a World War, rather than as the most adequate portrayal of the circumstances surrounding the creation of the GAP. Menninger envisioned a sweeping change in the aim of professional psychiatry, much more than a simple retooling of what was already present. From the rhetoric of visionary mental health professionals of this era, a sense of far-reaching social activism emerges, and that is exactly what Menninger and the GAP were advocating.

Little time was wasted in beginning the nosological revision: in 1948 the APA Committee on Nomenclature and Statistics opted to postpone changes in its current manual (i.e. *Statistical Manual for the Use of Institutions for the Insane*) and instead sought suggestions for a major change. By 1950 the Committee had prepared a draft of the new psychiatric nosology, an amalgam of three nomenclatures in use by the close of WWII: the APA's Standard Classified Nomenclature of Disease (the *Statistical Manual*), the Armed Forces Nomenclature (*War Department Technical Bulletin, Medical 203*), and the Veterans Administration Nomenclature (only slightly different from *Medical 203*) (Hours, 2000, p. 945).

The process of revision took only two years. The 1950 draft of the new manual, titled the *Diagnostic and Statistical Manual: Mental Disease (DSM),* was circulated to various individuals and organizations within the psychiatric profession and also to a sample of 10% of the APA membership (selected to represent a cross-section of geographic locations, occupational settings, and organizational memberships). Of that ten percent, 46% returned the 9-page questionnaire accompanying the draft, and 93% of these respondents were said to have approved the initial draft (Houts, 2000, p. 945). A second draft was prepared utilizing this first set of revisions, and this draft was approved by the APA membership and its governing body in 1951; the manual was published and distributed by the APA the following year.

In *DSM*, mental illness was divided into three broad, logical categories: organic brain syndromes, functional disorders, and mental deficiency (retardation). Comparatively, the *Statistical Manual* had twenty-two, rather specific categories. Additionally, *DSM* was much less dominated by psychoses and contained greatly expanded sections on psychoneurotic reactions, personality disorders, and transient situational personality disorders. Finally, as the name of the new manual suggested, it was not only oriented toward the facilitation of gathering statistical information but also towards professional diagnosis. George Raines (1953), chair of the committee responsible for *DSM*, explained why:

> It has become popular to decry diagnosis of psychiatric illness with the contention that each patient is an individual so different that standard labels cannot be applied. Without sound diagnosis, statistics are

> inaccurate and misleading, or unavailable; factual data cannot be accumulated from past experience to guide the future; and accumulated knowledge is transmitted with great difficulty, if at all (Raines, 1953, p. 548).

Ultimately, and in contrast to the *governmental* influences behind the previous standard nosology, *DSM* is best seen as a document influenced by sweeping changes in both the professional and social ideology of psychiatric *practitioners* in the years after WWH. Professionally, practitioners switched from a primarily medical, biological orientation to a chiefly psychoanalytic view as a result of their experiences in WWII; this change is mirrored in the greatly increased prominence of psychodynamics in *DSM*. In terms of social ideology, psychiatrists became much more interested in applying mental health practices to non-institutional populations as a result of growing social activism and prevailing post-war ideas of social betterment. William Menninger (1947/1967) explained this social activism by saying:

> Psychiatry should place high priority on its efforts to provide the "average" person with psychiatric information he can apply to his own problems. The public wants this education, Very possibly it may increase the number of patients who seek help from a psychiatrist, just as a campaign about cancer or tuberculosis increases the number of patients who go to doctors about these problems (p. 579).

Menninger's last sentence, in particular, highlights one of two caveats to the seemingly altruistic social activism proposed by post-war psychiatric professionals. This "possible increase in the number of patients" seeking psychiatric services was not only an off-handed coincidence of an increase in education, but also a professional necessity if the huge number of psychiatrists returning from the war were to have any hope of working. A doubling of active practitioners in psychiatry, which WWII generated, would need (at least) a doubling of patients in order to sustain that many professionals.

Secondly, the years after WWU saw a huge rise in the amount of federal funding available for training and research in psychiatry and clinical psychology. For example, as a result of the National Mental Health Act of 1946, the amount of fund dispersed by the NTMH between 1948 and 1962 for research and training grants rose from $374,000 to $42.6 million and from $1.1 million to $38.6 million, respectively (Starr, 1982, p. 346). Clearly there was a lot of money available within various areas of mental health care, creating strong incentives to remain in a profession that previously had been in the doldrums of the medical world.

DSM-II: The First Revision

In contrast to *DSM*, the first official revision of this manual, *DSM-II*, was not accompanied by the broad social and professional changes that shaped *DSM*. As Kutchins and Kirk (1997) explain, "making *DSM-II* was a relatively private and simple process, more like changing rules and regulations within one organization than negotiating treaties among many rivals factions, each with a very different objective" (p. 40). The rather modest goal of the work, according to two of its consultants, Spitzer and Wilson (1968), "is the improvement in treatment and prevention that will evolve with better communication among psychiatrists of all nations" (p. 1929).

Assisting international communication, in fact, was the main motivation for changing *DSM*. The *International Classification of Diseases (ICD)* had long been published by the World Health Organization (WHO) to facilitate the collection of disease statistics, including those on mental illness around the world. In 1965, asked its Committee on Nomenclature and Statistics to revise *DSM* in order to make it compatible with *ICD-8*. The new diagnostic manual would also include changes in professional concepts of mental disorder that had occurred since 1952, namely the inclusion of new disorders and the exclusion of unused ones. Gerald Raines, chair of the committee that produced *DSM*, had anticipated such revisions:

> Sound diagnosis is possible only with a nomenclature in keeping with current concepts of psychiatric illness, and sufficiently flexible and inclusive to permit the introduction of new ideas. It is therefore necessary that psychiatric nomenclature, as well as other medical nomenclature, be revised from time to time to keep it in step with the moving body of psychiatric knowledge (Raines, 1953, p. 548).

The actual process of revising and changing *DSM* was quite simple, and relatively isolated from outside influence. Whereas *DSM* organized mental disorders in to three categories, *DSM-II* contained ten such categories.[7] The categorical increase was chiefly the result of the reclassification of six of the mental illness clusters collected under a single *DSM* heading ("functional disorders") as individual categories to indicate how mental disorder was often

viewed in America. *DSM-II* also included a new section on childhood disorders ("behavior disorders of childhood and adolescence") that did not appear in *DSM*. All told, fifty-four diagnoses were added to *DSM-II*, raising the total from 108 in *DSM* to 162 in *DSM-II*, beginning a trend of increasing the number of diagnoses that has continued through the most recent edition (Houts, 2002, p. 20).

Perhaps the most notable occurrence in *DSM-II*, in that it foreshadowed greater changes to come in later revisions, was the elimination of the term "reaction" from the text. "Schizophrenic reaction," for example, became simply "schizophrenia." According to the Committee on Nomenclature and Statistics, this was done in order:

> ... to avoid terms which carry with them implications regarding either the nature of a disorder or its causes ... In the case of diagnostic categories about which there is current controversy concerning the disorder's nature or cause, the Committee has attempted to select terms which it thought would least bind the judgment of the user (APA, 1968, emphasis in original).

This move towards an atheoretical perspective was for the time being incomplete, as several diagnoses still retained the label of "reaction" ("psychotic depressive reaction," for example). Curiously, the category on childhood and adolescent disorders - the only entirely new set of diagnoses in *DSM-II* - was composed entirely of "reactions."

Taken as a whole, *DSM-II* was only subtly different from *DSM*. The major factors that had influenced the creation of *DSM* (i.e. psychodynamics and shift in focus away from practice in mental hospitals) remained intact in its first major revision. There were hints in its production, however, of greater changes to come. Spitzer and Wilson (1969), replying to various criticisms of *DSM-II*, suggested that future revisions involve various subcommittees to supplement the actions of the small committee charged with producing the next edition. In the same article, Spitzer and Wilson again noted, perhaps most presciently of all, that, "McCall and Jackson [two who critiqued the volume] make strong cases for considering the neuroses to be essentially symptom complexes devoid of any independent existence as nosological entities. Although we believe these ideas have considerable merit, they will have to convince the profession of their approach before they can be incorporated into an official classification system" (p. 424).

DSM-111 and the Next Nosological Revolution

DSM-11 reigned as the clinical standard for nearly twelve years, until it was supplanted by the appearance of *DSM*-111 in February of 1980. The official reason for revising the manual was fairly innocuous and was identical to the impetus given for the need for the revision of *DSM*: the WHO was preparing a revision of the ICD, and the United States government had treaty obligations to maintain the ICD as their official diagnostic manual. Unlike the professional climate surrounding the creation of *DSM-II*, however, more than the formality of a treaty obligation was going to shape the production of its nosological successor.

Neither was *DSM-II*I envisioned as a nearly identical offspring of the classification system that had come before it. As Kutchins and Kirk (1997) noted, "From the beginning, members of the task force wanted to make a radical changes in psychiatric nosology. They had not interest in a cosmetic updating of *DSM-II*"(p. 42). Power struggles in the profession of psychiatry were once again emerging, as they had in the years after WWII. Criticism of the diagnostic system was growing from disapproving clinicians and researchers within the field and also from those outside the profession, including such parties as social activist groups, pharmaceutical companies, and third party reimbursement organizations. The events and diverse influences that converged on the period of nosological revision culminating in *DSM-II*I could hardly have avoided producing a document radically different from those that had come before.

Under the leadership of Robert L. Spitzer, who was appointed chair of the Task Force on Nomenclature and Statistics in 1974, even the administrative process of revising the document changed noticeably. Spitzer's Task Force and their support staff worked for five years revising *DSM-II*, producing several drafts between 1974 and 1978 before its final approval in June 1979; in comparison, the production of both *DSM* and *DSM-II* took only two years each. But *DSM-II*I was quite unlike its two predecessors, and one of the most immediately noticeable differences was its size. Whereas *DSM* and *DSM*-H were both slim, spiral bound volumes of less than 150 pages; *DSM-II*I came in at just under 500 pages in length. The number of diagnoses also increased, jumping nearly 50% from 182 in *DSM-II* to 265 in *DSM-II*I (Hours, 2002, p. 20).

*DSM-II*I was not only quantitatively different but qualitatively distinct as well, embodying major shifts in the area of psychiatric diagnosis and classification and in the broader profession as well. One of the main alterations from *DSM-II* was a newly acquired predilection towards the use of empirical data when altering, including, or deleting diagnoses, This new requirement marked not only a change in the revision process but also reflected a shifting power balance in the profession. As Wilson (1993) explained, "With the appearance of *DSM-II*I, the essential focus of psychiatry shifted from the clinically-based biopsychosocial model to a research-based medical model. And through the development of *DSM-II*I, research investigators replaced clinicians as the most influential voices in the profession" (p. 400).

The zenith of research psychiatrists' struggle for control of mental health's professional orientation came over the decision to expunge a single word from the *DSM*III: neurosis. As Bayer and Spitzer (1985) elaborated, the conflict was:

> at base, a struggle over both the image and intellectual commitments of a profession seeking to fashion a paradigm for its discourse and work, a struggle over the relative status and authority of those working within distinct traditions. Thus, even though the new diagnostic manual was not conceived as an official textbook of psychiatry that would address definitively the broad etiological and therapeutic issues facing the profession, the preparation of *DSM*-111 placed into relief issues far beyond the more circumscribed matters directly related to the development of a classificatory scheme (pp. 187-88).

These issues, in large part, dealt with the rapidly eroding dominance of the psychodynamic tradition in American psychiatry during the 1960's and 1970's.

Although the decision to expunge theory-laden terms (such as "neurosis") was made in 1974 - and hinted as early as 1969 (Spitzer & Wilson, 1969) - the controversy over the exclusion of "neurosis" did not fully emerge until 1978, as *DSM-II*I was nearing the final stages of completion and approval. Widespread resentment grew among those with psychoanalytic backgrounds, and quite reasonably since they were on the verge of witnessing the utter deletion of psychodynamics from the volume that legitimized psychiatric knowledge. I do not know," a dissenting APA member wrote, "who determined that this small group of people should try to reorganize psychiatric thinking in the United States but I am ... concerned that they have such an arrogant view of their mission and are not willing to incorporate some of the things which we have learned over the past 70 years" (Wilson, 1993, p. 407).

A public and vitriolic series of arguments occurred regarding the removal of "neurosis," and support on both sides gathered steam as *DSM*411 moved towards the final stages of approval. Psychodynamically oriented practitioners managed to put up a rousing last stand, and in late April of 1979 the Board of Trustees of the APA nearly put forth a vote of "no confidence" in the revised manual, approving it in the end because of the tremendous allocations resources and "bureaucratic momentum" that it embodied (Boyer & Spitzer, 1985, p. 193). After the dust settled, a compromise had been reached that can only have been a dire disappointment for all psychoanalysts associated with the APA. While not completely eliminated, "neurosis" appeared only in a brief introductory section explaining why it had been expunged from the manual, and in parenthetical references next to the renamed "neurotic" syndromes. As Wilson (1993) notes, "The appellative 'neurosis' and the clinical, psychodynamic tradition for which it stood had been marginalized to the relative obscurity of parentheses" (p. 407).

This major shift in the orientation of psychiatric nosology was not the only noteworthy aspect of *DSM*-11I; the manual also included a significant innovation the nosology's structure. For the first time, the diagnostic categories were no longer construed as syndromes defined by symptoms that were "singly and jointly necessary" for an accurate diagnosis (Kihlstrom, 2002, pp. 286-287). Instead, disorders were reconfigured as "fuzzy sets," grouped in families that lacked sharp boundaries to distinguish between them. Each disorder, instead, possessed a set of characteristic features that identified it as unique, and these features were embodied in prototypes that captured many characteristics of that particular disorder and few features of any others. Indeed, third-party reimbursement for mental health issues had become much more difficult to attain in the years prior to *DSM-II*I, in part, insurance companies stated, because of the lack of "clear and uniform" diagnoses of mental illness, an issue that criterion sets helped to alleviate (Wilson, 1993, p. 403).

*DSM-II*I was born out of a tumultuous time in American psychiatry, a period of several years in which the profession experienced its most striking repolarization since the events following WWII. Out of this, the new nosology rose as a striking public success, selling hundreds of thousands of volumes and heralding a new era in

the mental health care, one backed by empiricism and scientific data. But whereas *DSM*-I and *DSM*H had lasted for sixteen and twelve years, respectively, before being eclipsed by new nosologies, *DSM-II*I was barely three years old when the process of alteration began anew.

In May of 1983, the APA appointed the Work Group to Revise *DSM-II*I, once again to be chaired by Robert Spitzer. The "Introduction" of the completed manual, *DSM*-11I R, contains three reasons for changing *DSM-II*I: data provided by new studies that was inconsistent with some diagnostic criteria, the need to revise all diagnostic criteria for "consistency, clarity, and conceptual accuracy," and to facilitate assisting in the latest ICD revision (APA, 1987, p. xvii). The whole process was touted as little more than a series of minor changes, mostly technical in nature.

Despite initial indications of only modest changes, *DSM-II*I-R was host to a significant refashioning of the newly create multiaxial system. Four of the five axes were altered, with only Axis III ("Physical Disorders and Conditions") left unchanged, possibly as a result of its extension beyond the boundaries of the psychiatric profession's authority. Disorders were shuffled between Axes I and H such that, "the Axis 11 disorders now all share the features of generally having the onset in childhood or adolescence and usually persisting in a stable form into adult life" (APA, 1987, p. 410). Axis IV measurements of psychosocial stress were to include a rating of either "acute" or "enduring," in addition to the severity rating, and the Axis V assessment of adaptive function was slightly changed to reflect a continuum of mental health-illness presented in the Children's Global Assessment Scale. *DSM-II*I-R also increased slightly in both page number and number of diagnoses, rising from 494 to 567 and 265 to 292, respectively (Hours, 2002, p. 20). None of these changes, however, were reflections or predictors of any major professional or nosological shifts, and the general orientation of *DSM*-111 remained quite clear. "In size, character, and structure," Kutchins and Kirk (1997) explained, "*DSM-II*I-R was an unmistakable younger, if not larger, sibling of DSWIT' (p. 46).

DSM-IV: A Significant Change

Only three months after *DSM*-111-R was first published, murmurs began to circulate in the APA about the creation of a Task Force to prepare *DSM*-1-V, by 1988 the revision process had begun in earnest. The official reason for the revision was, once again, to coordinate the publication of a modified American nosology with the release of the ICD, scheduled to enter its tenth edition in 1993.

Despite the fact that each of the three previous editions of *DSM* had been instigated by this same motivating factory, alignment with ICD-10 did not satisfy inquiries concerning the necessity of *DSM*-IV. Many psychiatric professionals wondered openly in journal articles and letters to the editor whether *DSM*-IV was worth the disruption in research that it would necessarily cause (Dean, 1991, p.1426). Mark Zimmerman (1990) wrote along and impassioned letter to the editor in Archives of General Psychiatrlv posing several important questions and concerns about the forthcoming manual, such why a full revision was necessary as opposed to a simply pamphlet update and whether financial motivations (and not advancement of psychiatry) were behind the APA's desire to revise.

In spite of these questions surrounding the rapid alteration of *DSM-III-R*, the process of revision began in 1988. Structurally speaking, the process of revising *DSM-III-R* was by and large identical to the method used since *DSM*-11, utilizing an executive committee supplemented by the advising of various subcommittees oriented towards specific grouping of disorder. One notable difference from the two previous revisions was the individual presiding over the revision process, a position passed from Robert Spitzer to Allen Frances. As Kutchins and Kirk (1993) explained:

> If Spitzer approached the task of constructing a new manual as an architect, Frances has approached it as a developer, carefully orchestrating all of the disparate forces who are ready to battle over words, phrases, and sentences. One long-time associate has described Spitzer as a pot-stirrer who liked to whip things up. If we were to apply a parallel simile to Frances he would be a Cuisinart, anxious to blend everything into a smooth homogenous concoction (p. 225).

Chief among the innovations of *DSM*-117 was a focus on empirical research, known widely as evidence-based medicine, embodied by the notion that "all changes should be based on systematic data collection and review" (Pincus & McQueen, 2002, p. 16). This attention to clinical data had its roots in a desire to create a manual

grounded in research, as opposed to one designed to help stimulate it, as *DSM-III* and *DSM-III-R* had done. Frances' conservative approach to change, however, and the general emphasis in *DSM-IV* of staying the course when empirical research could not disprove the status quo may have actually had a counter-intuitive effect, serving to effectively "institutionalize" a large proportion of the sweeping changes undertaken by *DSM-II*I, regardless of empirical foundations (Kutchins & Kirk, 1993, p. 225).

One of the greatest practical contributions of *DSM-lV* was the change made in diagnostic criteria sets to resolve confusion and reflect newly available data. Many decisions in *DSM-Ill* and *DSM-III-R* were made by balloting those with clinical experience, a situation that contributed to varying degrees of precision in the diagnostic criteria outlined for each disorder. Some illnesses specified discrete time frames for symptomology, such as the need for a sixty-day window for symptoms to appear and disappear in seasonal pattern for mood disorder. *DSM-lV* aided in answering queries into the exactitude of these time frames (What about a fifty-nine or sixty-one day window?) by making "pseudoprecise" categories less explicit (Pincus & McQueen, 2002, p. 20). Additionally, numerous whole diagnoses were included (acute stress disorder, Asperger's disorder, etc.) and excluded (e.g. identity disorder), with the result being an overall increase from *DSM-111-R* to *DSM-lV* in both page number, up from 567 to 886, and number of diagnoses, rising from 292 to 365.

Even before *DSM-lV* was published it was advocated that subsequent nosological revisions should only occur in the wake of highly compelling evidence of a need for change, such as the discovery of specific physical etiology. Zimmerman (1990) asserted that, "If psychiatry is to continue to move forward as a scientific discipline, an end must come to the practice of tinkering with criteria without evidence that the new product is an improved one" (p. 974). He proposed that new editions of the *DSM* be released no more than once every twenty years, to be supplemented with source books (collections of relevant research findings) every seven to ten years and APA-sponsored reports on an as needed basis (Zimmerman, 1990, p. 976).

DSM-IV-TR and Beyond

DSM-IV was released in May 1994, amid much coverage in the national media. Receiving far less attention nationally was the release two years later of a *DSM-IV Coding Update* that included numerous modifications in the code numbers assigned to particular mental disorders. Within this slim coding volume was an announcement of intentions to release a text revision of *DSM-IV* in 1999 or 2000, to include no alterations in diagnoses or criteria sets, but instead to make simple additions to sections providing information on course, prevalence, etc. Kutchins and Kirk (1997) recalled with suspicion that, "Very shortly after publication of *DSM-III*, a revision was announced and users were assured that it was to be a minor midcourse correction to incorporate new findings and rectify errors. When *DSM-III-R* appeared, most of the diagnoses had been changed, new ones had been added, and other substantial alterations had been adopted" (p. 265).

The revision of *DSM-IV (DSM-IV-TR)* was released in 2000 to little fanfare. In contrast to the liberties taken by the Work Group to Revise *DSM-III*, the group in charge of *DSM-IV-TR* stayed within the boundaries of a minor text alteration, adding only 50 pages to the manual and no new diagnoses. Its goal was simply to facilitate early inclusion of growth in research knowledge that had occurred, because *DSM-V* was not scheduled for print until at least 2010.

This timeline for *DSM-V* is still intact, with no hints of any changes in the schedule of release. The greater psychiatric profession, however, is already preparing for the next revising process, and a current search for *"DSM-V"* in PsycINFO yields over 35 hits for articles containing both suggestions for the manual and predictions of *DSM- V's* outcome. Barring any major paradigm shifts in the psychiatric profession, *DSM-V* will likely build on the evidence-based tradition that Frances firmly established in the creation of *DSM-IV*. In fact, it is likely that until research psychiatrists lose the hold on the profession that they gained in the 1970's with the fall of the psychodynamic orientation, future revisions will continue to parallel the current research-oriented trends of the mental health care world.

Ultimately, as psychiatry begins to uncover more and more of the "biological abnormalities" to which Kendell (1991) referred, a major shift in psychiatric nosology is liable to occur. This move will be to a diagnostic system that moves away from the current emphasis on symptom-based diagnostic criteria and towards etiological descriptions of mental disorders (Schaffner, 2002). As Kilhstrom (2002) entreats:

> For Kraepelin, diagnosis by symptoms was a temporary fall back, to be used only because diagnosis by pathology and etiology was not possible. This "fallback" has dominated our thinking for more than a century, and it is time to press forward, with all deliberate speed (p. 297).

Such a perspective is not only advocated by Kihlstronn (2002) and Schaffner (2002) but also, more subtly, by those producing each *DSM* edition, who hail each subsequent version as more efficacious and more valuable than the last. Grob (1991) addressed the idea of progress in nosology in the conclusion of his essay on the history of *DSM*:

> To contemporary psychiatrists the history of nosology represents aversion of the idea of progress; advances in knowledge supposedly lay the foundation for the creation of new categories that describe reality in better and more accurate terms. Within such a perspective, the history of psychiatry is moving on an upward gradient toward an ideal end. In this specific instance, the final goal is a definitive and presumably unchanging nosology of mental illnesses (p. 430).

It is difficult to argue with the desire for such an outcome, where all issues of etiology, diagnosis, and treatment can be comprehensively addressed with the publication of a single volume, however unwieldy. However, the want for such an outcome precludes an understanding of the history and development of psychiatry and psychiatric nosology; insights provided by this professional meta-narrative illuminate the danger in considering the eventuality of an ideal, unchanging psychiatric nosology.

There is the fallacy, often implicit in the claims of any profession (not just psychiatry), assuming that all progress is progress towards something better - in the case of psychiatric classification, an ideal, static nosology. In the case of psychiatry, this is not truly a fallacy, because it is relatively unarguable that the profession's nosology has progressed since Greek humeral theory and even since the first official nosology, *DSM*. However, one must take care not to equate *progress* within the limitations of the surrounding professional environment with *advancement* towards an ideal end. This is a mistake often made in the appraisal of biological evolution, where natural selection can easily be misconstrued (with only a small touch of anthropocentrism) as the means directed at achieving an "optimal" end.

Beutler and Malik (2002) applied this idea to *DSM's* using the evolutionary arguments of R.A. Fisher and Sewall Wright (see Provine, 1986), who argued back and forth regarding whether or not the majority of current species had reached their full evolutionary potential. Fisher asserted that species were mostly optimalized, residing upon what could be imagined as the highest peak, surrounded by valleys of lower evolutionary fitness. Wright countered this by proposing that the peak on which most species resided is not likely the highest peak in all the landscape but rather what he termed a "local optimum." This would represent the highest point that a species could see from where they were now, though not necessarily the highest point possible. Psychiatric nosology, Beutler and Malik (2002) asserted, is likely subject to the same shaping forces and the same tendency to reside on a local optimum.

As this thesis has examined, the profession of mental health and its practitioners have been prone to fluctuations throughout their history, exposed to numerous shifts in the loci of power, social and technological experience, theoretical orientation, and financial resources - the shaping forces that Beutler and Malik (2002) referred to. These professional alterations affected not just the day-to-day activities of mental health practitioners but also the predominant psychiatric nosology, resulting in the substantial changes in classification that have been discussed throughout this paper.

If this history of change affords us any glimpse of the forthcoming, then the profession of psychiatry is unlikely to exist as a static entity future. Additionally, based on historic trends, it is just as unlikely that future shifts in the psychiatric profession will be unaccompanied by alterations in the nosology of mental illness. The idea of progression towards a definitive, unchanging nosology seems a tenuous outlook to endorse.

Much less unreasonable is the belief, outlined earlier, that nosology will eventually move towards a focus less on symptomology and more on etiology and ultimate causation. As research into mental disorders progresses and knowledge of genetic and environmental contributions to psychopathology accumulates, it is hypothetically possible that later *DSM* editions could ultimately become objective, irrefutable sources of knowledge on classification and diagnosis, a sort of Periodic Table of mental illness. The notion of a *DSM* Task Force setting out

to revolutionize the classification of mental illness could be laid to rest, for the only changes possible in a definitive nosology would be the expansion of descriptive research literature and the accumulation of necessary terminological or statistical updates (similar to the mission of the text revision of *DSM-IV*).

The ultimate feasibility of this outcome for psychiatric nosology is highly and, for the moment, irresolutely debatable. What should be emphasized, however, is that psychiatric nosology does not emerge simply as the result of "advances of knowledge" (Grob, 1991, p. 430). Rather, systems of classification are born of a myriad of issues and influences that circumscribe the knowledge itself: whose knowledge is paid attention to (professional prominence), changes in where the knowledge comes from (locus of professional power), who has the funds to produce the knowledge (financial resources), how the knowledge is interpreted (theoretical conceptions), and the environment of knowledge application (social/technological surroundings). In this light, even the presence of a complete, objective knowledge base regarding mental disorders may not guarantee a definitive, unchanging nosology. As Grob (1991) noted, perhaps, "the only constant is the process of change itself. The search for a definitive nosology, therefore, may simply be an expression of the perennial human yearning for omniscience - an attribute eagerly sought by many but never yet found" (p. 430).

End Notes:

[1]Bearing in mind that there are two prominent APA's in the realm of behavioral science (American Psychiatric Association and American Psychological Association), it will be used in this paper only to refer to the American Psychiatric Association.

[2] "Nosology," a term frequently used in this paper, is a classification or list of diseases

[3]For a further exploration of the growth of medical professionalism as it relates to a specialized body of knowledge, see Friedson, E. (1970) Profession of Medicine: A Study of the Sociology of Applied Knowledge and Starr, P. (1982) The Social Transformation of American Medicine.

[4] The manual divided mental illness into 22 categories: traumatic psychoses, senile psychoses, psychoses with cerebral arteriosclerosis, general paralysis, psychoses with cerebral syphilis, psychoses with Huntington's Chorea, psychoses with brain tumor, psychoses with other brain or nervous disease, alcoholic psychoses, psychoses due to drugs and other exogenous toxins, psychoses with pellagra, psychoses with other sc)mabc disease, manic-depressive psychoses, involution melancholia, dementia praecox (later schizophrenia), paranoia or paranoid conditions, epileptic psychoses, psychoneuroses and neuroses, psychoses with constitutional psychopathic inferiority, psychoses with mental deficiency, undiagnosed psychoses, and a final category for patients without psychoses.

[5] Granted that the majority of psychiatrists in the military were not actually tit the United States d1iring the war years, their return following the war would result in indicated doubling.

[6] Adolph Meyer, who taught at Johns Hopkins from 1910-1941, expressed the view during that time that the etiology of mental illness was found largely in personal history, and that mental disorders were reactions to life events.

[6]Adolph Meyer, who taught at Johns Hopkins from 1910-1941, expressed the view during that time that the etiology of mental illness was found largely in personal history, and that mental disorders were reactions to life events.

[7]The ten categories in *DSM-II* are: mental retardation (all causes), organic brain syndromes, psychoses not attributed to physical conditions listed previously, neuroses, personality disorders and certain other non- psychotic mental disorders, psychophysiologic disorders, special symptoms, transient situational disturbances, behavior disorders of childhood and adolescence, and conditions without manifest psychiatric disorder.

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