

The Diagnostic and Statistical Manual: Historical Observations

Manual Diagnóstico e Estatístico: Observações Históricas

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Abstract

A variety of social, political, and economic factors influenced the creation of the first *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1952. Subsequent to DSM-I, cultural, medical, and economic factors shaped each successive version of the DSM; we discuss some of the more prominent controversies these editions have generated. Publication of the DSM-5 in May 2013 sparked a new round of debates concerning the possible impact on patients and society as a whole.

Keywords: History of Psychology; Diagnostic and Statistical Manual (DSM); mental illness.

Resumo

Uma variedade de fatores políticos e econômicos influenciou a criação do primeiro Manual Diagnóstico e Estatístico de Transtornos Mentais (DSM), em 1952. Após o DSM-I, fatores culturais, médicos e econômicos formataram as versões sucessivas do DSM; discutimos algumas das mais prominentes controvérsias geradas por essas edições. A publicação do DSM-5, em maio de 2013, levantou um novo ciclo de debates relativos ao possível impacto nos pacientes e na sociedade como um todo.

Palavras-chave: História da Psicologia; Manual Diagnóstico e Estatístico (DSM); doença mental.

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We considered all versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) from the first one published in 1952 to the latest revision published in mid-2013. To review these versions of the manual, we performed an extensive literature search using terms such as [DSM], [history of DSM] [mental disorders] [mental health insurance] [International Classification of Diseases (ICD)] [anti-psychiatry], and [American Psychiatric Association] as well as the names of the major figures associated with the manual. Our particular focus was on the impact of health insurance on the development of the DSM. A secondary focus was on the changes in structure and disease classification. Our interest was piqued by the controversy beginning in 2010 that surrounded the introduction of DSM-5; in reviewing the earlier versions of the manual of course we discovered that controversy has surrounded the DSM from its inception. A complete review of the history of the DSM would, naturally, discuss the interrelationships between early versions of the DSM and the Census, as well as place the DSM in the context of earlier classifications schemes of mental disorders such as those developed by Emil Kraepelin and Jacques Bertillon. The interested reader may find the familiar

themes in Munsche and Whitaker's (2012) review of 18th century classifications of mental disease of interest in this regard.

DSM-I: Epidemiological and Social Impetus, Precursors, and Formation

19th Century – 1952

Although the first Diagnostic and Statistical Manual of Mental Disorders (DSM) was not published until 1952, there is a great deal of history and a collection of driving forces that are responsible for its publication. In the 19th century, the prevailing attitude in psychiatry was that mental disorders ran individual courses; many believed that generalizations and nosology were not helpful (Grob, 1991). Owing to the fact that little about the link between physical pathology and mental disorders was well understood, psychiatrists were typically skeptical of defining internal symptoms by behavior. Eventually, demographic accuracy for Census applications became a factor that required categorical diagnosis of mental disorders, and this was partially the motivation to develop further classification (Grob, 1991).

Although nosologies of mental illness have been published since the 18th century (Munsche & Whitaker, 2012), Kraepelin's classification system was one of the first of the 19th century to move toward a modern generalized notion of insanity and away from individual characteristics of mental illness. He collected data from a large group of patients, factoring out personal circumstances and focusing on general and overriding characteristics that brought them together. Kraepelin has had a widespread influence on psychiatric nosology for the past hundred years, and this influence is still seen in psychiatric manuals today (Decker, 2007).

One early impetus for the creation of the DSM lies in the advent of the Census in 1790, a year after George Washington's inauguration, by the marshals of the US judicial districts (United States Census Bureau, 2013) leading to gathering information about each member of society in a format amenable to statistical analysis. The natural extension of this was a desire for epidemiological and statistical data on mental illness. The *Bertillon Classification of Causes of Death*, published in 1893 by Jacques Bertillon, was an early expression of this desire, and a precursor to the *International Statistical Classification of Diseases*. In 1898, the American Public Health Association recommended the adoption of Bertillon's system to registrars of Canada, Mexico, and the United States. The name of Bertillon's manual was changed to the *International Statistical Classification of Diseases, Injuries, and Causes of Death* in 1949, to indicate the expansion to include mortality and morbidity statistics (World Health Organization, n.d.). This was published about the same time as the publication of the first DSM in 1952; the *International Classification of Diseases (ICD)* can be thought of as the trunk of a tree, with the DSM composing the mental and behavioral disorders branch of the system (World Health Organization, n.d.). Carolus Linnaeus (1707–1778) had done much the same thing in the 18th century. His 1759 book *Genera Morborum* arranged all human diseases into 11 classes, 37 orders, and 25 genera; the subsection of Class 5, *Mentales*, divided mental illness into 3 orders and 25 additional genera (Munsche & Whitaker, 2012).

The DSM classifications may be described as arising out of a combination of moral, social, political, and ideological viewpoints of clinicians and researchers during the 200 years preceding the publication of the first DSM manual (Grob, 1991).

It is also important to remember that DSM-I was created after World War II, and was partially a reaction to the return of military veterans from the war. Many veterans showed nonpsychotic but nonphysical disorders, and a number of military medical officers from World War II turned their attention to the treatment of these disorders (Baker & Pickren, 2007; Pickren & Schneider, 2005). The creators of DSM-I were influenced by the large number of these environmentally triggered disorders from the war, and in turn, described nonpsychotic disorders as reactions to environmental stimuli. Psychiatrists believed in the combined forces of psychological and environmental factors; for example, many disorders were characterized as arising from poor living conditions (Grob, 1991). The experience of World War II and the large number of veterans returning home with severe psychological trauma from the war brought many disparate areas of Psychology together (Wilson, 1993). Kraepelin's discrete categorical approach was gradually replaced by the environmentally based psychosocial and psychoanalytical approaches that dominated psychiatry at the time. The asylum approach and related ideas were declining in popularity whereas the psychosocial and psychoanalytic ideas of Freud, Meyer, and others came to dominate the field of psychiatry (Wilson, 1993). The ideas of Menninger, a major figure in psychosocial thought after World War II, clearly exerted an effect on the DSM; instead of Kraepelin's discrete categorical descriptions of disorders, Menninger viewed all disorders as a "failure to adapt to the environment" (Wilson, 1993). This description impacted the treatment and classification of many mental disorders. The influence of psychoanalytic or psychosocial approaches weighed heavily upon the creation of the first DSM, and prominent psychoanalysts such as Franz Alexander (Marmor, 2002) were involved in the DSM development committee. Alexander was the co-director of the Chicago Psychoanalytic Institute (Oken, 2007) and was influential in psychosomatic medicine and criminology, as well as psychoanalysis in the United States (Gay, 1988). Alexander is credited with influencing the DSM committee to theorize that "reactions" can occur in the brain, causing psychological distress. These reactions could occur with or without clear physiological or anatomical changes in the brain (Oken, 2007). This all occurred, of course, before the development of brain imaging. The use of the word "reactions" in the DSM heavily

reflected the psychosocial approach, as well as the psychological aftermath of World War II for many veterans and civilians.

DSM-II: The Rise of Antipsychiatry, Controversy, and Skepticism: 1965–1980

The DSM-II (1968) was developed in the 16 years after the 1952 publication of the DSM-I. The primary difference between the DSM-I and DSM-II was that mental conditions were no longer described by the term “reactions”; they were referred to as neurosis, psychosis, or disorders (Oken, 2007; Rogler, 1997). In the DSM-II, mental illnesses that were referred to as psychosomatic reactions by Alexander and others were now referred to as psychophysiological disorders. This began the shift to making DSM diagnoses more neurobiologically grounded. At the same time, psychoanalysis was being partially replaced with behaviorism and cognitive sciences, as well as more social approaches (Oken, 2007; Rogler, 1997).

By the 1960s and 1970s, the psychosocial and psychoanalytical approaches to psychiatry were deeply criticized for a failure to deliver promised results (Rogler, 1997; Wilson, 1993). There was a great deal of criticism of the lack of reliable research and conclusive definitions of mental illness using psychoanalytic and psychosocial approaches, and many psychiatrists wanted to move toward a biological, research-based model of mental illness that did not rely so heavily on social constructs and other subjective indicators (Wilson, 1993). A famous example of the antipsychiatry movement in Great Britain was the establishment of “Kingsley Hall” by R. D. Laing in 1965, a residential treatment center reminiscent of the somewhat apocryphal story of Philippe Pinel freeing the insane at the Hôpital Bicêtre in the 1790s (discussed in Pernaski et al., 2013, pp. 534-543).

One major example of the skepticism directed at the validity of psychosocial and psychoanalytic direction of psychiatry in the 1960s and 1970s was the “Rosenhan experiment”. In 1973, David Rosenhan developed this psychological experiment to determine the validity of psychiatric diagnosis. The experiment involved the use of mentally healthy pseudopatients, three women and five men. These participants were sent to twelve psychiatric hospitals in five different states and were told to fake a psychotic episode, primarily complaining of auditory hallucinations

during the episode (Rosenhan, 1973). All participants who faked a psychotic episode were admitted to the hospital; the participants were instructed to tell the hospital staff that they are fine and not experiencing any more psychotic episodes for the duration of their stay. However, the doctors would not release them in spite of this; all the participants were forced to admit to having a mental illness and were administered antipsychotic drugs. Almost all of Rosenhan’s mentally healthy participants were diagnosed with schizophrenia in remission, and their average stay was 19 days in the psychiatric unit (Rosenhan, 1973).

After reporting the results to the hospitals that participants visited, one hospital challenged Rosenhan to submit the “pseudopatients” to the psychiatric unit over a 3-month period. The hospital claimed that their well-trained staff should be able to differentiate Rosenhan’s participants from those who are actually afflicted with a mental illness. Despite the fact that Rosenhan did not send any participants to the hospital in the 12-week period, the hospital found 41 potential pseudopatients (Rosenhan, 1973).

The Rosenhan study indicated that the diagnosis of mental illness is often neither a valid nor a reliable process, and that certain structural components of the American psychiatric institution contributed to this lack of differentiation between sick and well. These implications lead Rosenhan and others to conclude that the process of diagnosis should be more straightforward, specific, and stringent (Rosenhan, 1973). The DSM-III, published in 1980, attempted to tackle this problem by being more accountable, detailed, and containing multiple axes of evaluation (Mayes & Horowitz, 2005).

In addition to the growing antipsychiatry movement, there was also a deep controversy over the diagnostic category that covered homosexuality. Protests were held at American Psychiatric Association’s annual conferences from 1970 to 1973 to fight for the removal of homosexuality as a mental disorder under the category of sexual deviance in the DSM-II (Spitzer, 1981). Homosexuality was originally listed in the first DSM as a Sociopathic Personality Disturbance until 1968, when it was changed to a Sexual Deviance Disorder. In 1974, the protesters’ voices were heard and in the seventh printing of the DSM-II, homosexuality was no longer listed as a mental disorder (Spitzer, 1981). However, due to the insistence of Robert Spitzer, who was the chairperson of the DSM development committee at the time, the

DSM replaced the homosexuality diagnosis with a disorder known as Sexual Orientation Disturbance (Spitzer, 1981). This diagnosis lasted until 1980 when the DSM-III was published with homosexuality being listed as Ego-dystonic Homosexuality. It was not until 1987 that the disorder was altogether removed from the DSM with only one related classification under the sexual disorders not yet specified category (Spitzer, 1981).

The Insanity Defense and the Legal Influence of the DSM

The rise of the DSM-III and the medical model also had effects on society at large and the perception of mental illness within the legal system. One compelling example of the growing influence of the DSM-III is illustrated by the two trials of Charles Heads (Slovenko, 2011). Charles Heads, a Vietnam Marine Corps veteran, had various “flashbacks”, depression, and nightmares for the 10 years following his return from Vietnam, and in an incident that he claims was a “reliving of duty” (Slovenko, 2011), attacked his brother-in-law’s home as if pursuing an enemy combatant. Heads shot and killed his brother-in-law with a rifle, and, in his initial 1978 trial, was charged with homicide that was characterized by domestic violence; he received a life sentence. Three years later, in 1981, Heads received a second trial due to a ruling that the judge had not conducted his initial trial properly. In the second trial, Jack Wellbourn, Heads’s attorney, pursued Heads’s symptomology as basis for an insanity defense. The insanity defense was based on information that Wellbourn came across in 1980, when he read that the APA classified the symptoms presented by Heads as a mental disorder, namely, post-traumatic stress disorder (Slovenko, 2011). Post-traumatic stress disorder was used as the basis for an insanity plea, and the jury found Heads not guilty in the second trial. For the first time, post-traumatic stress disorder was successfully used as the basis for an insanity defense in a capital trial (Slovenko, 2011). This case illustrates the growing influence of the DSM and psychiatric classification over the span of only a few years; it is noteworthy that Heads was found guilty in 1978, before the DSM-III came out, but was found not guilty as based on an insanity plea in 1981, a year after the DSM-III was published. This suggests that the classification system and medical model of the DSM-III impacted the

way that legal responsibility is viewed in relationship to mental illness and specific diagnoses in a more significant manner than the DSM-II (Slovenko, 2011). The more extensive and empirically based system that arose in the DSM-III had a major impact on how psychiatry, the legal system, and society at large viewed mental illnesses at the time.

More recently, neuroimaging has been a tool in assessing the basis of insanity pleas in criminal trials. Although neuroimaging offers evidence of a physical basis for mental disease that many professionals and laymen view as sufficient for an insanity plea to be established, several problems with this method have recently come to light; see Schweitzer and Saks (2011) for a discussion that neuroscience-based evidence is more persuasive than DSM classifications in a legal context.

Insurance Providers, the DSM, and Mental Health Treatment

While the Civil War Era saw the advent of accident insurance, which provided coverage in the event of steamboat or railroad-related injuries, such insurance did not extend to cover disease or disability until later in the 19th century (Preskitt, 2008; Random History, 2009). When insurance policies did expand to cover diseases, it was quite different than our modern conception of health insurance; it was, in fact, “sickness insurance”. Sickness insurance provided a fund to alleviate the financial burden of missing work due to illness or injury, and this type of insurance was frequently used in the early years of the 20th century. At this point, medical care was not sufficiently sophisticated nor modern enough to significantly change the outcomes for many patients, and the amount of need for medical care generally did not justify paying for insurance policies covering it (Random History, 2009; Thomasson, 2002). Although significant advances in both sanitation and medical practices became increasingly institutionalized and modern, many people still did not see the need for health insurance during much of the early 20th century through the 1920s.

Despite this, in 1929, a group of teachers in Dallas negotiated with a hospital to provide a set number of days of hospitalization for a flat rate that was prepaid by the insured individual or group (Preskitt, 2008; Random History, 2009; Thomasson, 2002). This type of plan became popular, and was encouraged by the American Hospital Association

because it provided a consistent source of funding for hospitals. Very quickly hospitals offering this type of flat-rate, prepaid service joined together, and became the Blue Cross in 1929 (Preskitt, 2008; Random History, 2009; Thomasson, 2002).

To create competition and choice in the health-care market (as well as retain some sense of independence), physicians quickly devised their own prepaid plans and organized together under the Blue Shield. This was partially due to a concern that compulsory national health insurance would be created by the legislation, and there was a fear that this might eliminate both choice and profit in the health-care market at the time (Preskitt, 2008; Random History, 2009; Thomasson, 2002). Owing to the fact that health-care benefits remained voluntary and relatively privatized, physicians under the Blue Shield were able to control to a large extent the prices paid for health care. Patients paid the difference between reimbursement and the costs of the health care provided, allowing health-care providers some judgment and control of prices (Random History, 2009; Thomasson, 2002). Despite the colossal growth of privatized health care through the Blue Cross and Blue Shield programs, governments encouraged employer-provided health-care plans, in which many of the Blue Cross and Blue Shield providers would eventually take part (Random History, 2009; Thomasson, 2002).

Although the advent of commercial health insurance carriers occurred at the end of the 1920s, mental illnesses and psychiatric treatment were not covered by these plans (Blostin, 1987). Many individuals with psychiatric disorders resided in State mental hospitals, as treatments for mental illness were not covered by insurance plans and most general hospitals did not offer psychiatric care (Blostin, 1987). This pattern continued until after World War II.

In late 1945, President Truman addressed Congress on the need for national health insurance, and in 1946, the revised Wagner–Murray–Dingell bill was introduced; this bill proposed a national health insurance system. In the same year, Truman signed the National Mental Health Act of 1946, which was a major step forward in the arena of funding and research for mental health issues, as it was the first time that federal funds were mandated for such purposes in history (Herman, 1995; National Institutes of Health, 2013; Pickren & Schneider, 2005). The establishment of the National Mental Health Act also

led to the creation of the National Institute of Mental Health in 1949. In addition to these advances in funding and research, there were other steps toward parity for mental health treatment. Many states enacted laws that required commercial insurance companies to cover psychiatric treatment and mental illness, and this contributed to increasing the amount of treatment available for those with mental illnesses (Blostin, 1987). It became increasingly common for general hospitals to offer psychiatric treatment; as a result, many opened psychiatric departments and hired a number of staff psychiatrists (Blostin, 1987). These steps are all indicative of the post-World War II impetus to provide greater access to both mental and physical health services for American citizens, and were likely related to the advent of the DSM and the consequent increase of standardized terminology and descriptions for mental illnesses.

In 1961, another move toward greater coverage and access to care for psychiatric illnesses was established. President Kennedy had asked the United States Civil Service Commission to establish a requirement for the Federal Employee Health Benefits Program to cover psychiatric disorders on a similar level to physical illnesses. This was a major step in the coverage of mental health issues, as most providers under the Federal Employee Health Benefits Program had followed the lead of the private health-care providers, which only covered limited, if any, access to mental health care (Barry, Huskamp & Goldman, 2010). In addition to this, the Blue Cross and Blue Shield plans began to offer mental health-care coverage, and by 1971, all of the Blue Cross and Blue Shield plans provided coverage for mental health care (Blostin, 1987). The move toward parity for psychiatric treatment was a groundbreaking step in the recognition of mental illness as a serious and debilitating ailment. It is likely that the framework set by the DSM provided infrastructure for modern psychiatric treatment, as by adding structure and classification, it allowed clinicians to provide more standardized diagnoses that can be recognized as requiring treatment and meriting coverage by health insurance (Barry, Huskamp & Goldman, 2010).

Despite the initial progress, by 1975, the Federal Employee Health Benefits Program was allowed to severely limit their mental health coverage options. It was also found that while health insurers may cover hospitalization for mental illnesses at a similar level

to physical ailments, outpatient psychiatric treatment was covered much less than outpatient treatment for physically manifesting disorders. Many plans restricted the number of days, or amount of money spent on psychiatric treatment, while not imposing such limits on many treatments for other illnesses. The limitations imposed on mental health care are often cited as being due to the occasionally indefinite nature of such treatment, and the lack of objective evidence of disease (Barry, Huskamp & Goldman, 2010).

Despite this, coverage of mental health care has been gradually increasing over time, as more insurance companies and health-care providers recognize mental illnesses and the DSM characterizes more mental health disorders. One example of this trend is the passage of the Mental Health Parity Act in 1996, which prevents insurance providers from placing annual or lifetime limitations upon coverage of mental health treatments for certain psychiatric disorders (Mental Health America, 2013). This was a major step forward and today organizations are still working toward gaining parity for more mental illnesses to be covered without strict impositions from insurance and health-care providers.

DSM-III: Toward a Research-Based Medical Model and Axial System of Diagnosis

1980–1994

In the DSM-III, there was a major attempt to combat the controversy and skepticism encountered by the DSM-II (and the psychiatric profession in general), and there was a shift toward more specific and biologically rooted diagnostic criteria. They also added the multi-axial approach to evaluation in the DSM-III (Williams, 1985). This multi-axial approach entails that the individual be evaluated under several different clinically relevant categories. The concept of multi-axial evaluation was introduced in the 1970s and was incorporated into the DSM's structure in the DSM-III (Williams, 1985). The shift to evaluating patients based on multiple clinically relevant axes added a new dimension to the DSM system. Axis I assessed clinically relevant disorders such as anxiety or depression, Axis II assessed personality disorders, Axis III assessed general medical conditions, and Axis IV assessed the psychosocial and environmental issues present. Axis V referred to a global assessment of functioning (American Psychiatric Association, 2000).

The DSM-III was published in 1980 and was credited for returning descriptive diagnosis and the medical model back to the manual and American psychiatry (Wilson, 1993). There was a shift from a putative bio-psycho-social model to a research-based medical model, and there was a return of Kraepelin-esque descriptive psychiatry that marked the re-medicalization of the DSM system (Blashfield, 1998). There was a major shift from placing the most emphasis on the input of clinicians to focusing on the input of researchers (Wilson, 1993).

One major catalyst for the DSM-III's research-based medical model of mental illness was the crisis of legitimacy for the psychiatric profession that occurred during the antipsychiatry movements of the 1960s and 1970s, as discussed earlier (Wilson, 1993). Another driving force behind a more discrete and specific classification criterion found in the DSM-III is the potential for more effective psychiatric medications in this time period. Explicit and unambiguous diagnostic criteria were needed to ensure homogeneity and validity of participant sampling for clinical trials of various psychiatric drugs (Wilson, 1993). Medications could be said to be an impetus for a more experimental and empirically based approach to psychiatry at the time, and the DSM-III is in line with this more research-based model of mental illness.

DSM-IV: New Additions and Future Directions

1994–2013

The DSM-IV, released in 1994, continued the multi-axial, empirically based tradition of the DSM-III. One major change in the DSM-IV was the addition of a new criterion to roughly half of the disorders in the manual (American Psychiatric Association, 2000, 2013a, 2013b). This new criterion was that the symptoms cause a clinically significant level of distress or impairment in the functioning of the afflicted individual. This impairment could be social, occupational, or otherwise (American Psychiatric Association, 2000). The addition of this criterion into the DSM-IV marked an important shift in recognizing that some symptomology may not be pathology if it is not creating significant distress, impairment, or harm in the life of the afflicted individual or others.

Major controversies and additions to the DSM-IV included the addition of Culture Bound Syndromes, as well as Gender Identity Disorder (replaced in DSM-5 with Gender Dysphoria) (American Psychiatric Association, 2000).

Reminiscent of the controversy in the DSM-II over homosexuality, there was a great deal of controversy over the inclusion of the new diagnosis of Gender Identity Disorder (GID) in the DSM-IV. The disorder requires that the patient insists they are internally another sex or that they have the desire to be another sex, without a concurrent physical intersex condition (American Psychiatric Association, 2000). In addition to this criterion, the individual must also meet the clinically significant distress or impairment condition for diagnosis of GID under the DSM-IV (American Psychiatric Association, 2000). There have been significant amounts of controversy about this diagnosis, as it may unduly pathologize the experience of many afflicted individuals (Lev, 2006). Many individuals with GID disagree with the diagnosis as they do not feel that identifying with a different gender constitutes a mental illness (Lev, 2006). However, individuals afflicted with GID also need a diagnosis in order to be able to receive the medical treatment that would allow the sexual reassignment surgery that many affected individuals seek (Lev, 2006). Without the diagnostic label, these individuals are ineligible for treatment and would not be able to undergo sexual reassignment surgery, which is highly politicized and often difficult to obtain. This makes the diagnostic label both helpful and harmful to those with GID, and afflicted individuals must struggle between the desire to be freed of a pathologizing label and the need for recognition of the disorder to receive the medical procedures that they need (Lev, 2006).

Another important addition to the DSM-IV was the collection of Culture Bound Syndromes (American Psychiatric Association, 2000). The Culture Bound Syndromes category refers to culturally localized disorders that occur in only in specific cultural and societal settings throughout the world (Guarnaccia & Rogler, 1999). These disorders cannot include any physiologically presenting symptoms, such as abnormal tissue growth or anatomical changes, and there should be little occurrence of the disorder outside of a specific cultural setting for it to be considered a Culture Bound Syndrome (Guarnaccia & Rogler, 1999).

Some examples of the Culture Bound Syndromes include Amok, *Bouffée délirante*, Pibloktoq, and Zar. Amok, found in the Malaysian culture, refers to the patient experiencing a dissociative episode that climaxes in a hostile, violent, and possibly homicidal outburst. Amok is generally preceded by a slight insult or minor grievance that gradually pushes the afflicted individual to a dissociative and eventually violent episode (American Psychiatric Association, 2000). *Bouffée délirante* is a disorder affecting individuals in West Africa and Haiti, and it is characterized by inappropriate, violent outbursts that are followed by confusion and psychomotor excitement. Visual or auditory hallucinations may also present in an afflicted patient, and these episodes share some resemblance to the Western diagnosis of brief psychotic episodes (American Psychiatric Association, 2000). Pibloktoq, a disorder found in Artic Eskimo communities, refers to a sudden episode involving a dissociative component that is immediately followed by roughly 30 minutes of extreme excitement. The excitement generally leads to seizures and a brief comatose period, and patients generally report complete retrograde amnesia of the incident (American Psychiatric Association, 2000). Zar refers to a disorder found in North African and Middle Eastern societies, in which individuals claim to experience possession by spirits, and common reactions include shouting, laughing, weeping, or hitting one's head repeatedly against a wall. These are generally acute, temporary dissociative episodes, but have been known to occur chronically in some individuals (American Psychiatric Association, 2000). Interestingly, many of these disorders have "folk" treatment methods that are generally well established in the given culture in which they are presented (Guarnaccia & Rogler, 1999).

The inclusion of these culturally specific disorders provides an interesting addition to the DSM-IV, as many of these syndromes are not directly linked to particular diagnoses in the DSM, and they provide a link back to the earlier psychosocial and environmental perspectives that were more prevalent in earlier versions of the DSM. The inclusion of these disorders seems to mark a move away from the trend of including only extensively validated medical models that rely on empirical research and psychopharmaceutical treatments.

DSM-5: Broadening the Definition of Mental Illness and the (Partial) Demise of the Axial System

2013–Future

The long-awaited DSM-5 is now published, and a great deal of controversy and discussion has occurred about the new diagnostic categories and criteria. One example of a change from DSM-IV into the DSM-5 is that Intellectual Disability (intellectual development disorder) is the new term for mental retardation. The levels of the individual's adaptive function, rather than IQ score, now measure the severity of the disorder. The reason that intellectual developmental disorders are in parentheses in the name is due to classification of disorders as diseases in the *ICD-10*. The classifications of disabilities are on a different scale than the DSM that measures international classifications of functioning, disability, and health. This name was a compromise reached to create a bridge between the two diagnostic classification systems.

Another change in the DSM-5 is in the communication disorders. Stuttering is now referred to as childhood-onset fluency disorder.

There has been controversy over the synthesis of four separate conditions now being considered the autism spectrum disorder (ASD). The conditions were originally autistic disorder, Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder. Now, they will be referred to ASD; the disorder has different levels of severity and is divided into two domains. The first domain includes deficits in social communication and social interaction. The second domain in the diagnostic criterion for the disorder includes prevalence of restrictive repetitive behaviors, interests, and activities (American Psychiatric Association, 2013a, 2013b).

A study done by Ozonoff, South and Miller (2000) supports the DSM-5 synthesis of the four disorders. It was shown when children with high functioning autism and children with Asperger's disorders were observed and compared in three categories (early history, cognitive function, and current symptomology,) the core fundamental symptomology was the same, just with a different level of severity.

Amidst the changes in diagnostic criterion for the DSM-5, a startling 46.6% of the population

will fall under the classification for a mental disorder (Rosenberg, 2013). This astonishing number of Americans will fall under the label of mentally ill due to a variety of factors that have arisen in the decades since the DSM-IV was published.

One major contributing factor is that our medical and psychiatric institutions have placed a greater emphasis on the detection of mental illnesses, implementing increased awareness, detection, and treatment of disorders in the past few decades (Rosenberg, 2013). Another probable reason for the increase in individuals meeting the diagnostic criterion is that the population has actually become less mentally healthy in the past 40–60 years. Studies have compared anxiety levels in today's children to those of children in the 1950s, and it was shown that children today show higher levels of anxiety. In similar comparisons, it was demonstrated that adults score higher on neuroticism today than in the 1960s, and that the population has generally increased rates of narcissism (Rosenberg, 2013). A third reason for the increase in prevalence of individuals diagnosed with mental disorders is the loosened criterion for having a given diagnosis. One example of this is that in DSM-IV, three of six symptoms needed to be met for diagnosis with Generalized Anxiety Disorder, where in the DSM-5, only one of the criteria needs to be met for the diagnosis (Rosenberg, 2013). Yet another example of this is that Binge Eating Disorder was defined as being two episodes of binge eating per week over 6 months in the DSM-IV, whereas in the DSM-5, binge eating disorder is simply defined as binge eating once a week for 3 months (Frances, 2012). Another reason for the increase in individuals meeting diagnostic criteria is a shift in the perception of what is a normal emotional reaction. States that were once viewed as within the range of normal emotional reactions to a given situation are now being examined through a pathological lens, and this has major implications for diagnostic criteria in the DSM-5. This reclassification of what were once viewed as temporary and generally "normal" states into pathological states has widened the scope of mental illness diagnosis greatly. In addition to the pathologizing of some states that were once considered within the normal spectrum of human experience (Copeland, Angold, Costello & Egger, 2013), the DSM-5 has also added disorders that are far more medical than psychiatric in nature. One example of this is that Breathing Related Sleep Disorder is

now included, as well as Caffeine Intoxication and Withdrawal Disorders; these disorders are defined primarily by objective, physiological criterion rather than mental states (Rosenberg, 2013).

The ever-broadening scope of the DSM-5 diagnostic criterion leads to the question of why there are more diagnostic categories and why the criteria for diagnosis have been loosened so much. One reason for this is related to payment of insurance claims; often, a diagnosis is needed if a visit to a clinician or prescription to medication will be approved for coverage by insurance agencies (Rosenberg, 2013). Another reason for the increasing scope of diagnostic criteria is that many people may be able to get additional aid from governmental and community organizations if they have a diagnosis; these resources can be invaluable to those who are struggling with even minor mental or physical health issues. Pharmaceutical interests also play a role in the expanding number of individuals fitting a diagnosis, as when more individuals are diagnosed with a disorder, or if the DSM recognizes a new disorder, consumption of drugs treating such disorders increases. High rates of drug prescription and consumption are also related to the structure and expectations of our society; many patients and doctors favor prescription medications for treatment of mental health, partially due to the drive of consumerism and need for instant gratification in our modern society (Rosenberg, 2013).

As mentioned above, the diagnosis of mental disorders in the population has increased dramatically over the past 20 years. The number of people diagnosed with Attention Deficit Disorder has tripled whereas the diagnosis of autism has increased by 20 times. In addition to this, the prevalence of those diagnosed with childhood bipolar disorder has increased by 40 times (Frances, 2012). These increasingly diagnosed disorders are frequently treated with psychiatric medications. Many young children diagnosed with these disorders are heavily medicated, and some may be medicated unnecessarily (Frances, 2012). A study conducted by the Mclean Hospital and the National Institutes of Health using animals resulted in the findings that if a child is misdiagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and is subsequently treated with stimulants, that child is at a higher risk of developing depressive symptoms in adulthood (Leo, 2005). The results of this study illustrate the likely need for more stringent criteria for diagnosis of these disorders and prescription

of medication, as there is a potential for negative future outcomes in the case of a wrong diagnosis or inappropriate course of medication.

Dr. A. J. Frances is spearheading the recent criticism of the direction of DSM-5 and is by no means going about it quietly (Frances, 2012, 2013). Frances is well qualified to mount this criticism; he helped to prepare the DSM-III and the DSM-III-R and was the chairperson of the task force in the development of the DSM-IV. Part of his criticism of the DSM-5 is his concern that the steady increase of psychological diagnosis will take much needed attention away from the severely mentally ill and redirect it at people who show normal behaviors that happen to have been added to the DSM-5 as medically treatable mental illnesses (Frances, 2013).

Another example of the shift toward looking at what were once “everyday difficulties” as mental pathology is that the DSM-5 will now include Disruptive Mood Dysregulation Disorder. Disruptive Mood Dysregulation Disorder is a diagnosis constructed in a manner that could frame frequent early childhood temper tantrums as a pathological syndrome in need of medication. Only one research group has produced information supporting this diagnostic category, which makes the validity (and reliability) of the construct somewhat questionable, as it is neither well described or established in empirical research (Copeland et al., 2013). Some have suggested that this new diagnosis may lead to further overmedication of children, which can have unforeseen negative consequences on their development (Frances, 2012).

In the DSM-5, Grief now overlaps with Major Depressive Disorder, which may lead to an increase in antidepressant use by those experiencing what was once considered normal grief. The DSM-IV TR had an exclusion criterion for bereavement in Major Depressive Disorder, but it was removed in the DSM-5. It is thought that the change is due to the recognition that bereavement can make individuals more susceptible to major depressive disorder, but it should be considered that many individuals progress through the stages of grieving and are then able to move past the bereavement period. This change in diagnostic criterion may see an increase in those seeking antidepressants during grieving periods, and this could have implications for the acceptable manner to deal with grief in our society (Frances, 2012).

It is also notable that although the criterion for diagnosis of ADHD in the DSM-5 is similar to that

of the DSM-IV, fewer symptoms need to be present in adults. One less symptom present is necessary for ADHD, and this lowering of requirements will include even more individuals in the diagnostic criterion; a potential result is that prescriptions for medications such as methylphenidate could rise even further (Frances, 2012).

Changes in the DSM-5 compared to the DSM-IV are rather significant in the category of eating disorders. In the DSM-IV binge eating contained the criterion that a person had to binge at least twice a week for 6 months in order to be diagnosed. In the DSM-5 this criterion is cut in half; a person only needs to overeat once a week for 3 months to be considered to have a binge eating disorder. One of the more prominent treatments for eating disorders is the use of selective serotonin reuptake inhibitors (SSRIs). This weakened criterion for the disorder could cause a sharp increase in sales of SSRIs, which, while good for the pharmaceutical companies, may be harmful to those diagnosed who may not have a serious issue (Frances, 2012).

There has also been concern over the new diagnostic criterion for autism in DSM-5. The main cause of apprehension regards the legal benefits that those previously diagnosed under the DSM-IV receive from the government and whether or not these new decisive factors concerning the disorder will have an effect on their initial diagnosis, and subsequently, the government aid individuals with autism will receive for their disability (Wright, 2013). Despite this initial apprehension, the DSM-5 clearly states that any individual with a legitimate and well-established DSM-IV diagnosis of autism will continue to receive the treatment and benefits that were previously established (Wright, 2013). In fact, the merger of Asperger's and Pervasive Developmental Disorder (Not Otherwise Specified) into the single diagnosis of ASD has allowed access to treatment and/or government aid for individuals who may have not qualified for these programs under the previous classification system (Wright, 2013). It is also noteworthy that the initial uproar about the ASD classification has settled after release of the DSM-5; many experts on autism have responded positively to the new classification (Wright, 2013). One important modification to the classification system for ASD is that there is now an acknowledgement of the different features shown by males and females who have ASD; this modification should aid health

professionals in recognizing distinctive symptoms of ASD that may be sex specific. Despite the generally favorable outlook upon the new classification of ASD at this time, a major criticism is the new classification of Social Communication Disorder, a new, separate diagnosis from ASD. To establish a diagnosis of ASD, a diagnosis of Social Communication Disorder must first be ruled out (Grzadzinski, Huerta & Lord, 2013). The controversy about this new diagnosis is based on the fact that there is little validity or reliability to support the existence of this disorder; this may create room for misdiagnosis of patients who have ASD but show symptomology that correlates more closely with Social Communication Disorder.

Final Considerations

In conclusion, the structure of all versions of the DSM must be viewed in the context of westernized, non-European social expectations and definitions of mental health, as well as both institutional and economic considerations of our time. The pathologizing of categories in the DSM-5 is an example; a notable earlier example is removing homosexuality from the disease categories. Like the versions of the DSM before it, the DSM-5 can be viewed as a response to a multitude of factors impacting the profession of psychiatry, methods of classification and mental health treatment that have occurred over the last two centuries. One of the less obvious changes between the DSM-IV and the DSM-5 is the change in disease classifications to better align them with biological approaches and pharmacological treatment. The concomitant development of brain imaging techniques in North America and Europe has, perhaps predictably, led to an increase in research identifying altered structural and functional brain correlates of psychiatric illness. One would expect this in turn to begin to influence legal as well as clinical applications of the DSM-5, despite trenchant criticisms such as that of Uttal (2013).

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