DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

(THIRD EDITION - REVISED)

DSM-III-R

AMERICAN PSYCHIATRIC ASSOCIATION

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

(THIRD EDITION - REVISED)

DSM-III-R

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DSM–III–R

INTRODUCTION

Introduction

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This is the revision of the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* better known as DSM-III-R. The last sentence of the Introduction to DSM-III, published in 1980, stated ". . . DSM-III is only one still frame in the ongoing process of attempting to better understand mental disorders." DSM-III-R represents another still frame.

In 1983 the American Psychiatric Association decided, for several reasons, to start work on revising DSM-III. For one, data were emerging from new studies that were inconsistent with some of the diagnostic criteria. In addition, despite extensive field testing of the DSM-III diagnostic criteria before their official adoption, experience with them since their publication had revealed, as expected, many instances in which the criteria were not entirely clear, were inconsistent across categories, or were even contradictory. Therefore, all of the diagnostic criteria, plus the systematic descriptions of the various disorders, needed to be reviewed for consistency, clarity, and conceptual accuracy, and revised when necessary.

Also in 1983, the American Psychiatric Association was asked to contribute to the development of the mental disorders chapter of the tenth revision of the International Classification of Diseases (ICD-10), which is expected to go into effect around 1992. In order for the American Psychiatric Association to provide its best recommendations, it was necessary to assemble committees of experts to review DSM-III and to make suggestions for updating it.

The publication of DSM-III coincided with that of ICD-9; the publication of DSM-IV was planned to coincide with that of ICD-10. Although by 1983 there had been only a few years of experience with DSM-III, it was clear that, with the burgeoning literature in the field, revisions would be needed long before the anticipated publication of DSM-IV in the 1990s.

In this Introduction to DSM-III-R, we discuss the following:

THE IMPACT OF DSM-III

The impact of DSM-III has been remarkable. Soon after its publication, it became widely accepted in the United States as the common language of mental health clinicians and researchers for communicating about the disorders for which they have professional responsibility. Recent major textbooks of psychiatry and other textbooks that discuss psychopathology have either made extensive reference to DSM-III or largely adopted its terminology and concepts. In the seven years since the publication of DSM-III, over two thousand articles that directly address some aspect of it have appeared in the scientific literature. In some of these articles, the results of research studies using the DSM-III diagnostic criteria to select samples have been reported; in others, the reliability or validity of DSM-III-defined disorders has been critically examined.

DSM-III was intended primarily for use in the United States, but it has had considerable influence internationally. As a result, the entire manual, or the Quick Reference to the Diagnostic Criteria ("Mini-D"), has been translated into Chinese, Danish, Dutch, Finnish, French, German, Greek, Italian, Japanese, Norwegian, Portuguese, Spanish, and Swedish. Many of the basic features of DSM-III, such as the inclusion of specified diagnostic criteria, have been adopted for inclusion in the mental disorders chapter of ICD-10.

HISTORICAL BACKGROUND OF THE DSMs

DSM-I. The first edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* appeared in 1952. This was the first official manual of mental disorders to contain a glossary of descriptions of the diagnostic categories. The use of the term *reaction* throughout the classification reflected the influence of Adolf Meyer's psychobiologic view that mental disorders represented reactions of the personality to psychological, social, and biological factors.

DSM-II. In the development of the second edition, a decision was made to base the classification on the mental disorders section of the eighth revision of the *International Classification of Diseases*, for which representatives of the American Psychiatric Association had provided consultation. Both DSM-II and ICD-8 went into effect in 1968. The DSM-II classification did not use the term *reaction*, and except for the use of the term *neuroses*, used diagnostic terms that, by and large, did not imply a particular theoretical framework for understanding the nonorganic mental disorders.

DSM-III. In 1974 the American Psychiatric Association appointed a Task Force on Nomenclature and Statistics to begin work on the development of DSM-III, recognizing that ICD-9 was scheduled to go into effect in January 1979. By the time this new Task Force was constituted, the mental disorders section of ICD-9, which included its own glossary, was nearly completed.

Although representatives of the American Psychiatric Association had worked closely with the World Health Organization on the development of ICD-9, there was concern that the ICD-9 classification and glossary would not be suitable for use in the

United States. Most importantly, many specific areas of the classification did not seem sufficiently detailed for clinical and research use. For example, the ICD-9 classification contains only one category for "frigidity and impotence"—despite the substantial work in the area of psychosexual dysfunctions that has identified several specific types with different clinical pictures and treatment implications. In addition, the glossary of ICD-9 was believed by many to be less than optimal in that it had not made use of such recent major methodologic developments as specified diagnostic criteria and a multiaxial approach to evaluation.

For these reasons, the Task Force was directed to prepare a new classification and glossary that would, as much as possible, reflect the most current state of knowledge regarding mental disorders, yet maintain compatibility with ICD-9. Successive drafts of DSM-III were prepared by fourteen advisory committees composed of professionals with special expertise in each substantive area. In addition, a group of consultants provided advice and information on a variety of special subjects.

ICD-9-CM. Because of dissatisfaction with ICD-9 expressed by organizations representing subspecialties of medicine (not including the American Psychiatric Association), a decision was made to modify the ICD-9 for use in the United States by expanding the four-digit ICD-9 codes to five-digit ICD-9-CM (for Clinical Modification) codes whenever greater specificity was required. This modification was prepared for the United States National Center for Health Statistics by the Council on Clinical Classifications. The American Psychiatric Association, in December 1976, was invited to submit recommendations for alternate names and additional categories based on subdivisions of already existing ICD-9 categories. This made it possible for the developing DSM-III classification and virtually all of its diagnostic terms to be included in the ICD-9-CM classification, which in January 1979 became the official system in this country for recording all "diseases, injuries, impairments, symptoms, and causes of death." The ICD-9-CM codes and diagnostic terms for mental disorders are included in Appendix E.

THE PROCESS OF REVISING DSM-III

Work Group to Revise DSM-III. In May 1983, the Board of Trustees of the American Psychiatric Association approved the appointment of a Work Group to Revise DSM-III. The members of the Work Group were selected to ensure a broad representation of clinical and research perspectives. In addition, they were chosen to ensure expertise in major areas of DSM-III, such as disorders of childhood and adolescence, mood disorders, psychotic disorders, anxiety disorders, personality disorders, and multiaxial evaluation. From the beginning, the Work Group functioned, as did the DSM-III Task Force, as a steering committee to oversee the ongoing work. All of its members shared a commitment to the attainment in DSM-III-R of the same goals that had guided the development of DSM-III:

(1) clinical usefulness for making treatment and management decisions in varied clinical settings;
(2) reliability of the diagnostic categories;
(3) acceptability to clinicians and researchers of varying theoretical orientations;
(4) usefulness for educating health professionals;
(5) maintenance of compatibility with ICD-9-CM codes;
(6) avoidance of new terminology and concepts that break with tradition except when clearly needed;

(7) attempting to reach consensus on the meaning of necessary diagnostic terms that have been used inconsistently, and avoidance of terms that have outlived their usefulness;
(8) consistency with data from research studies bearing on the validity of diagnostic categories;
(9) suitability for describing subjects in research studies;
(10) responsiveness, during the development of DSM-III-R, to critiques by clinicians and researchers.

The major task of the Work Group members was threefold: to serve on advisory committees on subjects in which they had special expertise, to develop a process that would ensure that all proposals for revisions would be systematically reviewed by the appropriate advisory committees, and to resolve certain controversies that could not be resolved within the advisory committees.

Advisory Committees. Twenty-six advisory committees were formed with over two hundred members selected on the basis of their expertise in particular areas. Proposals for substantive revisions in the DSM-III classification and criteria were made and reviewed at a series of advisory committee meetings, several of which were co-sponsored by the National Institute of Mental Health. These were usually followed by smaller meetings of a few members to develop proposals further. Frequently, decisions made by an advisory committee had to be reconsidered when the details of the proposal were worked out by these smaller groups; in some cases, the advisory committee was reconvened to discuss a particular issue further. Most advisory committee decisions were the result of a consensus that emerged among committee members. However, several controversies, particularly in the areas of childhood, psychotic, anxiety, and sleep disorders, could be resolved only by actually polling committee members.

Most of the proposals for revisions came from advisory committee members; some came from other professionals with a particular area of expertise. Most of the proposals were based on clinical experience with the DSM-III criteria, which revealed the need for fine-tuning the criteria to improve their sensitivity and specificity. For example, the DSM-III criteria for Panic Disorder did not permit giving the diagnosis (as the Anxiety Disorders Advisory Committee agreed they should) to people who had only a single panic attack followed by agoraphobic avoidance.

Many proposals for revisions were based on experience using the DSM-III and the proposed DSM-III-R criteria in structured diagnostic interviews. For example, in the process of constructing questions to which responses would allow a clinician to evaluate the DSM-III criteria for Personality Disorders, it was found that many of those criteria were imprecise and in need of further specification. Some proposals were based on reconsideration of a DSM-III decision. For instance, a proposal to revise the DSM-III definition of Paranoid Disorder was based on the realization that a broader definition would be more consistent with historical and clinical concepts and with research findings. Finally, some of the proposals came directly from research studies that had evaluated DSM-III criteria. For example, a proposal to eliminate the DSM-III requirement that the onset of Schizophrenia be before age 45 came from a review of several studies in which that distinction was found to lack validity.

The advisory committees had the difficult task of balancing the potential advantages and disadvantages of each proposal. This often involved seeking informed answers to the following questions:

1. Was the proposal supported by data from empirical studies?

2. Was there a consensus among experts that the revision would significantly increase the utility (validity) of the category for making treatment and management decisions?

3. Would the presumed advantages of the proposal sufficiently offset the disadvantages to researchers of having to switch to new criteria when studies that had not yet been completed were still using the DSM-III criteria?

4. Was the proposed revision consistent with general approaches taken in the rest of the classification, for example, in restricting the use of diagnostic hierarchies to a limited number of situations (see discussion of diagnostic hierarchies below)?

5. Would the proposal interfere with compatibility between DSM-III-R and ICD-9-CM codes?

6. Could the proposal be operationalized in specified diagnostic criteria with the expectation of at least a fair degree of diagnostic reliability?

7. Did the proposal imply an underlying theory about the mechanism of the disorder that was not supported by data?

8. Was the proposal premature for consideration in DSM-III-R, and more properly within the scope of DSM-IV, e.g., a proposal for a new diagnostic class of disorders associated with psychosocial stress?

If the proposal involved dropping a category from the DSM-III classification (e.g., Ego-dystonic Homosexuality) or adding a new diagnosis to the classification (e.g., Late Luteal Phase Dysphoric Disorder), there were two additional considerations:

1. Does the proposed category meet the requirements of the DSM-III definition of mental disorder?

2. How compelling is the research or clinical need for the category?

In attempting to evaluate proposals for revisions in the classification and criteria, or for adding new categories, the greatest weight was given to the presence of empirical support from well-conducted research studies, though, for most proposals, data from empirical studies were lacking. Therefore, primary importance was usually given to some other consideration, such as: clinical experience; a judgment as to whether the proposal was likely to increase the reliability and validity of the diagnosis under consideration; or, in the case of a new diagnosis under consideration, the extent of the research support for the category as contrasted to its perceived potential for abuse.

It should be noted that in all of the discussions regarding the revision of the over two hundred DSM-III categories, the possible impact of a proposal on reimbursement for treatment was mentioned only with regard to three of the categories. Furthermore, that issue did not play a major role in the relevant decisions.

DSM-III-R in Development. During the process of developing DSM-III-R, two successive drafts (10/5/85 and 8/1/86) of the proposed revised diagnostic criteria were made available to interested professionals and widely distributed for critical review. Feedback from reviewers of these drafts was extremely helpful in identifying problems that needed further attention.

Field Trials of Proposed DSM-III-R Criteria. Three national field trials were conducted to help in the development of diagnostic criteria for the following diagnoses: Disruptive Behavior Disorders (Attention-deficit Hyperactivity Disorder, Oppositional Defiant Disorder, and Conduct Disorder); Pervasive Developmental Disorders (Autistic Disorder); and Generalized Anxiety Disorder and Agoraphobia without History of Panic Disorder. A brief description of each field trial and a list of its participants are given in

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