

FACT

S h e e t

Psychiatric Diagnosis and the *Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), DSM-IV*

The American Psychiatric Association published a Fourth Edition of its *Diagnostic and Statistical Manual of Mental Disorders* in 1994. It replaced *DSM-III (Revised)*, which was published in 1987.

DSM-IV's Importance to Psychiatric Diagnosis

Diagnosis is the foundation of any medical practice, and the twentieth century has seen a revolution in medicine's ability to identify--and treat--the illnesses that plague humanity.

The practice of psychiatry--the medical specialty that treats mental illnesses--has been a major participant in this revolution, and indeed in the last four decades has seen it accelerate. Psychiatrists depend on accurate diagnostic tools to help them identify precisely the mental illnesses their patients suffer, an essential step in deciding what treatment or combination of treatments the patient needs. The American Psychiatric Association's *Diagnostic and Statistical Manual (DSM)*, in its four editions, has become a central part of this process. *DSM-IV* is based on decades of research and the input of thousands of psychiatric experts from across the country and in every sub-specialty. It has evolved into a carefully constructed, numerical index of mental illnesses grouped by categories and sub-categories. Each entry contains a general description of the disorder followed by a listing of possible symptoms, which enables clinicians to identify their patients' illnesses with a high degree of accuracy and confidence.

In addition to its utility as a diagnostic tool, the *DSM-IV*'s mental disorders coding helps in the process of research data collection and retrieval, and also helps as researchers compile information for statistical studies. The *DSM-IV*'s codes are in agreement with the *International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM)*. *ICD-9-CM* is based on the *ICD-9*, a

publication of the World Health Organization used worldwide to aid in consistent medical diagnoses. The *DSM-IV*'s codes often are required by insurance companies when psychiatrists, other physicians, and other mental health professionals file claims. The U.S. government's Health Care Financing Administration also requires mental health care professionals to use the codes for the purposes of Medicare reimbursement.

DSM-IV's Special Features

- *DSM-IV* was developed through an open process involving more than 1,000 national and international researchers and clinicians drawn from a wide range of mental and general health fields.
- *DSM-IV* is based on a systematic, empirical study of the evidence (consisting of literature reviews, data re-analyses, and field trials).
- *DSM-IV* is accompanied for the first time by a separate *Sourcebook* which carefully documents the rationale and empirical support for the text and criteria sets presented in *DSM-IV*.
- *DSM-IV* is clearly more specific and easier to use than previous versions. *DSM-IV* reflects an increased emphasis on the influence of culture, ethnicity, age, and gender on psychiatric assessment and diagnosis.
- *DSM-IV* reflects an increased emphasis on differential diagnosis and the role of substance use and general medical conditions in the development of psychiatric disorders.

How Psychiatrists and Other Mental Health Professionals Use *DSM-IV*

It is important to understand that psychiatrists and other mental health professionals do not use *DSM-IV* as a "cookbook" for psychiatric diagnosis. *DSM-IV* has been carefully written and exhaustively researched, but

it cannot take the place of psychiatric training in the recognition and treatment of mental disorders and the clinician's informed judgment.

The process of diagnosis begins with the patient interview. Psychiatrists will order or conduct a careful general medical examination of each patient to assess his or her general health. They will request their patients' medical records from other physicians who've treated their patients. They will carefully question their patients about their past history and the symptoms of their disorder, the length of time they've had the symptoms, and their severity. If it seems warranted, the psychiatrist will also specify a period of observation. It is only after this careful assessment process that a psychiatrist will turn to the *DSM-IV*.

DSM-IV is organized according to phenomenology, that is, by groups of like symptoms which are commonly associated with a specific illness. Its descriptions of illnesses and lists of symptoms are meant to support the diagnostic process, providing clinicians with diagnostic guidelines, *not* a set of disorder "check lists."

As the number of psychiatric diagnoses has grown over time, researchers and clinicians have been able to share their knowledge of mental disorders with greater precision. An increased number of diagnoses does not mean, however, that more individuals are being diagnosed with mental illnesses. The diagnostic "pie" has not gotten larger; rather, the pieces of that pie have gotten smaller and more precise. More precise diagnoses significantly aid the advance of research and treatment.

After analyzing the information gathered in the patient interview and from other sources in the context of the *DSM*, a psychiatrist makes a *preliminary* diagnosis. Even with an increased number of diagnoses available, there are few perfect fits in the diagnosis of any medical condition, because symptoms may vary from person to person, both in their type and severity. For this reason, experienced clinicians know that it is important to observe a patient and the patient's symptoms over time, and to sharpen the diagnosis using the information this observation provides.

Use of *DSM-IV* in Forensic Settings

When the *DSM-IV* categories, criteria, and textual descriptions are employed in making legal judgments, there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of an imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. For example, the inclusion in *DSM-IV* of diagnostic categories such as pedophilia or pathological gambling does not imply that these condi-

tions meet legal or other non-medical criteria for what constitutes "mental disease," "mental disorder," or "mental disability." Many such terms, including "insanity" and "mental abnormality," are legal concepts, not medical ones. The clinical and scientific considerations involved in *DSM-IV*'s categorization of conditions as mental disorders may not be wholly relevant to legal judgments that take into account such issues as individual responsibility, disability determination, and competency.

When used appropriately, however, diagnoses and diagnostic information can assist legal decision makers in their determinations. *DSM-IV* can facilitate legal decision makers' understanding of the relevant characteristics of mental disorders. The literature related to diagnoses also serves as a check on ungrounded speculation about mental disorders and about the functioning of a particular individual.

Some History

The *DSM* had its origin in the Association's 1917 collaboration with the U.S. Bureau of the Census on a classification of mental illnesses that would enable the collection of uniform statistics on mental disorders seen in hospitals. The American Medical Association later expanded this classification system with its *Standard Classified Nomenclature of Disease*. During World War II, the U.S. armed forces medical services found these diagnostic criteria too restrictive, and developed a more expanded set, which was later revised for use by the Veterans Administration. In 1948, the World Health Organization (WHO) published its own diagnostic directory of mental illnesses as part of the sixth edition of its *International Classification of Diseases (ICD-6)*.

Users of these classification criteria found their differences confusing. Some used one system for clinical work, another to gauge levels of disability, and a third for statistical reporting. To rectify this situation, the APA began work on the document that would become *DSM*.

APA began with the military's diagnostic criteria, expanded them to create one system that could be used for diagnostic and statistical purposes, and included a glossary of definitions for the different illnesses the guide encompassed. APA brought the results of this work out as the first *DSM* in 1952.

As research has increased psychiatry's understanding of mental illnesses and sharpened its ability to diagnose and treat them, the *DSM* has changed to reflect this greater level of sophistication. APA published its second edition of the manual, *DSM-II*, in 1968. *DSM-III* came twelve years later, in 1980. APA published a major revision of this edition--*DSM-III (Revised)*--in 1987. *DSM-IV* was the next step in this continuing evolution.

The *DSM's* Importance

The value of the *DSM* series to those researching and treating mental illnesses has grown through the years. It is now widely accepted in the United States as the common language of mental health clinicians and researchers for communicating about mental illnesses. Major textbooks of psychiatry and other textbooks that discuss psychopathology have made extensive reference to *DSM* and have largely adopted its terminology and concepts. It has been translated into Chinese, Danish, Dutch, Finnish, French, German, Greek, Hungarian, Italian, Japanese, Norwegian, Portuguese, Russian, Spanish, Swedish, Turkish and Ukrainian. In light of this widening currency, it is vital that the *DSM* undergo periodic updates so that it reflects the latest research findings and clinical practices.

How the *DSM-IV* Was Created

In managing the process that yielded *DSM-IV*, the APA tried to continue the pattern laid down by the preceding volumes, providing clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study and treat the various mental disorders.

According to Dr. Allen Frances, Chair of the *DSM-IV* Task Force, "The major innovation of *DSM-IV* lies not in any of its specific content changes, but rather in the systematic and explicit process by which it was constructed and documented. More than any other nomenclature of mental disorders, *DSM-IV* is grounded in empirical evidence."

The special 27-member *DSM-IV* Task Force worked for five years to develop the manual in a process that involved more than 1,000 psychiatrists and other mental health professionals. Under Dr. Frances's leadership, the task force developed thirteen work groups, each of which focused on a section of the manual. The work groups and each of their advisory groups of 50 to 100 individuals developed the manual in a three-step process.

The first step in the three-stage empirical review was the development of 150 reviews of the scientific literature which provided the empirical data base upon which *DSM-IV* decisions could be made. In the second step, task force work groups reanalyzed 50 separate sets of data which provided additional scientific information to that available in the published literature. These reanalysis projects were funded by the John D. and Catherine T. MacArthur Foundation.

Finally, the task force conducted twelve field trials with funding from the National Institute of Mental

Health, National Institute on Drug Abuse, and the National Institution of Alcoholism and Alcohol Abuse, involving more than 88 sites in the United States and internationally, and evaluations of more than 7,000 patients. These field trials enabled one task force to evaluate the utility of alternate possible diagnostic criteria sets.

APA members and the mental health scientific community worldwide were kept informed of the manual's development from its inception through presentations at professional meetings; articles in the scientific literature; a special newsletter, *DSM-IV Update*; APA's *Psychiatric News*; and through publication in July 1991 of an "options book" which highlighted disorders or particular criteria being considered for revision.

The Task Force set high standards for evaluating proposals for changes in the new manual. Recommended changes had to be substantiated by explicit statements of rationale, supported by the systematic review of relevant empirical data.

The Task Force also published a multi-volume *DSM-IV Sourcebook*, which provides a comprehensive reference of the clinical and research data supporting the various decisions reached by the Work Groups and Task Force.

The manual defines a mental disorder as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain or disability. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, e.g. the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological or biological dysfunction in the individual. Neither deviant behavior, e.g., political, religious, or sexual, nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above." The *DSM-IV* Task Force stresses that "a diagnosis does not carry any necessary implications regarding the causes of the individual's mental disorder or its associated impairments."

It is also important to note that in preparing *DSM-IV* APA also established a working relationship with the World Health Organization to clear up the differences between the new *DSM* and future versions of WHO's *International Classification of Diseases (ICD)*.

Special Features of *DSM-IV* Related to Culture and Ethnicity

To make it easier for mental health professionals to use *DSM-IV* in diagnosing people from diverse cultural and ethnic settings, *DSM-IV* includes a section in the text that covers culturally-related features. The section describes culturally-specific symptom patterns, the ways people from different cultural backgrounds will describe their psychiatric symptoms, and prevalence data when available. It provides the clinician with guidance on how a patient's cultural and ethnic background will influence the way he or she appears during a consultation. For example, in some cultures, depressive disorders are characterized more by physical symptoms than by feelings of sadness.

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Other *DSM-IV* References Available From American Psychiatric Press

The Clinical Interview Using DSM-IV, 1994, 528 pps. Offers clinicians clear, concise, practical advice on mastering components of patient interviews.

DSM-IV Casebook, 1994, 544 pps. Uses clinical vignettes to illustrate the diagnostic process, using the concepts and terminology of *DSM-IV*.

DSM-IV Primary Care Version, 1995, 223 pps. Provides a framework tailored to educating primary care providers about mental disorders that is compatible with the standard approaches used in specialty mental health care (i.e., *DSM-IV*).

DSM-IV Sourcebook, 1994, 792 pps. Chronicles the efforts of the *DSM-IV Task Force* and documents the rationale and empirical support for the text and the criteria sets presented in *DSM-IV*.

Study Guide to DSM-IV, 1994, 400 pps. *Study guide to DSM-IV*, 1994, 400 pps. Interprets updated *DSM-IV* diagnoses through extensive case studies, clinical vignettes, and questions and answers.

To purchase *DSM-IV* or any of the related materials above, call the American Psychiatric Press, Inc., order line at 1-800-368-5777. Books are available in hard and soft cover, and *DSM-IV* also is available on computer disk and CD-ROM.



This fact sheet is one of a series including titles on the *Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) DSM-IV*; *Homosexual and Bisexual Issues*; *Electroconvulsive Therapy (ECT)*; *the Insanity Defense*; *Memories of Sexual Abuse*; *Patient/Therapist Sexual Contact*; *Pedophilia*; *Psychiatric Effects of Disasters*; and *Violence and Mental Illness*

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