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BOOK REVIEW

DSM: A history of psychiatry's bible

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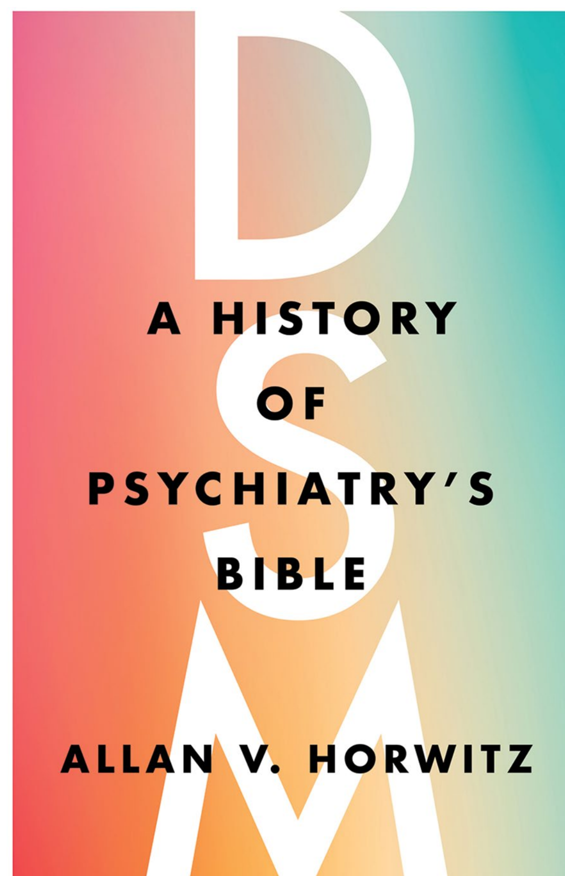

Reflecting on his professional success, the psychiatrist Samuel Guze remarked that "it wouldn't be easy to come up with a crisp distinction between marketing and education."[1] Throughout his career, he had made the case that mental disorders could only be grasped scientifically as disorders of brain circuitry. Just like any other medical syndrome, they could be recognized and diagnosed using standardized criteria. Psychiatry, he argued, would not progress through psychoanalysis or social work, but through advances in genetics, neurobiology, and epidemiology.[2] By the 1990s, Guze's biological vision of psychiatry had become the mainstream view among Americans. Yet at the dawn of the new century, there was clearly a sense that this view had been oversold. The approach had produced no substantial new drug treatments and no diagnostic tests for mental disorders. A new generation of biological psychiatrists debated who was to blame for the standstill and how to move forward, while older colleagues began to recognize the shortcomings of the approach that they had so strongly promoted.

The recent history of American psychiatry is marked by the ambivalent marriage of salesmanship and biomedicine, a relationship that has also infected its historiography. In the past decade, however, there have been a spate of histories of biological psychiatry, foregrounding its ignorance and honestly narrating its failures.[3–6] Allan Horwitz, at the behest of his editor at Johns Hopkins, has written yet another commentary on the controversial history of American psychiatry's most famous book: the *Diagnostic and Statistical Manual [DSM] of Mental Disorders*. Why another take on the *DSM*? Well, as Horwitz acknowledges, the answer is certainly not new historical research—there is nothing substantially new in Horwitz's account. Nor is it a new theoretical framework, as readers of Horwitz's earlier book *Creating Mental Illness* (2003) will recognize.[7] The rationale behind this latest book is to synthesize and summarize historical scholarship on the *DSM* and present it in a form accessible to the lay reader curious to know more about their diagnosis.

The book begins with a well-rehearsed story of humble origins. The *DSM* was first published by the American Psychiatric Association (APA) in 1952 to little fanfare. Its descriptions of the psychoses and neuroses commonly encountered by psychiatrists was of minor importance to clinical practice, and many psychiatrists simply ignored it. However, with the publication of its third edition in 1980, the *DSM-III* became a vehicle for the APA's commercial

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success and its monopoly over the diagnosis of mental illness in the United States. Behind the scenes of the *DSM-III* was a set of highly successful biomedical salespeople, including Samuel Guze, who promoted an overhaul of how mental illnesses were diagnosed and classified in an attempt to bring psychiatry more in line with contemporary biomedicine. The star of the show was the biometrician and psychiatrist Robert Spitzer, who led the APA's taskforce and helped secure the new manual's professional and popular acceptance through strategic compromises. But 40 years on, this scientific coup has failed to deliver on its promises of better explanations and better treatments for mental illnesses. Moreover, the latest revision of the *DSM* in 2013 was fraught with controversy and has terminally undermined the manual's scientific status.[8]

As Horwitz explains, most of the existing literature on the *DSM-III* and postwar biological psychiatry has fallen into two camps: the progressives and the reactionaries. The publication of the manual's third edition was accompanied by several popular science books that endorsed it as progressive, scientific, and revolutionary. The psychiatrist Nancy Andreasen wrote in her 1984 book, *The Broken Brain: The Biological Revolution in Psychiatry*, that the *DSM-III* Revolution was driven by a vanguard of psychiatrists (including herself) from outside the metropolitan centers of psychoanalysis whose "dust bowl empiricism" favored a more scientific medical model.[9] Similarly, psychiatrist Jerrold Maxmen argued in *The New Psychiatry* (1985) that as a result of the *DSM-III*, "mainstream American psychiatry has switched from being primarily psychoanalytic to being primarily scientific" (Horwitz, 84). Historian Hannah Decker offers a comprehensive history of the progressives' perspective in *The Making of the DSM-III: A Diagnostic Manual's Conquest of American Psychiatry* (2013).[10] Reactionaries were equally swift in publishing their criticisms of the manual. One of the most prominent, though later, critiques came from the social workers Stuart Kirk and Herb Kutchins in *The Selling of DSM: The Rhetoric of Science in Psychiatry* (1992),[11] which was followed by their more popular *Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders* (1997).[12] The process of classifying mental disorders in the *DSM* presented itself in terms of scientific methods, statistical objectivity, and theoretical neutrality. Kirk and Kutchins, however, found these methods to be not only inappropriate but also used to intentionally obscure a highly politicized process riddled with veiled interests. Put simply, there is a continuous tradition of progressive celebration and reactionary critique of the *DSM-III*, flowing from its publication up to the present as its legacy continues to divide professional and public opinion.

A sociologist by training, Horwitz positions himself somewhere in-between these two camps. Rather than be exclusively celebratory or purely critical, Horwitz presents what he calls a "social view," in which the manual and its diagnostic categories are neither totally objective nor totally coercive. The manual is a historical product of the psychiatric community, and its diagnoses serve various social functions. Therefore, it must be understood as a "fundamentally *social* document," which is invested with competing powerful interests. This obviously includes the professional interests of psychiatrists themselves: the *DSM* enables them to decide what counts as a mental disorder. But more critically, as Horwitz shows, there is a matrix of interests that have come together since the 1970s to give the manual unprecedented social importance. These include governmental agencies for medical research and regulating drug markets, like the National Institute for Mental Health (NIMH) and the Food and Drug Administration (FDA), as well as medical insurance companies, advocacy groups, and pharmaceutical companies. After the public thalidomide scandal in 1962, the FDA increased its regulation of medical drug markets, in particular, requiring companies to produce products shown to target specific *DSM* diagnoses. Clinicians widely adopted the *DSM* in the 1980s in order to conform to medical insurance systems: no diagnosis, no reimbursement. At the same time, research institutes, advocacy groups, and pharmaceutical companies all made use of epidemiological studies carried out using the new diagnostic categories to highlight the drastic need for more research, more advocacy, and more treatments. As Horwitz so clearly lays out, the manual was published by the APA, but it served and shaped diverse interests beyond the profession.

The novelty of Horwitz's contribution is to place the now well-known story of the *DSM-III* and the social transformation of American psychiatry in the context of the longer and less well-known history of the manual itself. In the first half of the 20th century, American psychiatry was an eclectic mixture of lobotomies, eugenics, and psychoanalysis. Physical treatments were the norm in the capacious mental hospitals where chronic patients collected in vast numbers, while outpatients were treated as maladapted individuals who might find salvation through mental hygiene. In this period, the primary role of diagnostic classifications was administrative. The predecessor of the APA periodically issued a manual designed to aid the collection of reliable statistics on mental hospital inmates. During the Second World War, this administrative system faced an unprecedented challenge, as numerous cases of traumatized soldiers scarred by war did not fit so easily into the existing classifications. The experts drafted in to help manage this epidemic did not come from the old mental hospitals, but were psychiatrists practicing in outpatient clinics, along with clinical psychologists and social workers. Under the auspices of the US Army, a new set of

standards for mental illness was produced, which focused primarily on what were seen as psychogenic illnesses. *DSM-I*, published in 1952, was born out of a reconciliation between this new set of standards and the older APA statistical manual. The fairly uncontroversial acceptance of the *DSM-I* can be seen both as evidence of its irrelevance and as a sign of its careful compromise between the needs of the mental hospitals and the expanding outpatient clinics.

The *DSM-II*, revised in 1968, expanded the number of diagnostic categories but provoked little controversy. The main driver of this reform, however, was not administrative, but was the growing international interest in psychiatric epidemiology. This was a field of increasing relevance since the creation of the World Health Organization (WHO) in 1948 and the inclusion of mental illnesses in its key publication, the *International Classification of Diseases*, one year later. Given the restricted focus on the *DSM*, the international field of psychiatric epidemiology is neglected, despite marking a crucial shift in thinking about the purposes of psychiatric diagnosis (Henry Wu has done recent work on this front).[13] Above all else, the scientific objective of these new international organizations was making communication between centers as clear and reliable as possible. The Austrian-English psychiatrist Erwin Stengel reported back to the WHO in the 1950s that given the diversity of classifications and concepts across nations, there was a need for "operational definitions" of mental illness—definitions which specified how they should be applied.[14] In light of this, the *DSM-II* removed the previous manual's focus on psychogenesis and presented general groupings of disorders defined mainly by the similarity of mental symptoms. This context was critical for the reforms of *DSM-III*, which were deeply inspired by an epidemiological study into the variable incidence of schizophrenia in the United States and the United Kingdom.[15] Horwitz's account presents an exclusively American story. The *DSM-III* was certainly a professional assault on psychoanalysis in the United States, but the methods used in this struggle did not simply emerge from nowhere: they were forged in the context of building an international psychiatric epidemiology.

The book is mostly convincing when dealing with the *DSM-III* itself. Horwitz presents a more compact account of Spitzer's role in driving through the reforms than that presented by Decker (2013) and carefully lays out the key social and institutional shifts discussed above. The reader is given insight into the machinations that guided the various committees that developed the new diagnostic criteria and the shift in expert authority from clinicians to researchers interested in reliability. However, it is perhaps too simplistic to say that the *DSM-III* was more scientific than its predecessors; they were also designed by expert committees and were broadly informed by psychobiology. What was new were the standards of knowledge production that insisted that diagnoses be shown to be reliable above all else. There is perhaps a danger of misleading the reader when Horwitz writes that in the *DSM-III* "visible symptoms" played a more important role, since it was not greater perceptual clarity that reformers were interested in, but greater semantic clarity in the communication and application of diagnostic criteria. Rather than involve himself in the extensive philosophy of science literature that has grown around the *DSM-III*, Horwitz plays the historian: the reformers saw themselves as making a scientific revolution, and the new manual brought about massive changes in American psychiatry.

The story of the manual after 1980 is marked by the rising influence of pharmaceutical companies and increasingly powerful advocacy groups. While the drug industry played no role in creating the diagnostic categories used in *DSM-III*, by the publication of *DSM-IV* in 1994 they were the main players in popularizing diagnoses. First with Xanax in 1981, the SSRIs in 1987, and Paxil in 1999, the drug industry helped turn Panic Disorder, Major Depressive Disorder, and Social Anxiety Disorder into the most commonly diagnosed mental disorders. Similarly, veterans' associations were pivotal to including posttraumatic stress disorder in the *DSM-III*. Feminist groups successfully forced the APA to remove several sexist personality disorders from the *DSM-IV*, such as masochistic personality disorder. With the *DSM-5*, pressure from parent associations and patient advocates who feared having their diagnoses taken away from them led the APA to maintain both its old and new criteria for Autism Spectrum Disorder. The story ends in controversy and uncertainty with the reforms for *DSM-5*. This time, the reform process was taken over by a new group of experts who sought to establish greater validity for the *DSM* by using complex psychological rating scales originally developed to study personality disorders. However, they struggled to show adequate levels of reliability for their new approach, and the whole process was rife with accusations of secrecy, indecision, and collusion with the drug industry. Most importantly, the NIMH defunded the whole project, undermining its credibility and hamstringing its field trials. A week before its publication in 2013, the NIMH announced it would no longer require researchers to use the *DSM* and would instead use its own classification system built for research, not clinical diagnosis, called Research Domain Criteria.

Horwitz concludes that the *DSM* will live on because there are so many social interests invested in its diagnostic entities. Yet he admits that there is no roadmap for the path ahead. The *DSM-III* revolution was not just a diagnostic revolution, but a social one. For the audience it will reach, this is perhaps enough said. But the future of scholarship on the *DSM* must move beyond the borders of the

United States and place this transformation in an international context. It is true that the *DSM* has not been widely used by clinicians around the world. However, the *DSM-III* and its successors were used internationally as biomedical research standards. In this form, they have worked their way into biomedical knowledge and healthcare policies around the globe. The use of the *DSM-III* from 1980 onwards as an international research standard is also part of the history of the *DSM*, but one which is typically separated from the received story. Horwitz's approach is eminently compatible with such an expansion of focus. As the *DSM* has been used to help create an international psychiatric epidemiology, so have the social interests that infuse it grown and diversified. While the American story is of central importance, I look forward to reading a more international history of the *DSM*.

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