

Values and Assumptions in the Development of DSM-III and DSM-III-R: An Insider's Perspective and a Belated Response to Sadler, Hulgus, and Agich's "On Values in Recent American Psychiatric Classification"

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It is widely acknowledged that the approach taken in the development of a classification of mental disorders is guided by various values and assumptions. The author, who played a central role in the development of DSM-III (American Psychiatric Association [1980] Diagnostic and statistical manual of mental disorders, 3rd ed. Washington, DC:Author) and DSM-III-R (American Psychiatric Association [1987] Diagnostic and statistical manual of mental disorders, 3rd ed, rev. Washington, DC:Author) will explicate the basic values and assumptions that guided the development of these two diagnostic manuals. In so doing, the author will respond to the critique of DSM-III and DSM-III-R made by Sadler et al. in their 1994 paper (Sadler JZ, Hulgus YF, Agich GJ [1994] On values in recent American psychiatric classification. *J Med Phil* 19:261-277). The author will attempt to demonstrate that the stated goals of DSM-III and DSM-III-R are not inherently in conflict and are easily explicated by appealing to widely held values and assumptions, most of which appeared in the literature during the development of the manuals. Furthermore, we will demonstrate that it is not true that DSM-III places greater emphasis on reliability over validity and is covertly committed to a biological approach to explaining psychiatric disturbance.

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Rejecting the notion that science can ever be value-free, Sadler et al. have correctly noted that "values, not cognitions, determine what we select as 'important,' 'crucial,' 'central,' 'decisive,' or 'related.' In other words, values lend structure to the field of attention, predefining background and foreground, and clustering disparate items into groups. Consequently, 'descriptive' statements about psychopathology issue from presupposed value stances that conceal their own deeper sources, compatibilities, and incompatibilities" (Sadler et al., 1994b). In this paper, the author, who played a central role in the development of DSM-III (American Psychiatric Association, 1980) and DSM-III-R (American Psychiatric Association, 1987), will attempt to explicate the basic values and assumptions that guided the development of these two diagnostic manuals. In so doing, the author will respond to the critique of DSM-III and DSM-III-R made by Sadler et al. in their paper, "On Values in Recent American Psychiatric Classification" (Sadler et al., 1994a).

Sadler et al. reproduced these goals of DSM-III-R from its introduction (American Psychiatric Association, 1987), which are nearly identical to those of DSM-III (American Psychiatric Association, 1980):

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; and

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10. responsiveness, during the development of DSM-III-R, to critiques by clinicians and researchers (American Psychiatric Association, 1987, pp. xix–xx).

They then go on to assert that “they lack explicit justification” and do not acknowledge “significant value commitments that inevitably entail conflict. As examples, there seems to be an emphasis on reliability over validity” (p. 264). According to Sadler et al., the DSM paradigm is “an attempt to bring disparate phenomena, problems, and practices under its broad umbrella, an attempt towards a task too grand for success” (p. 265). “Stating the DSM goals as if they represented a consensus has the effect of imposing such a viewpoint on the field at large. Moreover, the consensus is one whose precise commitments are left latent” (p. 264). If the “explicit values” of DSM-III and DSM-III-R had been acknowledged, this would have allowed for “rational discussion and debate” instead of the “obfuscation . . . that characterize the DSM literature” (p. 271). According to Sadler et al., the controversies surrounding DSM-III and DSM-III-R are “rooted in the value-laden choice of descriptive, symptom-oriented diagnosis, a value judgment that diminishes modes of practice that are not based on such a diagnostic approach” (p. 270). The manuals demonstrate a “preference for biological approaches” and a “covert commitment to an organic/neurological/biological form of explanation . . . and little place for the interpretation of psychic phenomena that characterizes the broadly psychosocial strand of psychiatry” (pp. 273–274). Sadler et al. consider it “odd” that DSM classifies “disorders” (p. 273). They ask: “Is it the case that when disease is truly found in the area of abnormal mental phenomena, then it will cease to be truly ‘psychiatric’ and become neurological in nature?” (p. 273). The “requirements of a scientific classification are in conflict with the practical demands of a psychiatric classification” (p. 272).

We thoroughly agree with Sadler et al. that the development of DSM-III and DSM-III-R was guided by commitments, often implicit, to various values including assumptions about how progress is best made in psychiatric nosology. We therefore deny that we subscribe to what he refers to as the “naïve” view of classification and science as value-free. However, we will attempt to show that the stated goals of DSM-III and III-R are not inherently in conflict and are easily explicated by appealing to widely held values and assumptions, most of which appeared in the literature during the development of the manuals. Furthermore, we will demonstrate that it is not true that DSM-III places greater emphasis on

reliability over validity and is covertly committed to a biological approach to explaining psychiatric disturbance. Finally, we argue that the critics of DSM-III and DSM-III-R have not provided a viable alternative approach to psychiatric classification that would better serve the broad needs of the mental health professions.

A proper assessment of the approach taken toward the development of DSM-III and DSM-III-R must start with a description of its predecessor, DSM-II (American Psychiatric Association, 1968) and of the issues that the DSM-III developers had to face. A critical appraisal of the DSM-III approach also needs to consider how other medical specialties approach classification. Both of these considerations are notably absent from Sadler et al.’s critique.

DSM-II

DSM-II, published in 1968, was developed by an eight-member committee of the American Psychiatric Association. Unlike its predecessor, DSM-I, published in 1958, the DSM-II classification—with only a few minor changes—adopted both the classification and text describing the various disorders, from the mental disorders section of the eighth revision of the International Classification of Diseases (ICD-8; World Health Organization, 1965). DSM-II was 134 pages and listed 83 separate mental disorders, which were classified in nine major groups. One of the groups, the neuroses, were described as having anxiety that was “felt and expressed directly, or it may be controlled unconsciously and automatically by conversion, displacement and various other psychological mechanisms.” Thus, such disparate presentations as depressed mood, obsessive compulsive symptoms, and dissociative symptoms were all seen as different ways of unconsciously dealing with internal conflict. DSM-II, like DSM-I, was primarily used for record-keeping purposes and because the descriptions of the various disorders were so brief and general, the manual had little influence on psychiatric education, research, or clinical practice. The importance of DSM-II to the psychoanalytic community is illustrated by the recollection of Dr. Irving Bieber, well-known psychoanalyst. He recalled how, in 1973 (a year before work started on DSM-III), a colleague called him and said, “Have you heard the terrible news? They are taking homosexuality out of further printings of DSM-II.” To which Dr. Bieber replied, “What is DSM-II?”²

² Personal communication, October 5, 1979.

Issues in the Development of DSM-III and DSM-III-R

DSM-III and ICD-9

The first decision the DSM-III committee had to make was whether to follow the DSM-II approach of adopting the ICD system (ICD-9; World Health Organization, 1977) or whether to develop an innovative classification for American psychiatric use (we had no idea that other countries would be interested in using DSM-III, as actually happened). From the beginning, the DSM-III committee that I assembled believed that despite the value of a single international system that would facilitate communication among mental health professionals from different countries, it was more important that psychiatric classification benefit from new developments in American psychiatry, such as the development of diagnostic criteria (Feighner et al., 1972). Although we had to use the ICD-9 diagnostic codes (actually, a special American clinical version called ICD-9-CM [Commission on Professional and Hospital Activities, 1978]) for all DSM-III and DSM-III-R categories, we were relatively unconcerned by frequently having a different definition of a DSM category than of a corresponding ICD-9-CM category. We believed this was a small price to pay for our ability to be innovative. It should be noted that early in the development of DSM-III, some influential members of the American Psychiatric Association did not agree with our resolution of this value conflict and argued against our decision to break new ground in psychiatric nosology.

Having decided to be innovative, we had to decide the following *substantive* questions:

- Who are the potential users of the classification (clinicians, researchers)?
- What should be the criteria for including a mental disorder in the classification?
- Should we adopt a “lumping” (broad categories) or a “splitting” (fine distinctions) approach?
- What guidelines should be given to help the user of the manual make a diagnosis (general description of common features as in DSM-II, diagnostic criteria)?
- What should be the basis for grouping disorders into major classes (etiology, pathophysiologic process, descriptive features)?
- Should nondisorder problems be included in the classification (as was done in DSM-II)?
- What kinds of information should be provided in the text describing the mental disorders?

- Would it be useful to attempt to define “mental disorder” (never done in a psychiatric classification)?

There were also *process* questions that needed to be answered.

- How should Task Force members be chosen?
- How should specialized committees be constituted?
- How should we deal with the growing concern, alarm, and anger as drafts of DSM-III and DSM-III-R were presented to the profession?

Core DSM-III Values and Assumptions

The Concept of “Mental Disorder”

DSM-III was a revision of DSM-II, and both manuals accepted the assumption that the concept of mental disorder (however defined) was a useful construct and that psychiatry is that branch of medicine whose primary responsibility is the study and treatment of mental disorders. Implicit in both manuals is the assumption that effective treatment of patients with mental disorders requires an accurate diagnosis. (This is in contrast to the belief of some clinicians, particularly those with a psychodynamic orientation, who have believed that psychiatric diagnosis is largely irrelevant for making psychotherapy treatment decisions.)

In both manuals, there is the assumption that the term “disorder” includes conditions with varying levels of understanding of etiology or pathophysiologic process and that in only a small number of mental disorders do we possess the knowledge for the condition to be regarded as a “disease” (Spitzer and Williams, 1980). It should be noted that the International Classification of Diseases also uses the term mental “disorder.” Thus, it is hard to understand the previously noted comment of Sadler et al. that they find it odd that DSM-III would use the term “disorder.”

Diagnostic Validity

A diagnostic concept is assumed to have *validity* to the extent that the defining features of the disorder provide useful information not contained in the definition of the disorder. This information may be about etiology, risk factors, usual course of the illness, whether it is more common among family members, and most important, whether it helps in decisions about management and treatment. In the history of medicine and psychiatry, many diagnoses when first recognized had little validity in terms of helping in management and treatment. Clinicians

and researchers cannot wait for a fully validated diagnostic system. One cannot study a disorder to develop effective treatment without first recognizing the disorder.

Diagnostic Reliability

A diagnosis is reliable to the extent that clinicians can independently agree on its identification in a heterogeneous group of patients. Although a diagnosis can be reliable but have no validity, unreliability provides an upper limit to the validity of a diagnosis. The DSM-III committee shared a commitment to efforts to improve the reliability of psychiatric diagnosis as a goal of value in itself and also of value in raising the credibility of psychiatry as a profession.

Progress in Psychiatric Nosology

The DSM-III committee shared the view that progress in psychiatric nosology (improving the validity of psychiatric diagnosis) will come primarily from data collected in empirical research studies. This assumption may appear to be self-evident but is in contrast to the view held by some that progress will come primarily from data collected in the intensive naturalistic treatment of patients in psychodynamic psychotherapy. Sadler et al. are thus correct when they note that the DSM committee attempted to place the manual in an “empirical research tradition.” Sadler et al. fault the committee for not evaluating “divergent psychiatric traditions” but never indicate how an alternative tradition would have been helpful.

How Core Values and Assumptions Influenced DSM-III Decisions

Who Are the Potential Users of the Classification?

The committee believed that although the highest priority was to make DSM-III useful for the clinician in making treatment and management decisions in varied clinical settings, there was obvious value if the same system could be useful for the psychiatric researcher. We therefore avoided the strategy taken by the ICD-10 in which they have developed a separate manual with separate diagnostic criteria for clinical as opposed to research use.

What Should Be the Criteria for Including a Mental Disorder in the Classification?

When work started on DSM-III in 1974, there were a large number of clinicians who used diagnostic concepts that were not recognized in official diagnostic systems. Examples of such concepts were

borderline personality disorder, narcissistic personality disorder, the atypical child, and posttraumatic stress disorder. Clinicians using these diagnoses in their work wanted their diagnostic concepts recognized because they were convinced of the clinical utility (validity) of the diagnostic concepts even if, as was almost always the case, they could provide little empirical research data showing either reliability or validity. Several members of the DSM-III committee were from the Department of Psychiatry in St. Louis that had developed the Feighner research diagnostic criteria for 16 “validated disorders.” According to the St. Louis tradition, unvalidated disorders need only be referred to as “other psychiatric disorder.” Had the DSM-III committee opted for this approach (never seriously considered), it would have been faced with massive opposition from the psychiatric community and been replaced by a new committee.

The committee adopted what I have termed the principle of “inclusiveness”—namely to seriously consider the inclusion of any diagnostic category currently of salience for large numbers of clinicians *even if* no empirical data supporting its reliability and validity were available. There was only one proviso: working with clinicians who proposed the category there had to be some ability to define it in a way that offered the possibility of some degree of diagnostic reliability. (The concept of the “atypical child” did not make it. When asked how to define the concept, the clinicians who proposed it responded by remarks such as: “That is very difficult. These children are all very different.”)

The principle of inclusiveness led to the inclusion of a large number of specific diagnoses not recognized by DSM-II or by the ICD-9 classification. It should be noted that many of these categories, such as borderline and narcissistic personality disorder, were proposed by clinicians with a psychoanalytic perspective, even though psychoanalytic clinicians (Cooper and Michels, 1988) and Sadler et al. have accused DSM-III of being antithetical to a psychodynamic approach.

The inclusion of diagnoses of uncertain validity in a medical classification is not unique to psychiatry. The ICD recognizes many medical disorders whose diagnostic status is controversial, such as fibromyalgia, chronic fatigue syndrome, and irritable bowel syndrome.

Should We Adopt a “Lumping” or a “Splitting” Approach?

If one examines successive revisions of the International Classification of Diseases, one will note

that with each revision a large number of new diagnoses are added, many of them subtypes of a single previously recognized category. The reason for this is that with time clinicians (and researchers) wish to make distinctions that they believe increase the clinical utility (validity) of the diagnosis. This splitting approach, which characterizes the rest of medicine, was also adopted by the DSM-III committee.

What Guidelines Should Be Given to Help the User of the Manual Make a Diagnosis?

DSM-I (American Psychiatric Association, 1952) advanced psychiatry by providing, for the first time in an official classification, brief descriptions of each disorder. This same approach was carried into DSM-II, but the brevity and general nature of these descriptions was of little help in indicating to the diagnostician which features of the disorder needed to be present in order to make the diagnosis. As is well known, the first systematic attempt to provide diagnostic criteria for psychiatric diagnosis was the Feighner criteria (Feighner et al., 1972), followed by the Research Diagnostic Criteria (Spitzer et al., 1978). Studies indicated that when clinicians used these criteria, diagnostic reliability improved. The DSM-III committee believed that the inclusion of such criteria for virtually all of the DSM-III categories would be an important development in psychiatric nosology. (One committee member argued—unsuccessfully—that such criteria should be offered to researchers in a separate manual.) ICD-10 (which in its overall structure resembles DSM-III) now includes diagnostic criteria.

A technical as well as value issue in developing diagnostic criteria is the level of abstraction with which the criteria are presented. Using Sadler et al.'s terminology, what assumptions determine what is included in the criteria? The DSM-III assumption is that the diagnostic criteria will be most helpful to clinicians of varying perspectives if they use language at the lowest level of abstraction possible yet adequately describes the features of the condition that makes it a specific disorder. In some cases, for example, major depression, the characteristic symptoms (*e.g.*, depressed mood, loss of interest or pleasure, disturbance in appetite and sleep) can be described with little inference and at a low level of abstraction. For other disorders, such as borderline personality disorder, the characteristic features (*e.g.*, identity disturbance, splitting) must be presented at a relatively abstract level, requiring a high degree of inference.

Sadler et al. note that values determine what is considered important, relevant, and of interest for “clustering disparate items into groups.” What values are implicit in the DSM-III diagnostic criteria? I suppose the answer is the things (behaviors, emotions, patterns of relating to and perceiving the world) that make clinicians decide the condition is a mental disorder are worthy of attention. Is there an alternative value system or approach that should be considered?

This is an appropriate time to carefully examine the most often stated critique of DSM, what Sadler et al. refer to as its “emphasis on reliability over validity.” What can it mean to place greater emphasis on reliability over validity? One way would be to only include in the classifications disorders whose reliability had been demonstrated. If one did this, many potentially valid categories would have been omitted. This clearly did not happen with DSM-III and DSM-III-R because, as already noted, we never demanded demonstrations of diagnostic reliability before adding categories that clinicians believed to be valid. If anything, we could be accused of putting greater emphasis on validity than reliability because we accepted categories with claims of validity even when there were no claims of reliability.

Another meaning to placing greater emphasis on reliability over validity could be that we gave more attention to diagnostic criteria (to improve reliability) than to providing other useful information about the disorder, such as usual age at onset, course, and presence of a familial pattern. In fact, far more of the DSM-III text involves such information than is taken in the presentation of diagnostic criteria. Thus, contrary to the many of the critics of DSM-III, there is absolutely no evidence that DSM-III placed greater emphasis on reliability than validity.

What Should Be the Basis for Grouping Disorders into Major Classes?

Discussions of psychiatric and medical classification often note the desirability of grouping disorders together on the basis of shared etiology or underlying pathophysiology because such knowledge usually (but not always) is helpful in making treatment decisions. However, in psychiatry, and often in the rest of medicine, this knowledge is lacking. Any perusal of the way in which the ICD is divided into chapters (*e.g.*, neoplasms; infectious and parasitic diseases, congenital anomalies; complications of pregnancy, childbirth, and the puerperium) and the chapters subdivided into major diagnostic groups (*e.g.*, circulatory divided into acute rheumatic fever, chronic rheumatic heart disease, hypertensive dis-

ease, ischemic heart disease, diseases of pulmonary circulation, and other forms of heart disease) should be enough to demonstrate that in medical nosology major grouping of disorders are made for purely *pragmatic* reasons that, hopefully, facilitate differential diagnosis. Sometimes the groupings indicate a group of disorders that are the primary responsibility of a subgroup of specialists (for example, the old “organic mental disorders” and the cognitive impairment disorders of DSM-IV are of special interest to liaison psychiatrists. There are now many specialty groups that focus on the study of newly created DSM-III major diagnostic classes, such as dissociative and anxiety disorders.

The DSM-III committee believed that differential diagnosis would be facilitated if diagnoses would be grouped together if they shared common *descriptive* features. By descriptive we mean those features that are part of the important defining features of the disorder. It should be noted that the descriptive features are not always “symptoms” (something that bothers the subject) but may be “signs,” such as the often ego-syntonic personality traits that characterize personality disorders or age at usual onset of the disorder (disorders usually first evident in infancy, childhood, or adolescence). With this strategy, the DSM-III committee grouped all of the disorders into 17 major diagnostic classes. The neurotic disorders of DSM-II, which were grouped together because they presumably resulted from unconscious ways of defending against unconscious conflict, were split asunder into mood, anxiety, dissociative, and somatoform disorders. The DSM-III committee believed that for nosologic purposes, the concept of the “neuroses” was no longer useful. Does anyone in 1997 now believe that DSM-III made a mistake in changing the name of obsessive compulsive neurosis to the more agnostic term of obsessive compulsive disorder?

This strategy of grouping disorders on the basis of shared descriptive features is no different from the strategy employed in the rest of medicine when knowledge of etiology or underlying pathophysiologic process is unknown. Sadler et al. and numerous other critics of DSM-III argue that such a strategy has an implicit theory of etiology. Humorously, most critics of DSM-III, like Sadler et al., claim that the theory favors an organic/biologic perspective, whereas Agich (1997; citing Mishara, 1994) has suggested that it has a covert commitment to a behavioral theory.

In taking a hard look at the issue of the DSM-III claim to neutrality regarding causation, we should not be confused by a related but different issue: have clinicians with a biological perspective been more

accepting of the DSM-III approach to grouping disorders than have clinicians with a psychodynamic perspective? Clearly many psychodynamic-oriented clinicians, many of whom had little interest in psychiatric diagnosis in the first place, viewed the abandonment of the category of neurotic disorders as an assault on Freud (Bayer and Spitzer, 1985). As such, they regarded the DSM-III approach—to put it mildly—as ill advised. Conversely, biologically oriented clinicians who generally regarded psychiatric diagnosis as crucial to their work viewed the DSM-III approach positively. This is not the same issue as whether the DSM-III approach is *inherently* biased toward a particular perspective.

Let us broadly divide etiological perspectives into two major (admittedly simplistic) groupings: according to the biological perspective, the causes of mental disorders will ultimately be shown to be disturbances in biological functioning that are relatively independent of life experience; according to the psychological perspective, the major causes of mental disorders will ultimately be shown to be disturbances in life experiences. The author challenges anyone to show how grouping disorders together on the basis of their shared descriptive features (*e.g.*, mood disorders, anxiety disorders, personality disorders) inherently suggests favoring either perspective. In fact, in addition to facilitating differential diagnosis, the DSM-III descriptive approach to grouping disorders makes it possible for users with different perspectives to use the same classification. An illustrative example is grouping panic disorder in the group of anxiety disorders. Such a grouping enables a clinician to comfortably make the diagnosis whether he or she has a biological, a cognitive behavioral, or a psychodynamic perspective that accounts for the phenomenology of unexpected recurrent panic attacks. Was not the value of psychiatric pluralism facilitated by the DSM-III descriptive approach to classification?

Should Nondisorder Problems Be Included in the Classification?

DSM-II provided a short list of problems that clinicians often focus their attention on that are not secondary to a mental disorder. Some of these problems, such as antisocial behavior, are part of the differential diagnosis of a mental disorder (*e.g.*, antisocial personality disorder). The inclusion of such a list acknowledges that clinical attention is often not limited to mental disorders and their manifestations and that not all problems in living are pathological. For these reasons (the value of clinical utility and the credibility of the manual), DSM-III and

DSM-III-R provided such a list, called the Z codes for “Conditions Not Attributable to a Mental Disorder that are the Focus of Clinical Attention.”

What Kinds of Information and How Much Should Be Provided in the Text Describing the Mental Disorders?

Having assembled a large group of experts in the various disorders, the committee decided that the clinical utility and credibility of the manual would be increased if nondiagnostic information (*i.e.*, information about the disorder that is not part of its defining features) was presented. Thus, information was provided, when it was available and relatively noncontroversial under the following headings: associated features, age at onset, course, impairment, complications, predisposing factors, prevalence, sex ratio, familial pattern, and differential diagnosis. It was obvious that it would serve no useful purpose to include speculations about etiology or suggestions regarding treatment. The large increase in the size of DSM-III (494 pages as compared with the 89 pages of DSM-II) is largely due to the inclusion of such material.

Would It Be Useful to Attempt to Define “Mental Disorder” (Never Done in a Psychiatric Classification)?

The issue of how to define mental disorder and whether having such a definition is helpful is extremely complex and has been discussed elsewhere (Klein, 1978; Spitzer and Williams, 1982). The DSM-III committee was initially opposed to a definition suggested by this author which, among other things, stated that mental disorders were a subset of medical disorders (Spitzer and Endicott, 1978). This statement angered psychologists who believed that such a statement had the effect of excluding them as experts in psychopathology. The DSM-III committee later decided to include a revised definition of mental disorders (without the statement about medical disorders), believing that the definition—despite its many limitations—increased the credibility of the manual by at least attempting to define the underlying construct of mental disorder. (The reader may wish to note that I acknowledge that Wakefield’s harmful dysfunction concept of mental disorder [Wakefield, 1992] is an elegant improvement over my own efforts at this difficult task.)

Sadler et al.’s critique of DSM-III and DSM-III-R addresses various *process* questions, such as:

How were DSM-III and DSM-III-R committee members chosen and how were decisions made?

Sadler et al. are not satisfied by the statement in the introduction to DSM-III that individuals were selected “because of their special interest in various aspects of diagnosis” and that “as the work progressed, additional members were added to insure representation of different perspectives . . .” Because no information is provided in the introduction about which “different perspectives” were included, Sadler et al. conclude that “the entire process is shrouded in mystery. The mystery is important as much for what it reveals as for what it conceals about the process of constructing the nosology. We do not know how key decisions were made, but we do know that the public posture of the Task Force is meant to convey consistency and consensus. A phone call or letter to me would have solved the mystery of the “additional members.” An APA oversight committee insisted that we add some members with a psychoanalytic perspective—which we did. Regarding how decisions were made, as can be seen in both DSM-III and DSM-III-R, I chaired all committees. Almost always decisions were made by consensus, but on some occasions votes were taken (in a few instances I lost). Does the reader of ICD-9 or ICD-10 know how its decisions were made?

How did the DSM-III committee respond to criticism?

Sadler et al. characterize the DSM response to criticisms as “reactive” and argue that had implicit value commitments been acknowledged, this would not have been necessary. I agree with his characterization of the DSM approach to criticism as “reactive,” by which I mean that we attempted, whenever possible, to respond to criticism by coming up with some solution that might at least partially satisfy our critics, provided we did not give away the store (so to speak). A good example—and little known—is the origin of the famous DSM-III multiaxial system. The actual impetus for this was to meet the mounting criticism that by developing such a large and seemingly authoritative diagnostic manual, American psychiatry was giving the impression that the only important part of a psychiatric evaluation was making (or not making) a psychiatric diagnosis. By providing a multiaxial system that included physical disorders (axis III), psychosocial stressors (axis IV), and level of functioning (axis V) enabled DSM-III to be presented as within a broad biopsychosocial model—rather than the narrow diagnostic model that its critics feared. We are proud of the DSM

multiaxial system, but its innovation was in response to criticism. Another example is the compromise in DSM-III of including the DSM-II terminology in parentheses for the “neurotic disorders” following the DSM-III terminology, as in panic disorder (anxiety neurosis). By the time of DSM-III-R, no one cared about the DSM-II terminology for the “neuroses,” and it was dropped entirely from the DSM-III-R classification. What values justify such a strategy? It is better to win (by offering your critics something) than to lose (offer them nothing and have the entire project stopped—as several times seemed possible).

Are the Goals of DSM-III and DSM-III-R Incompatible?

A central thesis of Sadler et al. is that the “requirements and demands of a scientific classification are in conflict with the practical demands of a psychiatric classification”—hence, the need for greater clarity about underlying assumptions and values. He also assumes that the stated goals of DSM-III and DSM-III-R are incompatible. First of all, what is a “scientific classification”? I would argue that a classification of mental or medical disorder is scientific to the extent that individual diagnoses are conceptualized as tentative hypotheses and presented in ways that facilitate their being systematically studied, evaluated, revised, and in some cases discarded. Such a classification is certainly not incompatible with the practical clinical demands for classification that is clinically useful. Where is the evidence that the DSM-III and DSM-III-R stated goals are incompatible? What “scientific” principle or knowledge was sacrificed by the demands made by the goal of creating a classification that would be as reliable as possible and consistent (when possible) with data from research studies? Similarly, what practical need for a clinically useful classification was sacrificed by adherence to any of the other stated goals?

What Was the DSM-III Controversy All About?

Sadler et al. are correct in noting that much of the controversy surrounding DSM-III was because large numbers of clinicians with a psychodynamic or family systems perspective felt that the DSM-III classification, and the authoritative way in which it was being presented to the profession, devalued their mode of practice. (In developing DSM-III-R, we actually encouraged a family systems group of psychiatrists to propose a classification of disturbed family units that we hoped could be included in a DSM-III-R appendix for use by family-oriented therapists. Un-

fortunately, the group could not agree on a system and the project was abandoned.)

I recall a psychoanalyst and chair of a DSM-III oversight committee who commenting on a draft of DSM-III said, “There is so much more that we know.” By this, he meant that DSM-III did not include all of the knowledge that his fellow clinicians had painstakingly learned about human behavior and motivation from the intensive study of patients in long-term psychotherapy. In a sense, the real controversy about DSM-III was a controversy about who were the leaders in the profession and whether progress in our field was most likely to come from empirical research studies or from clinical wisdom collected by intensive long-term psychotherapy (Bayer and Spitzer, 1985). It is hard to see how the controversy would have been conducted at a higher level if the DSM-III committee had made any clearer their value commitments.

Conclusions

Sadler et al. are correct when they assert that basic values, assumptions, and commitments determine how developers of a classification system of mental disorders approach their difficult task. In this paper, we have presented those values, assumptions, and commitments, which were, for the most part, widely known and were contained in the ongoing DSM-III and DSM-III-R literature (Spitzer et al., 1977, 1980). It is not true that DSM-III and DSM-III-R gave greater emphasis to reliability than to validity, and it is not true that the DSM atheoretical approach with regard to etiology is implicitly biased toward a particular etiological perspective (organic or behavioral).

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