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DSM-III AND THE REVOLUTION IN THE CLASSIFICATION OF MENTAL ILLNESS

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A revolution occurred within the psychiatric profession in the early 1980s that rapidly transformed the theory and practice of mental health in the United States. In a very short period of time, mental illnesses were transformed from broad, etiologically defined entities that were continuous with normality to symptom-based, categorical diseases. The third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) was responsible for this change. The paradigm shift in mental health diagnosis in the DSM-III was neither a product of growing scientific knowledge nor of increasing medicalization. Instead, its symptom-based diagnoses reflect a growing standardization of psychiatric diagnoses. This standardization was the product of many factors, including: (1) professional politics within the mental health community, (2) increased government involvement in mental health research and policymaking, (3) mounting pressure on psychiatrists from health insurers to demonstrate the effectiveness of their practices, and (4) the necessity of pharmaceutical companies to market their products to treat specific diseases. This article endeavors to explain the origins of DSM-III, the political struggles that generated it, and its long-term consequences for clinical diagnosis and treatment of mental disorders in the United States. © 2005 Wiley Periodicals, Inc.

DSM-III's Origins: Psychiatry's "Crisis of Legitimacy" in the 1970s

The 1970s were a turbulent decade for psychiatry. The field's dominant theory (psychoanalysis) and dominant treatment (psychotherapy) were under severe attack both from within and without the medical profession. During the three postwar decades, psychiatry's ruling psychodynamic paradigm viewed mental disorders as conflicts of personality and intrapsychic conflict. From the end of World War II until the mid-1970s, an environmental and behavioral model of mental disorders (informed by psychoanalytic and sociological thinking) was the organizing model for American psychiatry (Wilson, 1993).

Psychiatric practice in the first part of the twentieth century did not place much stake in particular diagnostic categories. The first official manual of the American Psychiatric Association (APA), the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-I; 1952), reflected the views of dynamic psychiatrists, especially of Adolf Meyer, the most prominent American psychiatrist of the first half of the twentieth century (Grob, 1991). Specific diagnostic entities had a limited role in the DSM-I and its successor, the DSM-II (1968). These manuals conceived of symptoms as reflections of broad underlying dynamic conditions or as reactions to difficult life problems. Dynamic explanations posited that symp-

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toms were symbolic manifestations that only became meaningful through exploring the personal history of each individual. The focus of analytic explanations and treatment, therefore, was the total personality and life experiences of the person that provided the context for the interpretation of symptoms (Horwitz, 2002). The DSM-I and DSM-II made little effort to provide elaborate classification schemes, because overt symptoms did not reveal disease entities but disguised underlying conflicts that could not be expressed directly.

Karl Menninger, a leading dynamic psychiatrist at the time, argued that separating individual mental disorders into discrete categories with unique symptom characteristics—scientific medicine's *modus operandi*—was a mistake. Instead, Menninger viewed all mental disorders "as reducible to one basic psychosocial process: the failure of the suffering individual to adapt to his or her environment. . . . Adaptive failure can range from minor (neurotic) to major (psychotic) severity, but the process is not discontinuous and the illnesses, therefore, are not discrete" (Wilson, 1993, p. 400). Rather than treating the symptoms of mental disorder, he urged psychiatrists to explain how the individual's failure to adapt came about and its meaning to the patient. In other words, "What is *behind* the symptom?" (Menninger, 1963, p. 325).

Given such a broad, unifying definition of mental illness, Menninger claimed, the mentally ill person was not an exception. On the contrary, almost everyone has some degree of mental illness at some point in their life. "Postwar psychiatric thinking," the historian Gerald Grob points out, "reflected an extraordinary broadening of psychiatric boundaries and a rejection of the traditional distinction between mental health and mental abnormality" (Grob, 1987, p. 417). The downside of this expansive view of mental illness, however, was that it poorly separated healthy from sick individuals. Between 1900 and about 1970, the focus of dynamic psychiatry broadened from the treatment of neuroses to more generalized maladaptive patterns of behavior, character, and personal problems. Its clients came to be people who were dissatisfied with themselves, their relationships, their careers, and their lives in general. Psychiatry had been transformed from a discipline that was concerned with insanity to one concerned with normality (Hale, 1995; Herman, 1995; Horwitz, 2002; Lunbeck, 1994). This focus, however, made the profession vulnerable to criticism that psychiatry was too subjective, medically unscientific, and overly ambitious in terms of its ability to explain and cure mental illness (Hackett, 1977).

Diagnosis had, at best, a minor role in dynamic psychiatry. In 1980, at one stroke, the diagnostically based DSM-III radically transformed the nature of mental illness. In a remarkably short time, psychiatry shed one intellectual paradigm and adopted an entirely new system of classification. The DSM-III imported a diagnostic model from medicine where diagnosis is "the keystone of medical practice and clinical research" (Goodwin & Guze, 1996). Psychiatry reorganized itself from a discipline where diagnosis played a marginal role to one where it became the basis of the specialty. The DSM-III emphasized categories of illness rather than blurry boundaries between normal and abnormal behavior, dichotomies rather than dimensions, and overt symptoms rather than underlying etiological mechanisms (Horwitz, 2002). What accounts for the revolutionary transformation the DSM-III brought about for psychiatry?

One explanation attributes the success of the DSM-III to the power of scientific knowledge. Its advocates equate its classifications with objectivity, truth, and reason. According to Gerald Klerman, the highest-ranking psychiatrist in the federal government at the time, the movement from the DSM-I and II to the DSM-III was a "victory for science" (Klerman, Vaillant, Spitzer, & Michels, 1984, p. 539). Melvin Sabshin, the executive officer of the American Psychiatric Association, called it a great triumph of "science over ideology" (Sabshin, 1990, p. 1272). For the proponents of the DSM-III, "the old psychiatry derives from theory, the new psychiatry from fact" (Maxmen, 1985, p. 31). According to another promi-

Table 1
DSM Versions I–IV, 1952–1994

Version	Year	Total Number of Diagnoses	Total Number of Pages
I	1952	106	130
II	1968	182	134
III	1980	265	494
III-R	1987	292	567
IV	1994	297	886

Source: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, I–IV (Washington, DC: American Psychiatric Association, 1952, 1968, 1980, 1987, 1994).

nent diagnostic psychiatrist, "scientific evidence" rather than the charismatic authority of "great professors" stood behind the classificatory systems of the DSM-III and subsequent DSM-IV (Kendler, 1990).

A second common explanation for the success of the DSM-III is that it represented a growing medicalization of psychiatry that placed a growing realm of behavior within the legitimate domain of psychiatry (Hale, 1995; Shorter, 1997; Wilson, 1993). The proponents of the medicalization thesis point to the exponential growth in specific diagnoses that occurred when the DSM-III replaced the DSM-II. As Table 1 indicates, the number of diagnoses in progressive editions of the DSM did steadily grow, as did the size of the manual itself. This growth is usually seen as evidence of the DSM-III's ability to classify a greater number of problems as medical ones and to legitimate psychiatry as the profession that should treat these problems.

This article presents a different explanation for the triumph of the DSM-III. The fundamental aspect of the new manual was its use of categorical, symptom-based diagnosis to define mental illnesses. In contrast to the position that these diagnoses represented the growth of scientific knowledge, we argue that *no* new knowledge led to the new paradigm. Likewise, although the DSM-III did greatly increase the number of specific diagnoses, it did not increase the number of behaviors that psychiatry laid claim to treat. Psychoanalysis had already medicalized a vast number of problems over the course of the twentieth century. By the 1970s, the clients of dynamic psychiatrists were people with poor marriages, troubled children, failed ambitions, general nervousness, and diffuse anxiety (Hale, 1995; Herman, 1995; Lunbeck, 1994). In addition, dynamic assumptions pervaded the treatment of deviant behavior in schools, juvenile courts, and child guidance clinics (Danziger, 1990). Dynamic psychiatry, not its diagnostic successor, was responsible for the tremendous growth of medicalization over the course of the twentieth century. Contrary to the common view that the DSM-III expanded the range of pathology that psychiatry should treat, in fact it simply recategorized as discrete disease entities the wide range of problems that dynamic psychiatry had already pathologized (Horwitz, 2002). Indeed, in many ways, the intentions of the framers of the DSM-III were to *limit* the realm of psychiatry to specific disease entities that could be reliably classified.

The basic transformation in the DSM-III was its development and use of a model that equated visible and measurable symptoms with the presence of diseases. This symptom-based model allowed psychiatry to develop a standardized system of measurement. Such a standardized system benefited numerous interests. It allowed research-oriented psychiatrists, a small but highly influential group in the profession, to measure mental illness in reliable and reproducible ways. It also helped silence the critics of the previous system, who claimed that mental illnesses could not be defined in any objective way. For clinicians, who comprised the vast

majority of the psychiatric profession, the new diagnostic system legitimized claims to be treating real diseases and, most importantly, allow them to obtain reimbursement from third-party insurers. Because the manual defined illnesses solely through symptoms without regard to causes, it was theory-neutral and could be used by clinicians of all theoretical persuasions. The symptom-based manual also met the needs of pharmaceutical companies to have specific diseases for their products to treat. The standardized diagnoses that the DSM-III created not only solved the deep crisis that the discipline faced in the 1970s but also established a powerful new model of mental illness that has reigned virtually without challenge to the present.

The Crisis of Legitimacy in Psychiatry

From the end of World War II to the mid-1960s, psychodynamically oriented psychiatry enjoyed an extraordinary prestige in American society (Grob, 1991; Hale, 1995; Herman, 1995). Beginning in the mid-1960s, however, its legitimacy was called into question from a number of quarters. Some of these attacks stemmed from critics who questioned the validity of psychiatry's central concept of mental illness. One group of critics, known as the "antipsychiatry movement," contended, in Thomas Szasz's terms, that mental illness itself was a "myth" (Szasz, 1961). For Szasz, whose politics stemmed from the libertarian right, psychiatry was an authoritarian extension of the state used for controlling nonconformists. Psychiatric labels were arbitrary designations that, instead of serving the needs of patients, served professional needs and the needs of dominant groups. According to another major critic of psychiatry, the sociologist Thomas Scheff, mental illness is merely a residual category of behavior, an explanation of last resort (Scheff, 1966). From this perspective, a mental disorder was a label behind which psychiatrists and the public hid their ignorance of the real causes behind deviant behavior. The extraordinarily popular philosopher Michel Foucault argued that classifications of mental illness emerged in a complex field of power relations during the eighteenth century. The mental institutions that appeared in Europe at that time replaced the leprosariums that previously had exerted control over nonconforming behavior (Foucault, 1965).

The antipsychiatry critics had great influence not only within academia but also in the broader culture. Many of their critical arguments were expressed in the film *One Flew Over the Cuckoo's Nest*, which won the top five Oscars in 1975 (best picture, best director, best actor, best actress, best screenplay). The film portrayed the exploits of an affable nonconformist, Randle P. McMurphy, who innocently had himself transferred from prison to a psychiatric ward because of his mistaken belief that he would be free of coercive institutional control while in the hospital. McMurphy does not have any psychiatric illness or disorder per se but is an iconic rebel who gets into fights and refuses to show sufficient deference to those in authority. By the end of the film, McMurphy is brutally lobotomized. Based on the popular, best-selling novel of the same name by Ken Kesey, one of the antipsychiatry movement's heroes, the film cost only $4.4 million to make but became United Artists' biggest hit and the seventh-highest grossing film ever at the time, bringing in almost $300 million worldwide.

The message of the film was that psychiatrists and other mental health personnel were "mental police," inpatient psychiatric treatment was akin to imprisonment, and the staff at mental facilities functioned, essentially, as prison orderlies (Kesey, 1962). Allied to the argument that mental illness was not real but a label used to coerce nonconformists, these arguments presented a powerful critique of psychiatric theory and practice. The antipsychiatry critics were not marginal eccentrics but major figures in an intellectually prominent counterculture. They found a receptive audience with many college students, intellectuals, and the anti-authority ethos of the time.

An entirely different line of attack on psychiatric practice stemmed from insurance companies that bemoaned psychiatry's lack of financial accountability and clinically demonstrated effectiveness. For the first half of the twentieth century, most clients of dynamic psychiatry paid for their therapy as an out-of-pocket expense so that therapists were not generally accountable to third parties. During the 1960s, many medical insurance plans began to include psychotherapy as a partially reimbursable expense, and private insurance paid for about one-quarter of outpatient treatment (Horwitz, 2002). During the 1970s, the rate of private insurance coverage continued to rise, and the federal Medicaid program also became a major source of payment for therapy (Mechanic, 1998). The economic basis of the therapeutic relationship was no longer solely between therapists and their clients but had come to involve private and public third-party payers. The rise of third-party payers contributed to pressures to change the dynamic model: the continua and symbolic mechanisms of dynamic psychiatry did not fit an insurance logic that would only pay for the treatment of discrete diseases (Horwitz, 2002).

Third-party payers required not only the treatment of categorical diseases but also some sort of accountability for the outcomes of treatment (Frank, McGuire, Regier, Manderscheid, & Woodward, 1994). While psychiatrists struggled in their efforts to pass insurance companies' tests of cost-benefit analysis, social scientists conducted empirical studies casting doubt on the long-term effectiveness of psychotherapy (Starr, 1982). Psychotherapy was consuming larger amounts of total health care spending but lacked persuasive scientific evidence that it worked effectively and consistently. Insurance companies viewed psychotherapies as a financial "bottomless pit" requiring potentially uncontrollable resources; patients could spend years in psychoanalytic therapy.

Nobody regulated the claims clinicians made on behalf of different therapies, so it appeared that the number of them was likely to grow without any proof that they worked. The implication, the psychopharmacologist David Healy points out, was that there were charlatans in the marketplace and that a number of practices were probably harmful (Healy, 1997). The problems of psychotherapy research and the cost and effectiveness of psychoanalysis were continually bemoaned by insurance companies and the government, both of which paid enormous amounts of money for mental health services. They wanted answers to basic questions: Were patients in psychotherapy "medically ill"? Was psychotherapy cost-effective compared to alternative treatment methods? How predictable were the costs given the frequency and length of treatment (Hale, 1995). Insurance companies and the federal government, Mitchell Wilson explains, were becoming increasingly skeptical about psychiatry's legitimacy:

> In the 1960s the Federal Employees Health Benefits Program, underwritten by Aetna and Blue Cross, reimbursed psychiatric illness dollar for dollar with other medical illnesses. By the mid-1970s, however, Aetna had cut back coverage to 20 outpatient visits and 40 inpatient hospital days per year. Blue Cross Vice-President Robert J. Laur summarized the views of many third-party payers when he said in 1975, "Compared to other types of [medical] services there is less clarity and uniformity of terminology concerning mental diagnoses, treatment modalities, and types of facilities providing care. . . . One dimension of this problem arises from the latent or private nature of many services; only the patient and the therapist have direct knowledge of what services were provided and why." In 1977, speaking for the federal government, Senator Jacob Javits echoed this view: "Unfortunately, I share a congressional consensus that our existing mental health care delivery system does not provide clear lines of clinical accountability." (Wilson, 1993, p. 403)

In 1980, the Senate Finance Committee proposed limiting government support of mental treatment to therapies judged, by the Food and Drug Administration (FDA), to be "safe and

effective on the basis of controlled clinical studies which are conducted and evaluated under generally accepted principles of scientific research" (Marshall, 1980, p. 35). Those who provided psychiatrists' chief source of income were becoming increasingly skeptical of the product being delivered and unwilling to continue reimbursing for mental health treatment unless changes were made. Outpatient care in office settings, the primary venue for most psychotherapists, came under attack as ineffective, unaccountable, and financially wasteful. Both insurance companies and the federal government increasingly demanded diagnoses and treatments that were both demonstrably effective and financially accountable.

Another source of major disenchantment with psychiatry during the 1970s was that psychiatrists mainly treated people who had problems of living but not true mental illnesses. As Stuart Kirk and Herb Kutchins explain, "[I]t appeared that psychotherapists preferred clients who were young, attractive, verbal, intelligent, and successful—what came to be labeled the YAVIS syndrome. Psychotherapy was described as the purchase of friendship. Psychotherapists were accused of creating demands for services from those who were not really ill, but were merely discontent—the worried well—and neglecting the more needy" (Kirk & Kutchins, 1992, p. 19). This focus on problems of living seemed particularly inappropriate during the 1970s, as thousands of patients with serious mental illnesses were released from state mental hospitals and entered the community.

Deinstitutionalization

Psychiatry was facing a confluence of severe pressures and criticisms by the 1970s but was also experiencing an increase in demand for its services stemming from, among other factors, roughly two decades of deinstitutionalization. The term *deinstitutionalization* refers to the release of many long-term psychiatric patients from state-run mental health hospitals, which housed people with mental disorders for long periods of time (Grob, 1995). Prior to the 1960s, the most severely mentally ill were institutionalized in state-run mental hospitals. Labeled the "shame of the states" by Albert Deutsch, for the frequently appalling conditions that existed in these institutions, asylums quarantined the mentally ill away from normal communities (Deutsch, 1948). Psychiatrists had largely abandoned practicing within these institutions, and by 1957, only 17 percent of the members of the American Psychiatric Association had any affiliation with a mental institution (Grob, 1991).

One factor conducive to deinstitutionalization was the introduction of chlorpromazine (also known as thorazine), an antipsychotic drug, in 1954. Following its approval that year by the FDA, chlorpromazine was used effectively to calm agitated patients and control the most serious symptoms of psychosis, so that persons with serious mental illnesses could, in theory, live in community settings. From a peak of 559,000 individuals in 1955, the number of those institutionalized declined modestly to around 475,000 a decade later, a decrease of 15 percent (Grob, 1995). While chlorpromazine helped facilitate deinstitutionalization, the federal government's introduction of new public policy—the Community Mental Health Centers (CMHC) program in 1963 and Medicare and Medicaid in 1965—had even greater impacts on the pace of this process (Gronfein, 1985). In addition, civil rights advocates argued for expanding legal protections against involuntary commitments to mental hospitals. According to David Rochefort, "[D]einstitutionalization accelerated in the late 1960s and 1970s with the growth of the welfare state and with the reinforcement of an egalitarian noncoercive ethic. By the late 1960s, lawyers socialized in the civil rights battles of the decade turned their attention to the rights of the mentally ill with an attack on civil commitment, and the development of a legal theory advancing patient rights and the least restrictive alternative" (Rochefort, 1993, p. 213).

The cumulative effects of these new federal policies, psychotherapeutic drugs, and legal efforts were remarkable. In the 1970s, the states greatly accelerated the discharge of many severely and persistently mentally ill patients from public mental asylums (Grob, 1994). From 475,000 individuals in 1965, the number of those institutionalized in 1980 had fallen to 138,000, a decrease of almost 60 percent (Hale, 1995). Whereas "before 1965 many patients spent years, if not decades, in asylums," explains Grob, "after 1970 length-of-stays began to be measured in days or weeks" (Grob, 1994, p. 287). Some of the deinstitutionalized—including nonelderly individuals who failed to qualify for Medicaid—ended up on the streets or in the criminal justice system (Shorter, 1997). They joined a new demographic group of young adults with severe or chronic mental illnesses who drifted in and out of emergency medical facilities, psychiatric wards, and correctional institutions. This new cohort of younger mentally ill included many persons with alcoholism and substance abuse problems, which made them unattractive to mental health professionals who found these patients extremely frustrating to try to heal. Psychiatrists, who had largely established themselves in outpatient practices that catered to urban, cosmopolitan intellectuals amenable to lengthy and expensive treatments grounded in psychoanalysis, were ill suited to deal with the conditions of schizophrenia and degenerative brain disorders common among formerly institutionalized patients. They also expressed little interest in treating alcoholic patients or those with drug addictions but often referred them to psychologists and social workers (Redlich & Kellert, 1978).

Another impact of deinstitutionalization on the future of psychiatry and mental health in general was to facilitate a noticeable increase in the use of psychotherapeutic drugs by psychiatrists in rapidly expanding private and public care settings (Brown, 1985). Most deinstitutionalized persons were not responsive to Freudian psychoanalysis or generic talk therapy. Psychiatrists increasingly turned to drugs as treatment, especially for four categories of mental illness that many deinstitutionalized patients had: psychosis, depression, anxiety, and manic-depressive disorder (Young, 1995). By the late 1970s, the psychiatrist who did not prescribe drugs was the exception (Redlich & Kellert, 1978). Even three-fifths of Freudian psychoanalysts had come to prescribe medications for their patients. Psychiatrists' use of psychotherapeutic drugs in these new, noninstitutional settings was becoming a familiar modality of treatment before the development of the DSM-III. The symptom-based diseases that the new manual would create greatly facilitated the expanding role of drug treatments in psychiatry. Psychoanalysis, in contrast, was becoming further marginalized because of its inability to respond to the growing need to treat seriously mentally ill persons in community settings and to provide the specific disease entities that were required before a drug could be marketed and prescribed.

Researchers' Critiques of Psychiatry

The crisis in psychiatry during the 1970s was exacerbated by attacks on the dominant psychodynamic paradigm from disenchanted psychiatrists who sought to bring the profession into the mainstream of scientific inquiry. They also came from other mental health clinicians—psychologists, social workers, and counselors—who wanted the government and insurance companies to grant them the same reimbursement status as psychiatrists for providing psychotherapy. If psychotherapy was the primary treatment device used by psychiatrists, these other clinicians argued, then what granted them a professional monopoly for treating patients with mental disorders? Moreover, if psychotherapy performed by psychiatrists could not be demonstrated to be more effective than similar talk therapy from other mental health clinicians, why would the government and insurance companies want the cheaper alternative provided by psychologists, social workers, and counselors?

Alan Stone, president of the APA in 1976, concluded that social psychiatry and social activism, "carrying psychiatrists on a mission to change the world, had brought the profession to the edge of extinction" (Wilson, 1993, p. 402). In the *American Journal of Psychiatry* in 1977, Thomas Hackett, a professor of psychiatry at Harvard Medical School, pointed out that the number of medical students going into psychiatry had shown a marked and substantial drop throughout the country and that it reflected, in his opinion, a growing skepticism about psychiatry's useful future as it is seen from the outside. "Apart from their training in medicine," he claimed, "psychiatrists have nothing unique to offer that cannot be provided by psychologists, the clergy, or lay psychotherapists" (Hackett, 1977, p. 434). Even proponents of maintaining psychiatry's focus on empathetic psychotherapy within community mental health settings acknowledged that the economic and political pressures on psychiatrists were mounting. The ground rules for what was considered reimbursable medical care were becoming more demanding. As a result, many of them argued, psychiatry had to respond to the demands for better standards and criteria, more valid outcome studies, better peer review, and other proofs that their diagnoses and treatments were legitimate and effective (Somers, 1977).

Research-oriented psychiatrists insisted that the discipline needed to expand scientific research on mental disorders, increase diagnostic reliability among clinicians, and more clearly demarcate different mental disorders. With the rise in computer technology aiding the use of quantitative analysis in field research, these critics argued for a more systematic approach to classifying disorders based on their unique symptoms. Perhaps most importantly, the critics contended, where specific etiologies of mental disorders could not be empirically ascertained, they should not be attributed to any cause at all (and especially not to such theoretical psychoanalytic concepts such as "neurosis" or "regression to anal conflicts"). Instead, psychiatrists should focus exclusively on the unique symptoms of each disorder and the optimal treatment to alleviate those symptoms. To objectively determine what the optimal treatment was for a given mental disorder, the critics called for new and stringent standards for demonstrating effectiveness, such as those used by the FDA to test the efficacy of drugs: quantitative and comparative studies based on matched samples of patients uniformly diagnosed, randomly assigned, and treated with standardized procedures, with outcomes judged not only by clinicians but by impartial observers not involved in the treatment (Hale, 1995).

Professional Threats from Psychiatrists' Competitors

Criticisms from the antipsychiatry movement, insurers, federal policymakers, and researchers damaged psychiatry's status as a genuine medical specialty. They highlighted the urgent need for psychiatry to substantiate its practices and defend itself from competing practitioners (including psychologists) who were making inroads among psychiatrists' most lucrative clientele: college-educated, middle- and upper-income patients. By having partially abandoned their claim to special expertise rooted in medicine, psychiatrists were successful in promoting psychotherapy as a cultural institution. But they also spawned their own professional competition. Since the 1950s, psychologists in particular had contested psychiatric authority over the practice of psychotherapy (Buchanan, 2003). Medical training seemed irrelevant for the understanding of the central dynamic processes of repression, childhood sexuality, and symbolic interpretation of symptoms. There was nothing explicitly *psychiatric* about dynamic psychiatry; nonmedical and medical professionals alike were equally able to learn and practice it.

By 1980, the National Medical Care Utilization and Expenditure Survey (NMCUES) reported that there were 28,000 psychiatrists, 50,000 psychologists, and 300,000 social workers, with the latter two groups having increased their ranks by 700 percent since 1950 (NMCUES, 1980). Psychologists were providing as much outpatient treatment as psychiatrists, each profession supplying about one-third of the total, while social workers and primary care physicians provided another third. Psychiatrists' use of talk therapy might be helpful for many patients with mild mental illness, general anxiety, or mood problems. But critics charged that clinical psychologists, social workers, and lay counselors could also employ talk therapy with the same relative degree of success *and* at cheaper rates. The courts were beginning to agree (Greenberg, 1980).

In a landmark case in 1980, the United States Court of Appeals for the Fourth Circuit ruled that refusal by defendants Blue Shield of Virginia and Blue Shield of Southwestern Virginia to pay for services rendered by clinical psychologists unless such services were billed through a physician was anticompetitive behavior on the part of psychiatrists and unnecessary to maintain "good medical practice." The Court went on to question whether, in fact, the medical practice of having psychiatrists supervise psychologists was necessarily "good":

> Any assertion that a physician must actually *supervise* the psychologist to assure the quality of psychotherapy treatment administered is refuted by the policy itself. The Blue Shield policy provides for payment to psychologists for psychotherapy if billed through *any* physician—not just those who regularly treat mental and nervous disorders. It defies logic to assume that the average family practitioner can supervise a licensed psychologist in psychotherapy, and there is no basis in the record for such an assumption. (*Virginia Academy of Clinical Psychologists and Robert J. Resnick* v. *Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980))

Psychiatrists faced a major professional dilemma. With psychotherapy growing in popularity, psychiatrists had to collectively decide if they were going to try to restrict talk therapy to themselves behind the guise of medicine or if they were going to surrender most of this type of practice to the psychologists, social workers, and lay counselors who could consistently undercut them in price. The more nonmedical psychotherapy became in the eyes of insurance companies and the government, the more professionally vulnerable psychiatrists became. If psychiatrists could not sufficiently demonstrate that their practice produced superior results to those of their competitors, they would have to define psychiatry's exclusive contributions and jurisdiction in other ways.

In conclusion, many issues converged to force psychiatrists to consider changing definitions of mental disorders and what constituted optimal treatment for them: psychiatry's marginal status within the medical profession, the increasing reluctance of insurance companies and the government to reimburse long-term talk therapy, the need to treat formerly institutionalized seriously mentally ill persons in the community, the growing influence of medication treatments, and the growing professional threat from nonphysicians such as clinical psychologists, counselors, and social workers. The confluence of these pressures led to a new DSM that fundamentally redefined what mental disorders were and how they should be identified, diagnosed, and treated. "By intent and careful plan," according to Kirk and Kutchins, "the developers of DSM-III sought to bring about a revolution in how mental health professionals thought about and practiced psychiatric diagnosis. On many levels, the revolution succeeded remarkably well" (Kirk & Kutchins, 1992, p. 11). What is of particular interest to social scientists is the extent to which politics and the underlying economics of psychiatric practice permeated the DSM-III's creation.

Creating the DSM-III: Political and Economic Aspects of Mental Diagnoses

The growing threats that psychiatry faced in the 1970s led to the single greatest catalyst for transforming how society perceives, defines, and treats mental disorders: the creation of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders*. At the time, it was not viewed by most observers, not even by most psychiatrists, as a cataclysmic change. But with its symptom-based orientation, the DSM-III contributed significantly to a biological vision of mental health—which stresses the neurosciences, brain chemistry, and medications—superceding the psychosocial vision that had dominated for decades. This new framework focused on the symptoms of mental disorders rather than their causes and emphasized pharmacological treatments over talk therapy and behavioral changes. In time, the DSM-III created new and enormous incentives for pharmaceutical companies to create new drugs. In short, it realigned the incentives of a great many stakeholders—clinicians, insurers, the government, pharmaceutical companies—to standardize the criteria for defining and treating mental disorders.

The first step in the process of developing the DSM-III came in 1974, when Robert Spitzer, a leading psychiatrist at Columbia University and consultant to the development of the DSM-II, was appointed by the APA to coordinate the DSM-II's revision. Initially, the only purpose in revising the DSM-II was to make its nomenclature consistent with the International Classification of Disease (ICD), which was scheduled to be modified by the World Health Organization. The original impetus for revising the DSM was not, therefore, revolutionary in its intention, but rather a matter of making the manual's terminology match that used outside of the United States. Those who appointed Spitzer, however, including Melvin Sabshin (medical director of the APA at the time), and Spitzer himself, had entirely different intentions. As Spitzer commented at the time, "[W]hether we like it or not, the issue of defining the boundaries of mental and medical disorder cannot be ignored. Increasingly there is pressure for the medical profession and psychiatry in particular to define its area of prime responsibility" (Healy, 1997, p. 233).

The Changing Status of "Homosexuality" as a Harbinger of the Political Conflict Ahead

A precursor to the politics involved in the DSM-III's drafting that strongly motivated Spitzer and his colleagues to redefine psychiatry's area of prime responsibility was the embarrassing public debate over homosexuality's status in the DSM-II as a mental "disorder" (Bayer, 1981). Was homosexuality fundamentally similar to other diseases such as depression or psychosis? Psychiatrists had enormous difficulty defending this pathological definition of homosexuality. Annual protests by gay activists at the APA's convention from 1970 to 1973 questioned psychiatry's criteria for defining disorders. The controversy suggested that psychiatric diagnoses were strongly influenced not solely by scientific criteria, but by public opinion, social constructions of deviance, and political pressure. As a harbinger of the role he would play in the DSM-III's creation, Spitzer's participation in the homosexuality debate demonstrated his adroit political skills in mediating conflict. Spitzer himself wanted a middle-ground position of defining homosexuality as an "irregular sexual behavior," not a disorder, but not normal either. After discerning that the APA's task force preferred to completely delete homosexuality from the DSM as a disorder, he acquiesced to gay activists' demands and dropped his preference for a middle-ground position. The APA membership voted in a referendum to confirm the decision to delete homosexuality in 1974 as a disorder and replace it with a much milder description as a

"sexual orientation disturbance." The seventh printing of the DSM-II in July 1974 included the following "Special Note" on page vi:

> SPECIAL NOTE—SEVENTH PRINTING
>
> Since the last printing of this Manual, the trustees of the American Psychiatric Association, in December 1973, voted to eliminate **Homosexuality** per se as a mental disorder and to substitute therefore a new category titled **Sexual Orientation Disturbance**. The change appears on page 44 of this, the seventh printing. In May, 1974 the trustees' decision was upheld by a substantial majority in a referendum of the voting members of the Association.

The political expediency underlying an otherwise scientific debate over diagnosis was expressed in a stroke, Shorter observes, when "what had been considered for a century or more a grave psychiatric disorder ceased to exist" (Shorter, 1997, p. 303).

The debate over homosexuality demonstrated to Spitzer and his colleagues how difficult it would be to entirely remove social and political considerations from any process of defining mental disorders. Nevertheless, it reinforced their desire to move away from the reigning approach to psychiatric classification, "because the debates about homosexuality could have been about most other diagnoses, had there been strong differences of opinions and hungry media," note Kirk and Kutchins. "The debates had nothing to do with the ability of psychiatrists to identify homosexuals, but everything to do with a conceptual and theoretical problem, namely, whether homosexuality constituted a disorder. In order to address that question, psychiatrists would have to define disorder convincingly" (Kirk & Kutchins, 1992, p. 30). The use of narrow, symptom-based definitions could make diagnostic criteria seem more objective and, therefore, avoid political conflicts that exposed the field to widespread ridicule.

Freud versus Kraepelin and the Politics of Selecting the DSM-III Task Force

During the period when dynamic psychiatry was dominant, the Department of Psychiatry at Washington University was an outpost of diagnostically oriented thinking. Led by two prominent psychiatrists—Eli Robins and Samuel Guze—the Washington University group followed Kraepelin in their emphasis on using well-defined, specific criteria as the basis for diagnostic decisions. In 1972, John Feighner, then a resident in the department, codified and published 14 of these diagnostic criteria in what came to be known as the "Feighner criteria" (Feighner, 1972). Spitzer used these criteria for his classificatory model of mental illness, and the faculty at Washington University and the students they had trained became his major allies in the development of the DSM-III.

In determining what would and would not be considered a mental disorder, the membership of Spitzer's task force was hugely consequential. Spitzer selected a group of psychiatrists and consultant psychologists who were committed primarily to medically oriented, diagnostic research and not to clinical practice (Millon, 1986).[1] Clinicians with other, nonmedical backgrounds were included later in the process, but only after the DSM-III's med-

1. In addition to Spitzer, the initial assemblage consisted of Nancy Andreasen, MD, PhD, Jean Endicott, PhD, Donald F. Klein, MD, Morton Kramer, Sc.D., Theodore Millon, PhD, Henry Pinsker, MD, George Saslow, MD, PhD, and Robert Woodruff, MD. Most were well-recognized contributors to the research and theoretical literature (Millon, 1986).

ically oriented and symptom-focused ground rules had been set. Instead of Freud, Spitzer and most of his colleagues (excluding Theodore Millon) favored the approach promulgated by Emil Kraepelin, a German psychiatrist of the late nineteenth century whose teachings had been controversial at the time, briefly popular, and then subsequently marginalized for several decades aside from the Washington University group (Kroll, 1979).

Rather than focusing on any underlying psychological causes for mental disorders, Kraepelin stressed classifying them according to their unique symptoms, course of development, and eventual outcome. In his view, "Depression, schizophrenia, and so forth were different just as mumps and pneumonia were different" (Shorter, 1997, p. 108). Generally speaking, science inherently requires classification schemes. Using infectious diseases as an example, for scientists to be able to identify and eradicate tuberculosis or malaria, they first need to be able to distinguish the two both from each other and from other diseases. Epidemiology represents the formal study of classifying diseases according to rational and empirical criteria. For psychiatry to be a medical science, it had to devise a similar epidemiological scheme for classifying mental disorders (known as a "nosology"). Kraepelin's approach to psychiatric classification, explains Allan Young, was based on three ideas: that mental disorders are best understood as analogues with physical diseases; that the classification of mental disorders demands careful observation of visible symptoms instead of on inferences based on unproven causal theories; and that empirical research will eventually demonstrate the organic and biochemical origins of mental disorders (Young, 1995).

With Kraepelin's theories as his guiding framework, Spitzer became committed to the controversial belief that "mental disorders are a subset of medical disorders" (Spitzer, Sheehy, & Endicott, 1977, p. 4). This belief was repugnant to psychologists, social workers, and counselors who saw it as a "power play" by psychiatry to try to preempt the mental health field and lay exclusive claim to diagnosing and treating mental disorders. In response to this concern, Theodore Millon, a distinguished psychologist, wrote that "to attribute marital conflict or delinquency . . . to a biological defect, to biochemical, nutritional, neurological, or other organic conditions . . . is to sell our psychological birthright for short term gain" (Millon, 1986, p. 45). When put to an official Task Force vote, the phrase was defeated and substituted with "in the DSM-III each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome" (Millon, 1986, p. 45).

Nevertheless, the phrase "mental disorders are a subset of medical disorders" represented the intention of Spitzer and a minority of his colleagues to define and demarcate the field of psychiatry with testable diagnostic criteria. In their desire to reduce reliance on the vagaries of diagnosticians' subjective understandings of mental disorders, their approach replicated the positivistic drive in the behavioral sciences toward operational definitions of concepts (Rogler, 1997). The result, Spitzer and his colleagues hoped, would be diagnoses that could be reliably verified by a standard classification scheme that focused on describing the symptoms of disorders with the least amount of inference necessary. Increasing the DSM's reliability meant, for instance, that if ten psychiatrists saw the same depressed patient separately, all ten should conclude—based on the patient's observable symptoms—that the patient had a depressive disorder. At the time, the DSM-II's reliability was "horrifyingly low," because not all users of it were equally familiar with the disorders and because definitions of some of the disorders included untestable assumptions about their causes (Rogler, 1997). With the DSM-II's lack of formal criteria for determining diagnostic boundaries, clinicians were forced to rely on global descriptions of disorders that often entailed subjective

assumptions about a disorder's cause. Spitzer and his colleagues made their disdain of the diagnostic status quo and their intent to classify disorders on the basis of their symptoms clear from the beginning:

> It was the unanimous opinion of the Committee that etiology [cause] should be a classificatory principle only when it is clearly known, and that conventional speculations about etiology should be explained if they must appear. . . . A diagnosis should be made if the criteria for that diagnosis are met. . . . It is hoped that this will stimulate appreciation, among psychiatrists, of the distinction between the known and the assumed. In everyday practice, then, there will be fewer assignments to diagnostic categories on the basis of probable correctness, and more diagnoses which force the clinician to admit what he does not know. . . . The sense of the committee is that mental disorder should be defined narrowly rather than broadly, that a definition which permits false negatives is preferable to one that encourages false positives. (Wilson, 1993, p. 405)

For Spitzer, the etiologically driven DSM-II brought too many unproven conditions within the realm of psychiatric diagnosis. He expected that the new symptom-based system would narrow, rather than expand, the criteria for defining mental disorders.

Drafting DSM-III and the Controversy over "Neurosis"

Within a year, Spitzer's task force had produced its first draft of the new manual, which included considerably more diagnoses and more lengthy descriptions of each diagnosis than its predecessors. At first, DSM-III's preliminary drafts triggered relatively modest interest among rank-and-file psychiatrists. There were some expressions of vehement opposition by those who favored psychiatry's current psychodynamic orientation (Berk, 1977). But psychoanalysts—the group with the most to lose with the revised manual—did not register any formal response until the latter part of 1976 (Bayer & Spitzer, 1985). Because most psychiatrists and other mental health practitioners rarely used the DSM-II as a diagnostic device at the time, a radical change to the manual struck few practitioners as threatening or revolutionary. The notion that the DSM-III would become *the* textbook for all mental health clinicians, as opposed to the "little manual" (less than 140 pages) its two predecessors had been since 1952, was slow in developing (Madow, 1976).

Between 1977 and 1979, Spitzer and his colleagues ran field trials of the DSM-III sponsored by the National Institute of Mental Health (NIMH). As a government institution, the NIMH played an important supportive role in psychiatry's remedicalization by financing its research and legitimizing the results by granting them the government's seal of approval (Grob, 1994). Approximately 500 psychiatrists from across the country used preliminary drafts of the DSM-III in diagnosing more than 12,000 patients. Around 300 psychiatrists were paired and their evaluations compared for consistency (American Psychiatric Association, 1980). The results were mildly encouraging and agreed upon as a success. But it should be noted that those who did the "agreeing" were primarily of the same view of what the DSM-III should be: a narrowly defined set of criteria that focused on the symptoms of disorders (Hyler, Williams, & Spitzer, 1982). It should also be noted that these field trials did not compare the new symptom-based system to any other classification system but took for granted that the proposed criteria for the DSM-III provided the optimal method for classifying mental disorders.

The political controversy over the task force's deletion of "neurosis" as a diagnosis most clearly illustrated the political aspects of the DSM-III's crafting. It became the most hotly contested and divisive struggle in the DSM-III's ratification. Neurosis was both a synthesizing rationale and a fundamental concept for Freudian psychoanalysts. The term, as

used by advocates of psychotherapy, described the underlying process of internal psychological conflict present in virtually all individuals, which resulted in symptoms that served to unconsciously control anxiety. Everyone, then, existed on a continuum of minimal to severe neurosis. Neurosis had evolved into a staple diagnostic term that many psychiatrists used. Freudian psychoanalysts were especially fond of it as justification for their services—primarily different forms of long-term, individual talk therapy—when no other more specific diagnosis seemed to fit an individual's mental symptoms. Spitzer and his colleagues had intended to delete neurosis from the outset of their efforts. In their opinion, neurosis had no empirical basis in fact. It was, instead, a sloppy term that had outlived its usefulness (Millon, 1983). Besides, Millon argued, since everyone—even those without psychiatric disorders—experienced internal, psychological conflict, neurosis could not serve as the basis for classifying different mental disorders, which is the purpose of a diagnostic manual (Bayer & Spitzer, 1985).

Faced with enormous political opposition, such that the DSM-III was in serious danger of not being approved by the APA Board of Trustees unless "neurosis" was included in some capacity, Spitzer and his task force found a political compromise and reinserted the term in parentheses after the word "disorder" (Bayer & Spitzer, 1985). The term would be used to describe a disorder rather than explain it. But there was more to the opposition of deleting neurosis as a diagnostic term than simply philosophical opinion. To Spitzer and a number of his colleagues, there appeared to be economic concerns involved. "Psychoanalytic practitioners," they believed, "feared that a change in psychiatric nomenclature might result in a challenge by third-party reimbursement sources seeking to limit payment to patients receiving long-term therapy. It was no coincidence, in their view, that this new source of opposition arose in Washington, D.C., where federal employees received generous coverage for psychotherapeutic treatment" (Bayer & Spitzer, 1985, p. 192).

Spitzer and his colleagues were themselves far from being unconcerned about how the new DSM would be received by the organizations that paid for mental health treatment and research. On the contrary, several of those intimately involved in the design of the DSM-III later acknowledged that the manual's structure was "strongly influenced by the need for diagnoses for which insurance companies could provide reimbursement and that could be reliable for researchers" requesting federal money (Healy, 2000). During the DSM-III's drafting, representatives from Blue Cross/Blue Shield and Aetna virtually begged Spitzer and his task force to standardize the manual's diagnostic criteria so that insurers could separate legitimate mental illness from nonpsychiatric problems like "floundering marriages, trouble raising children, and the difficulties in finding meaning in life." As the insurance companies saw it, "Medical insurance should only be asked to cover medical mental disorders. Insurance is meant to pay for the sick, not the discontented who are seeking an improved lifestyle. We need your help in differentiating between those who have mental disorders and those who simply have a problem" (Sharfstein, 1987, p. 532).

Once the task force reinserted "neurosis" and "neurotic" into the final draft of the DSM-III, the APA's Board of Trustees formally approved it for publication in 1980. In retrospect, Spitzer admitted, the politics associated with the "neurosis" controversy was a source of unavoidable embarrassment for many psychiatrists:

> The entire process of achieving a settlement seemed more appropriate to the encounter of political rivals than to the orderly pursuit of scientific knowledge. On each side of the controversy, it was held that important scientific truths were at stake, and yet the situation had demanded, of those who found themselves in opposition, the adoption of strategic postures and the employment of the technique of politics. Of course, these postures and tech-

> niques took on a special character required by the professional nature of the controversy and were often mediated by the language of psychiatric discourse. Thus, in addition to the efforts at persuasion, the reliance on negotiation, the use of polemics, and the threats of a referendum, there were the more traditional appeals to reason and empirical evidence. Scientific politics is not a mere replica of more ordinary politics, but it is politics nevertheless. . . . That this dispute took on a political form and that it was at times passionately fought should therefore come as no surprise. (Sharfstein, 1987, p. 195)

Professional Implications of the New Manual

With the DSM-III, for the first time, psychiatrists, psychologists, social workers, and counselors had one common language to define mental disorders. This language became the code by which all mental health clinicians communicated with both the payers that provided financial reimbursement (insurance companies, managed care operations, the government) and the organizations that would come to pour billions of dollars into mental health and psychopharmaceutical research in the years ahead (pharmaceutical companies and the government) (Gambardella, 1995).

In addition to changing the language of mental health, the DSM-III created enormous professional and financial incentives for both researchers and pharmaceutical companies. It gave them specific diagnoses to target their research and development efforts for prospective treatments. Under the DSM-I and II, large-scale clinical research was impossible, because the manuals' lack of reliable diagnostic categories precluded replication by multiple researchers. In addition, the Food and Drug Administration would not approve the marketing of medications unless they were shown to be effective in the treatment of specific illnesses. The FDA requirements helped ensure the dominance of the DSM-III's symptom-based model of categorical diseases.

Ultimately, the DSM-III triggered a critical change of political power within American psychiatry. "DSM-III is a political document in many ways," Gerald Klerman, the leading psychiatrist in the federal government at the time, admitted several years later. "It appeared in response to some of the ideological and theoretical tensions within the profession of psychiatry. It also has been caught up in the rivalries and tensions among the various mental health professions—psychiatrists, social work, psychology" (Klerman, 1987, p. 3). The DSM-III also changed its economics and what it considered medical knowledge for optimal mental health care. In response to growing professional threats from nonphysicians, increasing limitations and reductions in third-party reimbursement for psychotherapy, and decreasing legitimacy within the medical community, a group made up primarily of neo-Kraepelinians changed the mental health community's diagnostic orientation. In revising the DSM-III, they transformed the little-used mental health manual into a biblical textbook specifically designed for scientific research, reimbursement compatibility, and, by default, psychopharmacology. Although the struggle over the DSM-III appeared to be solely a clinical and academic debate among psychiatrists, underlying it all was a vehement political struggle for professional status and direction.

The Aftermath of the DSM-III: Decline of Psychoanalysis and Rise of Psychopharmacology

The DSM-III was declared a "victory" by its advocates largely due to the manner in which it quickly became the dominant approach to diagnosing mental disorders. The change it wrought was quick, thorough, and irreversible. Within six months of its publication, more orders were re-

ceived for the DSM-III than all the previous DSM editions combined, including their 30-plus reprintings. Unlike previous editions, the DSM-III rapidly became the authoritative text in mental health and was sanctioned by key institutions, notably the NIMH. By the early 1980s, "American medical schools and residency programs routinely expected students and physicians to pass examinations based on DSM-III criteria," explains Young. "Both referees and journal editors expected manuscripts submitted to scholarly journals to be written in its language, and it was simply assumed that psychiatric research proposals would conform to its conventions. Researchers and clinicians who resisted these conventions could assume that they would be excluded from these arenas and their resources" (Young, 1995, p. 102).

Government regulators and insurance companies were especially enamored with the DSM-III, because it introduced much greater clarity into the reimbursement process. Insurance companies and managed care organizations, which were beginning to gain market share in the 1980s in the form of health maintenance organizations (HMOs), had been demanding accountable diagnoses and threatening to reduce or refuse reimbursement if changes were not made. For them, the DSM-III represented a substantial improvement over the previous manuals.

The new manual also opened up numerous opportunities for clinical research. Researchers responded enthusiastically to it because they were able to submit grant proposals to the government that satisfied standardized scientific criteria. They could also collaborate with colleagues at other locales using the same diagnostic language. Government funding of mental health research increased considerably after the introduction of the new manual (National Institute of Mental Health, 1998). During the 1980s, a period when President Reagan and Congress slashed funding for community mental health services and Social Security disability benefits for the mentally disabled, the NIMH's research budget grew 84 percent, to $484 million annually (Hall, 1993). The greatest gains in funding were seen in basic biological research and clinical research focused on schizophrenia and major mood and anxiety disorders. The results of this increased research were sufficiently encouraging such that, on July 25, 1989, at the urging of Congress and with the support of the NIMH, President George Bush declared the 1990s to be the "Decade of the Brain" (Goldstein, 1994).

Freudian psychoanalysts and other talk-oriented psychotherapists who were critical of the DSM-III's biological and medical emphasis assailed it for being parochial, reductionist, overly simplistic, and adynamic (Vaillant, 1984). They argued that in focusing so much on the brain, psychiatrists were "losing the mind" (Reiser, 1988, p. 148). Many of their substantive points highlighted methodological weaknesses in the DSM-III. They even alleged that Spitzer and the members of his task force constituted an "invisible college," unrepresentative of American psychiatry, that surreptitiously took over the DSM-III's development. "True, it is a brilliant and productive [college]," the critics contended, referring to the institutional allegiances of the Washington University–trained psychiatric allies, including the prominent psychiatrists George Winokur (University of Iowa) and Paula Clayton (University of Minnesota), as well as Spitzer himself. "It extends from St. Louis to Iowa, from Minnesota to northern Manhattan. It has made important contributions to our thinking, but it represents only one way of thinking" (Klerman et al., 1984, p. 549). Their complaints had little practical effect. By the mid-1980s, pockets of resistance to the DSM-III and its categorical approach to diagnosis still existed. But as the critics themselves acknowledged, the historic shift from a psychosocial to a symptom-based view of mental health was complete (Robins & Helzer, 1986). They were left to cry "on to DSM-IV!" (Vaillant, 1984, p. 545). Subsequent editions in 1987 (DSM-III-Revised) and 1994 (DSM-IV) reaffirmed and solidified the transformation of psychiatry and mental health that the DSM-III began in 1980.

With the DSM-III, biomedical investigators replaced clinicians as the most influential voices in the field. Even though few of those involved in Spitzer's task force were associated with work on psychopharmacology or the biology of mental disorders, the biological default in what they proposed came about as one of the assumptions of neo-Kraepelinians—that the core symptoms of mental disorders stemmed from some form of brain malfunctioning. Consequently, psychotherapy became the primary domain of clinical psychologists, counselors, and social workers, who appeared to practice it as effectively as psychiatrists but who charged less. Psychopharmacological therapy became the private "turf" of medically trained psychiatrists.

Conclusion

The publication of the DSM-III in 1980 caused a revolution in psychiatry. It also triggered a paradigm shift in how society came to view mental health. Prior to the DSM-III, psychiatrists primarily targeted the underlying psychological causes of mental illness and disorder with psychotherapy. Alternative approaches, such as behavioral therapy, were subordinated to the dominance of psychodynamic theory and practice (Buchanan, 2003). With the DSM-III, they gradually shifted to primarily targeting the symptoms of mental illness and disorder with psychopharmacology, the use of drugs to treat mental ills. The direct and indirect institutional change the new manual produced extended far beyond psychiatry, because the DSM is used by clinicians, the courts, researchers, insurance companies, managed care organizations, and the government (NIMH, FDA, Medicaid, Medicare). As a classificatory scheme, it categorizes people as normal or disabled, healthy or sick. And as the definitive manual for measuring and defining illness and disorders, it operates as mental health care's official language for clinical research, financial reimbursement, and professional expertise. Few professional documents compare to the DSM in terms of affecting the welfare of so many people.

The DSM-III's creation was not the result of a carefully orchestrated conspiracy, but neither was it an accident or "chance-like sequence" of events as some have argued. It did not stem from any new knowledge about the causes of mental illnesses nor their treatments. In addition, it did not enlarge the realm of behaviors that the psychiatric profession was to treat. Instead, its symptom-based focus stemmed from the efforts of research-oriented psychiatrists who wanted to standardize diagnostic criteria and focus attention on the symptoms of mental disorders, rather than on their underlying causes. This standardization, in turn, brought about many advantages. In the postwar period, psychiatry had come under the influence of Freud's teachings and made psychotherapy its leading form of treatment for mental disorders and illnesses. But there was no one standardized form of classifying mental illnesses or of psychotherapy. Each psychiatrist practiced different versions of it based on his or her own personal beliefs and academic training, which varied considerably from one university and institute to another. Hence, psychiatrists struggled in their efforts to scientifically demonstrate psychotherapy's accountability and effectiveness. Insurance companies and the government grew increasingly reluctant to provide unregulated financial reimbursement. Meanwhile, psychologists, counselors, and social workers were growing in numbers. They were also becoming more effective in persuading the courts and third-party payers that they could perform psychotherapy as well as psychiatrists and at lower costs. The more nonmedical psychotherapy began to look, the more difficult it became for psychiatrists to retain exclusive use of it even if they had wanted to, an issue over which many psychiatrists were divided. The struggle over the drafting and publication of the DSM-III

appeared to be a clinical debate among psychiatrists, but underlying it all was a vehement political struggle for professional status and direction. "DSM-III is a political document in many ways," observed Gerald Klerman. "It appeared in response to some of the ideological and theoretical tensions within the profession of psychiatry. It also has been caught up in the rivalries and tensions among the various mental health professions—psychiatrists, social work, psychology" (Klerman, 1987, p. 3).

Finally, while the DSM-III standardized the diagnostic classification scheme for mental illnesses and disorders, it did not include treatment guidelines. By virtue of its Kraepelinian orientation, however, it allowed pharmaceutical companies to market their products for a growing number of specific, symptom-based disease entities (Healy, 1997). The DSM-III unintentionally positioned psychopharmacology on a growth trajectory that various institutions—insurance companies, managed care organizations, pharmaceutical companies, and the government—propelled significantly in subsequent years as they responded to the DSM-III's new diagnostic guidelines and the research incentives that it fostered.

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