DSM: A Brief History and Background (And My Two Cents)

I don't know how many times I have cringed when I have seen or heard the DSM referred to as "The Bible" for mental health clinicians, as if holding it (and clinicians who practice by it) up to some exalted status. Meanwhile, consumers of mental health care often feel judged by certain diagnoses, and consumers and non-consumers alike indicate near-paranoia that mental health care providers are secretly diagnosing them based on everything they say and do. Today I came across a couple of excerpts describing what the DSM actually is and is not that I feel compelled to share. (Along with my two cents at the end.)

> *"The Diagnostic and Statistical Manual of Mental Disorders (DSM) initially developed out of a need to collect statistical information about mental disorders in the United States. The first attempt to collect information on mental health began in the 1840 census. By the 1880 census, the Bureau of the Census had developed seven categories of mental illness. In 1917, the Bureau of the Census began collecting uniform statistics from mental hospitals across the country.*
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> *"Not long afterwards, the American Psychiatric Association and the New York Academy of Medicine collaborated to produce a "nationally acceptable psychiatric nomenclature" for diagnosing patients with severe psychiatric and neurological disorders. After World War I, the Army and Veterans Administration broadened the nomenclature to include disorders affecting veterans.*
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> *"In 1952, the American Psychiatric Association Committee on Nomenclature and Statistics published the first edition of the Diagnostic and Statistical Manual: Mental Disorders (DSM–I). The DSM–I included a glossary describing diagnostic categories and included an emphasis on how to use the manual for making clinical diagnoses. The DSM– II, which was very similar to the DSM–I, was published in 1968. The DSM–III, published in 1980, introduced several innovations, including explicit diagnostic criteria for the various disorders, that are now a recognizable feature of the DSM. A 1987 revision to the DSM–III, called the DSM–III–R, clarified some of these criteria and also addressed inconsistencies in the diagnostic system. A comprehensive review of the scientific literature strengthened the empirical basis of the next edition, the DSM–IV, which was published in 1994. The DSM–IV–TR, a revision published in 2000, provided additional information on diagnosis. Since 1952, each subsequent edition of the DSM aimed to improve clinicians' ability to understand and diagnose a wide range of conditions."*
> http://pubs.niaaa.nih.gov/publications/dsmfactsheet/dsmfact.pdf

In 2013, the APA released its newest edition, the DSM-5. The volume includes mostly modest alterations of several diagnostic categories, from autism spectrum disorders to mood disorders, however, other modifications were met with considerable controversy based on a lack of consensus in the mental health field about the volume's validity. The director of the National Institute for Mental Health in 2013 published the following:

> *"The goal of this new manual, as with all previous editions, is to provide a common language for describing psychopathology. While DSM has been described as a "Bible" for the field, it is, at best, a dictionary, creating a set of labels and defining each. The strength of each of the editions of DSM has been "reliability" – each edition has ensured that clinicians use the same terms in the same ways. The weakness is its lack of validity. Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical*

> *symptoms, not any objective laboratory measure. In the rest of medicine, this would be equivalent to creating diagnostic systems based on the nature of chest pain or the quality of fever. Indeed, symptom-based diagnosis, once common in other areas of medicine, has been largely replaced in the past half century as we have understood that symptoms alone rarely indicate the best choice of treatment." –Thomas Insel on April 29, 2013*
> *https://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml*

I would add to this that, especially in the area of personality disorders, there is so much overlap of symptoms, as well as patients exhibiting symptoms of several different personality disorders while not necessarily meeting full criteria for any single personality disorder, that diagnosis can remain elusive at best sometimes. Further, in the age of pressure to use diagnosis-specific Evidence Based Treatment, the ambiguity around diagnosing personality disorders results, too, in uncertainty for clinicians as well as clients about best treatment strategies.

My personal belief is that good therapy, and good therapists, rely upon the DSM as a guideline (and as a mechanism by which to communicate with other mental health professionals in short-hand generalities as well as to bill insurance companies), but never as a bible.