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DSM-III: Guiding Principles

ROBERT L. SPITZER, M.D., MICHAEL SHEEHY, M.D., and JEAN ENDICOTT, PH.D.

In September, 1973 a new Task Force on Nomenclature and Statistics of the American Psychiatric Association was constituted to develop the Third Edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-III). This conference is an opportune time to discuss the principles that have guided the Task Force. Many of these principles are clear to us now only as we step back and review the logic implicit in the countless decisions that we have made. As these principles become more explicit, they can guide subsequent work and provide standards for review of what already has been accomplished.

The Task Force's goal has been to develop a classification system that would reflect our current state of knowledge regarding mental disorders, and only secondarily to insure its compatibility with the chapter on Mental Disorders of the International Classification of Diseases. The original timetable scheduled publication of DSM-III in January, 1979 to coincide with introduction throughout this country of a clinical modification of the Ninth Edition of the International Classification of Diseases (ICD-9-CM). More recently, there has been a discussion as to the wisdom of extending field trials of DSM-II beyond that time in order to refine the system on the basis of extensive clinical use prior to its official adoption by the American Psychiatric Association.
Psychiatric Diagnosis

This work is not the product of a small isolated committee. Although the Task Force itself now numbers 12 individuals, work on DSM-III has involved 10 advisory committees for portions of the nomenclature* and well over 100 individuals with special expertise in different areas of psychiatric diagnosis. Although many contributors are primarily academic or research psychiatrists or psychologists, there is ample representation of psychiatrists with predominantly clinical activities. As the work has progressed, it has been presented at several local and national professional meetings. A special conference was held in St. Louis, Missouri in June of 1976 to examine DSM-III in midstream. This conference, co-sponsored by the American Psychiatric Association and the Missouri Institute of Psychiatry, was attended by approximately 100 individuals who had expertise or special interest in various aspects of the classification. Several national mental health associations sent representatives, as well. Sessions at this conference were devoted to discussion of work to date on the major subdivisions of the classification. As a result of these discussions, additional diagnostic categories were added, some were deleted, and a decision was made to proceed with the development of multiaxial diagnosis. A number of new individuals became actively involved in the work of the Task Force, extending its efforts to areas such as Adolescent and Reactive Disorders. Formal liaison committees are now being set up with a large number of professional organizations representing psychiatry, psychoanalysis, medicine, neurology, pediatrics, psychology and social work, all of which have an interest in the development of DSM-III.

Multipurpose Classification

From the outset, the Task Force has assumed that in medicine an effective classification has many purposes. It is first a means by which the profession communicates briefly and clearly within itself about clinically recognizable conditions for which it has professional responsibility for diagnosis, care or research. Secondly, when possible, the classification should be a useful guide to current differentiated treatments. A third purpose is to provide information about the likely outcome of the psychiatric disorders with and without treatment. Finally, the classification should reflect what is known about the etiology or pathophysiological

* Organic Brain Disorders, Drug Use Disorders, Schizophrenia and Affective Disorders, Anxiety Disorders, Somatoform Disorders, Personality Disorders, Sexual Disorders, Psychosomatic Disorders, Child and Adolescent Disorders, Reactive Disorders.