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The history of nosology and the rise of the Diagnostic and Statistical Manual of Mental Disorders

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The current Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 arose from a tradition filled with haphazard science and politically driven choices. The nosology of modern psychiatry began with the German classifiers of the late 19th century, especially Emil Kraepelin. Psychoanalysis then blotted out the classificatory vision for the next half-century, and most of this European psychopathological science failed to cross the Atlantic. The DSM series was a homegrown American product, beginning with Medical 203 in 1945, then guided by psychoanalytic insights through DSM-I in 1952 and DSM-II in 1968. In 1980, DSM-III represented a massive “turning of the page” in nosology, and it had the effect of steering psychoanalysis toward the exit in psychiatry and the beginning of a reconciliation of psychiatry with the rest of medicine. With the advent of DSM-5, however, questions are starting to be asked about whether this massive venture is on the right track.

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Introduction

“**T**he wit of man has rarely been more exercised than in the attempt to classify the morbid mental phenomena covered by the term insanity. The result has been disappointing.”¹ (Daniel Hack Tuke, lecturer in psychological medicine at the Charing Cross Hospital Medical School in the late 1800s.)

It would be easy to think that the *Diagnostic and Statistical Manual of Mental Disorders (DSM)-5* evolved as a logical and scientific progression from *DSM-IV*. In fact, it evolved in a haphazard and politically driven manner from a century and a half of effort to get the classification of psychiatric illness right. In addition, the disappointing outcome of this entire endeavor is that, today, the field’s nosology seems even farther from “cutting nature at the joints,”—discerning the true illness entities locked in the brain—than in the days of Emil Kraepelin around 1900.

A rich European tradition

The classification of psychiatric illness began with the Ancients and accelerated forward with the European nosologists of the 19th century. There were two rival systems of classification, the symptom-based or “symptomatomological,” and the causation-based or “somatoeti-

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ological.” The latter, of course, is preferable, as nosology in the rest of medicine, is based on causation, and a number of different diseases may share some of the same symptoms. Yet, over the years, causation-based classifications have had a poor track record in psychiatry because the causes of most disorders are unknown, and when they become known, as with avitaminoses or neurosyphilis, they are abducted from psychiatry and vanish into the diagnosis warehouse of other medical specialties.

The great European nosological tradition was, therefore, primarily symptom-based. The French dominated the field in the first half of the 19th century. Well known to specialists in the history of psychiatry are such names as Philippe Pinel, who, in 1809,² ventured the first modern classification, or Etienne Esquirol,³ who, from 1816, differentiated delusional disorders (“monomania”) from the mix. The somatoetiological systems, by contrast, have rarely survived their originators, and in retrospect, often appear ludicrously misguided: Edinburgh psychiatrist David Skae, for example, based his nosology largely on disorders he attributed to the organs of reproduction.⁴

However, in the European tradition, diagnosis was important (even though most psychiatric illnesses were entirely untreatable except through milieu therapies emphasizing diet, rest, exercise, and prolonged applications of spa water).⁵ One asylum in Venice required patients to wear different colors, depending on their diagnosis: those with mania wore red; melancholy, green; delusional disorder, deep blue; etc.⁶

After the mid-19th century, the classification of psychiatric illnesses belonged to the Germans, and by the 1920s, German was the international language of psychiatry. The German primacy was initiated with the publication of the second edition of Berlin psychiatrist Wilhelm Griesinger’s textbook in 1861⁷ (the principal means of conveying new ideas in psychiatry, in those days, was in textbooks rather than articles). Griesinger argued that the brain represented the basis of psychiatric illness, and thus initiated a long tradition of biological thinking in psychiatry.

This German tradition gave rise to three diagnoses of special interest:

- *Melancholia* was not, of course, the specific creation of the Germans, and went back to the Ancients; yet, this sturdy diagnostic term had persisted over the ages because it corresponded to the profound sadness, an-

hedonia, and psychomotor change (stupor or anxious agitation) that ran like a red thread through the history of psychiatric illness.⁸ The specific German contribution in the 19th century was the 1867 distinction by Richard von Krafft-Ebing, then a staff psychiatrist at the Illenau Asylum, between “simple depression” and “psychotic melancholia” as two different illnesses⁹ (a distinction lost in the *DSM*).

- *Catatonia* was a term coined in 1874 by German psychiatrist Karl Kahlbaum as a collective term for a variety of movement disorders, including the historic “catalepsy” (waxy flexibility).¹⁰
- *Hebephrenia* was named in 1871 by Kahlbaum’s associate Ewald Hecker for psychosis of adolescent origin, which involves avolitional syndromes plus blunting of affect.¹¹

The individual fates of these important diagnoses cannot be followed here. However, they constitute fundamental nosological building blocks.

Kraepelin

The German whose figure towers over us, even today, in the *DSM* series is Kraepelin, professor of psychiatry before World War I: first in Heidelberg, then in Munich. A series of editions of Kraepelin’s textbooks, which started to attract world attention with the fourth edition in 1893 and concluded with the great eighth edition, published in its five volumes between 1909 and 1915, grew to be anticipated with the same rapt attention that awaits new editions of the *DSM* today.¹²

The genius of Kraepelin’s classification was not that it was biological, but clinical. He used biological concepts, such as “endocrinological,” to organize his classification. However, the main disease entities in the Kraepelinian system—manic-depressive insanity and dementia praecox (later “schizophrenia”)—were not included for biological, or pseudobiological, reasons. Rather, it was because Kraepelin had studied the patients in detail and believed that he had discerned two starkly different courses and outcomes. Manic-depressive insanity was a fluctuating illness that did not necessarily deteriorate into “dementia.” Dementia praecox, by contrast, had its onset in adolescence and within a short period of time progressed to dementia and institutionalization. There was a firewall between them. He saw no possibility of one turning into the other; and even though the two great diseases might share some

symptoms, it was based on this course that he believed them to differ.

It should be noted that Kraepelin's manic-depressive insanity included all mood disorders, of any polarity, thus all manias and serious depressions (he made "psychogenic depression" a separate illness, not part of manic-depressive insanity). Kraepelin's manic-depressive was not the predecessor of the DSM's "bipolar disorder." Kraepelin also abolished the solid historic term "melancholia" and substituted for it "depression."

Kraepelin's magnum opus is notable for several other reasons. He had no use for "anxiety" as a separate diagnosis, and the term does not appear as an independent disease entity, even though he said anxiety accompanied other disorders as an omnipresent symptom. He ratified, though he did not initiate, the separation of the paranoid thinking of schizophrenia, with its plastic and ever-changing forms, from the fixed delusional systems of "paranoia" as an independent and nondeteriorating disorder.

With Kraepelin's textbook as its major war engine, German psychiatry went on to capture the world of classification. The English, never big systematizers in the first place, fell virtually silent on the "new diseases" front. English neurologist Clifford Allbutt quipped that the Germans operated by proposing "complex hypotheses" that they then tested; the English, in contrast, contented themselves with "groping in the dark" in the hopes of hitting a lucky find, "which no ingenuity could have anticipated."¹³ The idiosyncratic French system, with its opaque diagnoses, might have had a good deal to recommend it (for example, "systematic progressive psychosis" as distinct from schizophrenia¹⁴), but never made much impact abroad.

Yet, even after Kraepelin's death in 1926, by no means did this great European tradition come to an end. Careful psychopathological observation was its hallmark, and the academic psychiatrists made a great virtue of fine differentiation. To take one example of post-Kraepelinian contributions in German-language psychiatry; in 1941, Manfred Bleuler, about to assume the psychiatry chair in Zurich, described several different courses in schizophrenia: one group of "wavelike" courses would begin acutely, then occur in repeated illness episodes with no severe defect apparent in the intervals; a second typical course, which Bleuler called "simple," might begin either insidiously or acutely, but resulted in a rapid disintegration of the personality

("schizophrenic catastrophe") or chronic "defect."¹⁵ This concept of two schizophrenias, like other Central European thinking based on close inquiry into psychopathology, never crossed the Atlantic.

A distinctively American tradition begins

There is a certain misunderstanding in the literature about the nature of European influences on American psychiatry,¹⁶ one that overlooks the radical discontinuity that occurred between the 1920s, when European influences were strong, and the 1950s, when, aside from Sigmund Freud's psychoanalysis, they had virtually vanished. However, the drafters of *DSM-III*, in 1980, despised psychoanalysis, were unilingual and uncultural to the core, and had little insight into distant European influences, except for those of Kraepelin, whom they understood only dimly at best.

With the later editions of *DSM*, it was time for American exceptionalism. This is how it began. In 1913, the American Psychiatric Association (APA) set up a standing committee on "statistics." Four years later, in 1917, that committee took responsibility for shepherding the new nosology that the APA had just adopted; it was a disease classification suitable for hospitals, but in fact, covered the entire range of psychiatric phenomena. From 1918 on, the APA committee cooperated with the National Committee for Mental Hygiene in organizing state mental hospital statistics based on the APA's classification.¹⁷ By 1936, this classification was in its seventh edition.¹⁸ The classification preserved some European traditions, such as the several depressions. It distinguished between Kraepelin's "manic-depressive psychosis" versus involuntional psychosis, which Kraepelin had, until the final editions of his work, seen as a separate disease of midlife. "Reactive depression" figured in the APA mix as well, not as a mood disorder, but as a psychoneurosis. The large section on psychoneuroses came, of course, from the psychoanalysts; the rest owed much to the Old World.

To add to the confusion, in 1933, another classification came into play, the *Standard Classified Nomenclature of Disease* of the National Conference on Medical Nomenclature, the brief psychiatric portion of which was called "Diseases of the Psychobiological Unit."¹⁹ It was merely a listing of diagnoses and would have been entirely unhelpful to anyone wishing to apply them.

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Outside the state mental hospitals, neither the joint APA-Mental Hygiene document nor the “Diseases of the Psychobiological Unit” had much impact. These publications were not germinal in the making of *DSM*.

Medical 203

The immediate origins of *DSM* lay not in the statistical classification for the mental hospitals, but in a nosology directed by psychoanalyst William Menninger, who, during World War II, was a brigadier-general and the head of psychiatry in the Office of the Surgeon General. The military nosology appeared in October 1945 as the Technical Medical Bulletin number 203 of the United States Army, and it was thereafter referred to as *Medical 203*. The bulletin breathed the spirit of psychoanalysis, describing “psychoneurotic disorders” as “resulting from the exclusion from the consciousness (ie, repression) of powerful emotional charges, usually attached to certain infantile and childhood developmental experiences.” Drawing on Johns Hopkins psychiatrist Adolf Meyer, as well as on Freud, the disorders were referred to as “reactions.” Of “dissociative reaction” it was said, “in acute cases, the personality (ego) disorganization appears to permit the anxiety to overwhelm, and momentarily govern the total individual. The repressed impulse, giving rise to the anxiety, may be either discharged or deflected into various symptomatic expressions such as fugue, amnesia, etc.”²⁰ This document became the basis of psychiatric classification in postwar America.

US psychiatry goes it alone

As stated, with the exception of the Kraepelinian psychotectonics, most of the Central European writing on nosology never came to American attention. It essentially became forgotten. Why is this?

For one thing, the events of World War II and the Holocaust tended to discredit German as the international language of science. In some quarters, the very sound of the German language was heard with dismay. The world’s scientific center of gravity was shifting from Berlin, Munich, and Vienna to New York and quite particularly to Bethesda, Maryland, where a generous Congress was investing huge amounts of federal money in research at the National Institutes of Health (NIH), one of which was the National Institute of Mental Health (sometimes independent of the NIH, sometimes not).

Ugo Cerletti, by now an emeritus professor of psychiatry in Rome and the originator of electroconvulsive therapy, told an English-speaking audience in the mid-1950s (reading laboriously from a manuscript text heavy with diction directions):

“Sixty years ago, when I began to work in psychiatry, the languages that in Europe seemed indispensable were two – German and French. And therefore it was necessary for me to learn them well. In these sixty years, scientific research in English-speaking countries has taken so formidable a jump forward, that English has become the international language, and I am reduced to presenting myself to you, not speaking English, but rather to clumsily reading to you. Excuse me.”

(Cerletti papers, Kansas State Historical Society, Topeka, KS).

During these years, Freud’s psychoanalysis, which had no use for hoary German diagnostic traditions, vaulted to the fore. Psychoneurosis was the main diagnosis in psychoanalysis, its fundament anxiety. In the index of Freud’s collected papers, the entries referencing Freud’s articles on “anxiety” (angst) go on for a full 11 pages.²¹ Small wonder that in postwar America, with its infatuation with psychoanalysis, anxiety suddenly became the disease *du jour*, trumping “nerves,” “catatonia,” and those other now-forgotten German diagnoses. Catatonia became a subtype of schizophrenia; this was, admittedly, something Kraepelin had initiated, yet much German psychiatric opinion opposed the downgrading of this important diagnosis to a subtype of something else.

Under the influence of psychoanalysis, US psychiatry began to lose interest in the systematic study of psychopathology that had distinguished the German school. Baltimore psychiatrist Wendell Muncie, after several years of training in German psychiatric hospitals, said, in 1935, that the difference between American and German psychiatry lay “in the German dominance of the concept of disease entity, in which ‘mental illness’ was practically synonymous with ‘brain illness’.”²² In the US, by contrast, the rather vague ideas of Meyer, who was dedicated to psychoanalysis, prevailed. In Meyer’s thought, patients had to be understood in their own terms, a notion that, however laudable in its humanitarian objectives, ruled out the quantitative scientific method.

The psychoanalytic period began to be rung out with the introduction of effective new pharmaceutical agents. At a 1959 conference, the year the tricyclic anti-

depressant imipramine was launched in America, Hans Hoff, professor of psychiatry in Vienna, told a conference at McGill University that he and “Paul Schilder (a Viennese colleague, then at Johns Hopkins University) had once tried to destroy the Kraepelinian nomenclature because of the feeling that psychodynamics and personal reactions were more important.” However, now that a treatment for depression was available, “Diagnosis is essential,” said Hoff.²³

Is it, therefore, any wonder that the American disease-designers, as they sat down to compose their own nosology, were largely cut off from the rich continental traditions of learning?

DSM-I: 1952

In 1948, unhappy about the confusing diagnostic systems currently in play, the APA asked its Committee on Statistics to take in hand the preparation of an official nosology that would preclude all others. George Raines, head of neuropsychiatry at the Navy Department Bureau of Medicine—later director of psychiatry at the Georgetown University Medical Center—was evidently seconded to assist in the effort. In 1952, what subsequently became known as “*DSM-I*” was published.²⁴ Despite Raines’ insistence in the preface on wide streams of input, it was pretty much a rehash of *Medical 203*. The wording of the sections on “anxiety reaction” and “depressive reaction” (in *DSM-I*, the latter became termed “neurotic depressive reaction”) was virtually identical. What accounted for this widespread duplication is unclear because only one of the seven members of the statistics committee—Moses Frohlich—was an analyst, and Raines’ own interests were on the neurological side of things. In any event, such was the prestige of psychoanalysis at this point that there could not have been too much caviling about the contents of the “psychoneurosis” section.

By 1962, *DSM-I* had gone through fifteen printings. Increasingly unmoored from psychoanalysis and its main diagnosis of psychoneurosis, psychiatry was clearly in need of diagnostic guidance.

DSM-II: 1968

The second edition, in 1968, led by Ernest Gruenberg, was justified on the grounds that American diagnosis should be brought into line with the forthcoming eighth

edition of the World Health Organization’s *International Classification of Diseases*.²⁵ Only some of the committee members were analysts, and Gruenberg himself was not. Nevertheless, *DSM-II* abandoned the Meyerian “reactions” in favor of the psychoanalytic “neuroses.” The other changes were not of great interest.

The architecture of *DSM-II* was quite similar to *DSM-I* in terms of the main diagnoses of the field: (i) a schizophrenia section with numerous subtypes; (ii) a mood disorders section featuring manic-depressive illness, which meant serious depression of any polarity and mania, plus other depressive states (psychotic, melancholic, involuntal, etc, which varied between the editions); (iii) a Freudian section on what were called “psychoneurotic disorders” in *DSM-I* and “neuroses” in *DSM-II*. Kraepelin’s paranoia recurred in both, meaning a fixed delusional system in patients who did not deteriorate; and (iv) there was, finally, a substantial section on “personality disorders.” As stated, depressions were not classified based on polarity, and there was no bipolar disorder alongside unipolar depression.

By the late 1960s, the great swing from psychoanalysis to biology was in full course. The success of the new psychopharmacology had demonstrated that the brain was involved in illness after all and that biological perspectives were the field’s future. Donald Klein at Columbia University and John Davis, then at NIMH, sounded the tocsin for the new era when, in 1969, they wrote “we believe that there is a variety of discrete etiologies causing specific diseases among some psychiatric patients. We will attempt [in this book] to utilize categorizations that have an explicit validity. That is, class membership will convey information beyond the gross symptomatology of the patient. Diagnosis will have specified prognostic and treatment response correlates.”²⁶ Terms such as “specific diseases” and “validity” were new for American psychiatry, and were the wave of the future.

Two events, one expected and the other unexpected, brought *DSM-II* to an end. The expected event was a looming new edition of the *International Classification of Diseases*, agreed upon by the World Health Organization in 1975²⁷; an American edition followed in 1978.²⁸

The unexpected event was the outcome of the US-UK Diagnostic Project, organized by the Biometrics Unit of the New York State Department of Mental Hygiene and the Institute of Psychiatry in London. Audiences of psychiatrists in the eastern US and several

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parts of the United Kingdom were shown videotapes of diagnostic interviews with three American and five English patients, and asked to make diagnoses. The results indicated, “that the American concept of schizophrenia is much broader than the British concept, embracing not only part of what would be regarded as depressive illness but also... manic illness, neurotic illness, and personality disorder.” The authors of the report expressed alarm about the prospects of diagnostic communication between US and British psychiatrists.²⁹ The report of these results, in 1971, really put the cat among the pigeons: clearly, US psychiatrists, under the influence of psychoanalysis, were diagnosing everything that could not be considered psychoneurosis as “schizophrenia.” It was time to tighten up American diagnostics.

DSM-III: 1980

In 1973, the APA decided to commission a new edition of the *DSM* series. A few minor tucks were really what they had in mind. They asked Robert Spitzer, a biometrician at Columbia University, to direct the task force. Spitzer had played a leadership role in *DSM-II* and was the obvious candidate for the job (this story has been told in detail elsewhere and I shall not repeat it again here³⁰). Appointing Spitzer was, from the viewpoint of the APA, a huge mistake, because Spitzer took as his remit the construction of an entirely new nosology. The essential change in *DSM-III*³¹ was to replace the idiosyncratic diagnoses of psychoanalysis, such as “psychoneurosis,” with diagnoses that were consensus-based. The idea of founding a nosological system on consensus rather than on clinical experience, as in the Kraepelinian system, was rather startling.

The path to *DSM-III*, in 1980, led via St Louis, Missouri, where a nosologically inclined department of psychiatry, led by Eli Robins and Samuel Guze, had been toying for some years with the concept of operational criteria, or diagnostic criteria, in nosology. Guze recalled an encounter with William Menninger’s brother Karl at an APA meeting in the 1950s or 1960s. Menninger had been talking about a “descriptive paragraph” noting the main features of the case as the best way of doing nosology. Guze said, “I raised my hand and I said ‘Dr Menninger, you know those of us who are interested in the importance of diagnosis want a label that could substitute for just that paragraph. What we want that

paragraph to include are the key items that research will have shown important for classifying that person.’” Menninger just smiled and moved onto the next question, said Guze.³²

Led by resident John Feighner, and then joined by the staff, in 1972, the St Louis group proposed specific criteria required for a diagnosis. For depression, the patient would need to have a “dysphoric” mood plus five out of eight other criteria on a list. The diagnostic criteria soon became known as the “Feighner criteria” and the article, helmed by a resident, qualifies as one of the most important contributions in modern psychiatry.³³ The concept of diagnostic criteria became the backbone of *DSM-III*.

On a parallel track, Spitzer at Columbia University had been collaborating with Guze and Robins in working out some early ideas about diagnosis. In 1974, Spitzer had become head of the task force that was to design the *DSM-III* precursor, called “Research Diagnostic Criteria” (RDC), and in 1975 their first effort at a redesign reached fruition.³⁴ Three years later, in 1978, Spitzer guided the final version of the RDC into print,³⁵ and theoretically, that should have served as the spinal column for *DSM-III*. However, in reality, Spitzer had to make so many political compromises in getting *DSM-III* through the APA that RDC was not really a template at all.

Thus, *DSM-III* saw the light of day in 1980. What did it do?

The impact of *DSM-III*

Even though various authorities called *DSM-III* “Kraepelinian,” it deviated in many ways from Kraepelin’s concepts. However, one of the few features of Kraepelin’s nosology that *DSM-III* imported into American psychiatry was the firewall between “schizophrenia” and mood disorders. *DSM-III* innovated mightily in distinguishing depressive disorders by polarity, introducing a “bipolar disorder” separate from “major depression.” This separation went back to the Frankfurt psychiatry school that flourished between the wars led by Karl Kleist and his student Karl Leonhard. In 1948, Leonhard introduced the term “bipolarity,” as distinct from unipolarity, and therewith “bipolar disorder” was born.³⁶ Then, in his 1957 work, *Aufteilung der Endogenen Psychosen* (The Classification of the Endogenous Psychoses), Leonhard laid out the psychopathological

difference between the depression of unipolar disorder and the depression of bipolar disorder.³⁷

Virtually none of the other features of Leonhard's nosology was taken up internationally, but bipolar disorder was enough! The term went on to become among the most popular diagnoses in psychiatry, as well as the foundation of pharmaceutical fortunes selling "mood stabilizers." As noted, this was not Kraepelin's manic-depressive insanity. I have traced elsewhere the pathway that led from Leonhard's Frankfurt (via Erfurt in East Germany and East-Berlin) to the drafting of *DSM-III* in New York.³⁰ However, it was with Leonhard's students in the West, such as Frank Fish in Liverpool, George Winokur in St Louis, and Heinz Beckmann in Würzburg, that this otherwise rather obscure East German psychiatrist was to have such a huge impact. European nosologies had made "circular psychosis" a separate disorder since the 1850s, but it was separate based on severity, not psychopathology.

DSM-III introduced numerous other new diagnoses, such as attention deficit disorder, post-traumatic stress disorder, and a host of new anxiety disorders (sundering the traditional psychoanalytic "angst" into fragments). It is not the place of this review to comment on the validity of these innovations. One does have to cut Spitzer and the members of his task force some slack, considering that they were working with a nosological tabula rasa. Psychoanalysis had carved a sharp discontinuity into the historical flow of diagnoses, and the task force members do not even seem to have been aware, at least based on their correspondence preserved in the archives of the APA, that previous efforts existed before psychoanalysis swept the board. Therefore, they essentially had to make it up as they went along, and there was a lot of value in their work, aside from their merging of psychiatry's traditional two depressions (melancholia and nonmelancholia) into one "major depression." "Schizophrenic disorder" became, in their hands, a single entity, divided into the traditional Kraepelinian subtypes of paranoid, catatonic, and hebephrenic.

The main innovation in *DSM-III* was not in the architectonics of the diagnoses, but in the Feighner "diagnostic criteria," the list of symptoms a patient would require into order to "get into" the diagnosis, as the expression went. Since *DSM-III*, there has been much debate about exactly what criteria should go with each disease. That there should be any criteria, aside from

the psychiatrist's own possibly idiosyncratic views, was a major change.

DSM-III had a revolutionary importance in psychiatry for two reasons. One, it began the end of psychoanalysis as the intellectual core of the field. Spitzer had to continually repel efforts by the analysts to insert psychoanalytic concepts in the draft version, and the long list of specific diseases that emerged in the volume, together with diagnostic criteria for each, ran totally contrary to the diagnostic "impressions" of the analysts. What psychopharmacology had begun, *DSM-III* finished off; the analysts were shown the exit sign from the field, or at least from its commanding heights.

Secondly, *DSM-III* began a rapprochement between psychiatry and the rest of medicine. Having a nosology composed of specific diseases with diagnostic criteria for each dates, in medicine, back to the days of Edinburgh's William Cullen in the late 18th century and has always been the standard of the field: diagnoses that are clinically well defined, verified with physical findings and laboratory data, and validated with specific responses to treatment. This is the "medical model," and Robins and Guze proposed it for psychiatry in 1970.³⁸ Arguments continue about the medical model vs the "biopsychosocial model," yet psychiatrists today value, more than ever, the medical training that permits them to situate psychiatric symptoms and responses to treatment in the context of the brain and the whole body.

Subsequent editions of the DSM

DSM-III-R, meaning revised edition, followed, in 1984, on the heels of *DSM-III*; *DSM-IV* was published in 1994 and *DSM-5*, the latest, in 2013. Although each edition trimmed at the edges of its predecessor, there were no fundamental changes in the architectonics of the diagnoses or the content of the operational criteria. There was nothing comparable to the magnitude of Kraepelin's accomplishment, or to *Medical 203* as a "turning of the page." This is not to say that subsequent volumes did not have their own distinctive impacts, as diagnoses bubbled to the surface that few had previously considered and that now went on to become virtually epidemic.³⁹ Bipolar disorder type II, meaning major depression plus hypomania,⁴⁰ produced a virtual diagnostic frenzy in the world of pediatric psychiatry, leading an embarrassed APA to attempt to dial it back in *DSM-5* with "disruptive mood regulation disorder."⁴¹

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The ever greater size of the volumes—*DSM-IV* had 886 pages, *DSM-5* had 945—began to create the impression of a diagnostic sausage machine that was somehow cranking out of control. Paul Chodoff, speaking from the perspective of 60 years of practice, said in 2005:

As new diagnoses proliferate in each successive *DSM*... I feel concern about a burgeoning furor diagnosticus—offering a name and number for every untoward feeling or behavior in a way that trivializes the human condition by denying its inescapable, somber, and even tragic elements.⁴²

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La historia de la nosología y la aparición del Manual Diagnóstico y Estadístico de los Trastornos Mentales.

El actual DSM-5 (Manual Diagnóstico y Estadístico) surgió de una tradición llena de ciencia casual y opciones impulsadas políticamente. La nosología de la moderna psiquiatría comenzó con los clasificadores alemanes de finales del siglo XIX, en especial Emil Kraepelin. Posteriormente el psicoanálisis empañó la visión clasificatoria por el siguiente medio siglo, y la mayor parte de esta ciencia psicopatológica europea no logró cruzar el Atlántico. La serie de los DSM es un producto americano hecho en casa, que comenzó con Medical 203 en 1945, y luego fue orientado por concepciones psicoanalíticas a través del DSM-I en 1952 y el DSM-II en 1968. En 1980 el DSM-III representó una masiva "vuelta de página" en la nosología, encauzó el psicoanálisis hacia la salida de la psiquiatría y comenzó con la reconciliación de la psiquiatría con el resto de la medicina. Sin embargo; con la aparición del DSM-5 están surgiendo preguntas para ser respondidas acerca de si esta gran iniciativa está por el camino correcto.

L'histoire de la nosologie et essor des Manuels diagnostiques et statistiques des troubles mentaux (DSM)

L'actuel DSM-5 (Manuel diagnostique et statistique) provient d'une tradition nourrie de science peu méthodique et de choix politiques. La nosologie de la psychiatrie moderne a commencé avec les classificateurs allemands du XIXe siècle, en particulier Émile Kraepelin. Pendant la première moitié du siècle suivant, la psychanalyse a ensuite effacé la vision classificatrice et la plupart de cette science psychopathologique européenne n'a pas réussi à traverser l'Atlantique. La série des DSM est un produit américain autochtone, commençant avec le Medical 203 en 1945, puis guidée par des points de vue psychanalytiques du DSM-I en 1952 au DSM-II en 1968. En 1980, le DSM-III a permis de « tourner la page » complètement en nosologie, en ayant pour effet de guider la psychanalyse vers la sortie en psychiatrie et de débiter une réconciliation entre la psychiatrie et le reste de la médecine. Cependant, l'avènement du DSM-5 remet en question la pertinence de la voie de cette gigantesque entreprise.