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Diagnostic and Statistical Manual of Mental Disorders (DSM)

Abstract:
The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a classification of mental disorders published by the American Psychiatric Association (APA). This entry discusses the current uses of the DSM, its history, the processes by which the DSM is developed and revised, the conceptual structure of the classification, and common criticisms.

1. The DSM as it is used today

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a classification of mental disorders published by the American Psychiatric Association (APA). The latest edition, DSM-5, was published in 2013. Although published in the United States, the DSM has come to structure mental health research worldwide. Mental health textbooks are organised around DSM diagnoses; information systems, such as the PsycINFO database seek to be consistent with DSM terms; and research is standardly directed at DSM-defined subject populations. In the United States, the DSM takes on an additional significance; mental health care tends to be insurance-funded and insurers routinely require a DSM diagnosis before they will cover the cost of care. Legal systems and bureaucracies also make much use of DSM categories — schools, for example, can be obliged to offer extra support to children with particular diagnoses; criminals may be detained in different facilities dependent on their diagnosis. The classification is regularly revised and is hugely controversial.

The DSM-5 is published as a book of 947 pages. For each disorder, the text provides a set of diagnostic criteria. These specify the symptoms that must be present for the condition to be diagnosed. Some sets of diagnostic criteria are polythetic, i.e. the patient need show only a subset of a list of possible symptoms. Commonly, there is also a duration requirement (e.g. symptoms must have been present for more than six months), and exclusion criteria that rule out the symptoms being caused by some other medical condition. There may also be an age requirement; some diagnoses are restricted to either children or to adults. Many sets of diagnostic criteria also require that the affected individual suffers some sort of harm before the diagnosis can be made. This criterion is designed to differentiate those who are psychologically quirky from those who might need professional help. Each diagnostic category is accompanied by some pages of text, which provide details regarding the typical clinical course, cultural variations, gender differences, associated laboratory findings, and so on.

The DSM is not the only important classification of mental disorders. The World Health Organisation (WHO) publishes the *International Classification of Disorders* (ICD), which includes a chapter of "Mental and Behavioural Disorders". Over recent decades, the APA and the WHO have sought to align the DSM and ICD, with the result that the two are now very similar (First 2009a) [1]. The mental disorders section of the forthcoming ICD-11 is expected to be much the same as the DSM-5.

There has been very little research conducted that examines how the DSM is used in actual practice. As the DSM is a very big book, it seems likely that few mental health professionals read the DSM

cover to cover and that most read only the sets of diagnostic criteria (if that). A recent internet-based survey by Michael First (in preparation) found that most of his sample of US-based mental health clinicians claimed to comply with DSM diagnostic criteria when diagnosing patients [2]. On the other hand, anecdotal evidence suggests that at least some clinicians will make diagnoses even when DSM criteria are not strictly met (Greenberg 2013, 68, 253; Phillips 2010, 70). In their study Williams et al. (2008) found that most of their sample of children who had been given diagnoses of Asperger's did not actually meet DSM-IV diagnostic criteria. It is likely that the diligence with which clinicians use the DSM varies with institutional setting and professional affiliation. While many US-psychiatrists are happily DSM-compliant, Fraser et al. (2009) found that clinical social workers reported that they are obliged to record DSM diagnoses, for example for insurance forms, but are themselves often sceptical of the validity or usefulness of the classification.

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2. History of the DSM series

The first edition of the DSM was published in 1952, but the DSM-I was itself a continuation of an earlier series. The APA (which had previously been called the American Medico-Psychological Association) had been regularly publishing classifications of psychopathology for use in mental hospitals since 1918 (American Medico-Psychological Association 1918). In the late nineteenth and early twentieth centuries, Germany was a principle centre for psychiatric research, and the 1918 *Statistical Manual for the Use of Institutions for the Insane* largely followed the classification of mental disorders developed by Emil Kraepelin (Cooper and Blashfield 2016). When the DSM-I was developed, the 10th edition of the *Statistical Manual for the Use of Hospitals for Mental Diseases* (APA 1942) was in use in most US mental hospitals. Many sections of the DSM-I were revised versions of this classification. The DSM-I was also influenced by classifications designed for use with military personnel during World War II (Office of the Surgeon General, Armed Service Forces 2000 [1946]; Veterans Administration 1947). These military classifications concentrated on conditions that were acute reactions to stress, and, largely as a result of the involvement of the psychoanalyst William C. Menninger, had a psychodynamic orientation (Houts 2000).

Physically, the DSM-I was a slim, ring-bound paperback. It contained short descriptive paragraphs that set out what a typical patient might be like. Clinicians chose the diagnosis on the basis of the description that seemed to best fit their patient. In theoretical orientation, the DSM-I was eclectic; while the descriptions of some disorders drew on psychoanalytic theory, others were based on Kraepelinian thinking (Cooper and Blashfield 2016). The DSM-I circulated widely, and was employed in the collection of mental health statistics, in textbooks, and by some researchers (Cooper and Blashfield 2016). The DSM-II, published in 1968, was similar in size, orientation, and influence.

In the 1960s and 1970s, US psychiatry felt itself under attack. Many disputes involved classification. In keeping with psychiatric tradition, the DSM-II included a diagnosis for homosexuality. In the late 1960s and 1970s this drew increasing protests from gay activists who demanded that homosexuality should be removed from the classification (Bayer 1981). After heated debates, in 1973, members of the American Psychiatric Association were allowed to vote on the issue, and homosexuality per se was removed from the classification. During this period the antipsychiatry movement was also in full swing. The antipsychiatrists were a loosely-associated group of thinkers who argued on diverse grounds that psychiatry is an illegitimate activity. Some of their concerns revolved around questions

of reliability; accusations were made that psychiatrists could not reliably distinguish people with mental disorders from those without (Rosenhan 1973). Concerns about the reliability of diagnosis were also widespread in mainstream psychiatric journals in this period. In particular, the results of the Cross-National Project for the Study of the Diagnosis of Mental Disorders in the United States and the United Kingdom, which indicated that UK and US psychiatrists had been diagnosing "schizophrenia" very differently, caused widespread professional alarm (Kendell et al. 1971).

The DSM-III, published in 1980, differed from its predecessors in many respects. When the DSM-III was under development, psychoanalysis remained an important school of thought in US psychiatry, but psychoanalysts had little interest in classification in the DSM-style (Decker 2013, ch. 11). The DSM-III thus came to be shaped mainly by researchers who adhered to a more biologically-oriented outlook. Robert Spitzer, who had worked for decades constructing diagnostic criteria for use in research, was appointed chair of the committee to develop the DSM-III. Spitzer decided that the DSM-III should adopt an atheoretical, "descriptive" approach to classification; disorders were to be described in a way that assumed no particular theory about their etiology. The introduction to the DSM-III says that the aim was to produce a classification that would be acceptable to clinicians of all theoretical orientations (APA 1980, 7). In practice, the "descriptive" approach proved more acceptable to biologically-oriented psychiatrists (as psychoanalysts tend to consider the surface symptomatic presentation of a disorder a poor indication of its "true" nature).

In an effort to address concerns about the reliability of psychiatric diagnosis, diagnostic criteria in the "check-list" style were introduced for the first time. The DSM-III contained lists of symptoms and specified exactly how many (say, five from nine) a patient needed for diagnosis. Spitzer and his colleagues had worked on developing diagnostic criteria for the use of researchers in mental health for many years and some of the DSM-III criteria were based on the Research Diagnostic Criteria (RDC) that has been published a few years earlier (Spitzer, Endicott and Robins 1975). However, the RDC included sets of diagnostic criteria for relatively few conditions. The DSM-III took a far more inclusive approach and sought to include diagnostic criteria for fairly much all the putative mental disorders on which research was being conducted. In the cases of conditions where relatively little work had been done, criteria were constructed via expert consensus, with Spitzer and his committees deciding whether, say, four or five symptoms should be required for diagnosis (APA 1980, 8; Decker 2013). When the DSM-III was produced the thought was that the sets of diagnostic criteria that it contained were required so that researchers could with some reliability pick out similar groups of patients for study. It was envisioned that as research progressed the DSM-III categories would be refined and improved (APA 1980, 8). Arguably this thinking turned out to be naïve. DSM categories have come to be widely used, and revising categories causes widespread disruption. As a consequence, in many cases DSM-III categories have proved remarkably resistant to revision (Cooper 2015a).

With the publication of DSM-III, the classification became a large and expensive book. It also became a best-seller. US mental health care had come to depend on insurance and the use of DSM-codes in the financial systems became routine. As such not only psychiatrists, but other US mental health professionals (psychologists, social workers, and counsellors) bought the DSM (Miller et al. 1981). Sales of the DSM-III brought in $9.33 million (Blashfield et al. 2014, 32), and the DSM became an important source of revenue for the APA. Researchers were also enthusiastic users of the

classification, and the use of DSM diagnostic criteria for picking out groups of patients for research quickly became routine (Cooper 2005, ch. 4).

Shortly after the DSM-III had been published, Robert Spitzer and his team started work on a new edition, the DSM-III-R, published in 1987. The DSM-III-R was marketed as a minor revision of the classification, although the changes that were made turned out be quite extensive, and a number of new categories were added.

A new chair, Allen Frances, was appointed for DSM-IV, published in 1994. Overall the DSM-IV was similar to the DSM-III-R, but the DSM-IV development process was distinguished by the greater importance that was attached to documenting the decision processes and rationales for changes. A five volume sourcebook was published alongside the DSM-IV which contained the literature reviews that justified the revisions that were made (APA 1994, xviii-xx). The next edition DSM-IV-TR (APA 2000) was marketed a "text revision", i.e. it was sold on the basis that the diagnostic criteria remained the same but that the descriptive text was revised (although the opportunity was taken to discretely fix a few sets of diagnostic criteria that had contained errors in DSM-IV, such as the criteria for paraphilias).

Work began on the DSM-5 in 2006 (APA 2013, 6). By the early 2000s a consensus had developed that all was not well with the classification of psychopathology. *A Research Agenda for DSM-V* (the Latin numerals were abandoned later) set out the perceived problems, and the ambitions for DSM-5 (Kupfer, First and Regier 2002). When the DSM-III was published it had been hoped that once researchers could reliably pick out syndromes they would make progress in discovering the causes of psychopathology and in developing treatments. By the early 2000s many had become disappointed with the rate of progress. Some suspected that the classification might be the root of the problems; if the DSM was grouping together patients who actually had heterogeneous problems then this might be holding back research. *A Research Agenda for DSM-V* suggested that a "paradigm shift" might be required for DSM-5 (Kupfer, First and Regier 2002, xix). Ultimately no paradigm shift occurred and on publication the DSM-5 proved remarkably similar to the DSM-IV. On publication, the DSM-5 co-chair, David Kupfer, described the new edition as "an aggressive, conservative document"; in his view, the committees were aggressive in their pursuit of revision, but conservative in their decisions in the end (Levine 2013).

3. Processes of development

The APA publishes the DSM and controls the process by which it is revised. Nowadays revising the DSM is a huge and expensive undertaking. Developing the DSM-5 cost about $25 million (Frances 2013, 175). The process of developing DSM-5 was overseen by a Task Force of around 30, chaired by David Kupfer and Darrel Regier. Distinct workgroups, each consisting of around ten experts, worked on the different sections (mood disorders, childhood disorders, sleep disorders, and so on). The workgroups reviewed the evidence that had accumulated since the last edition was published to see where changes might be needed. During the process of DSM-5 development, the workgroups developed proposals for revision which were then widely circulated for comment. Proposals were discussed at professional conferences and in journals. Drafts of proposed new criteria were also posted online and anyone who wanted to comment was able to do so.

When proposing revisions, the workgroups are much interested in the extent to which distinct putative disorders can be "validated". When a disorder is correctly delineated it is supposed that cases will be more or less homogeneous with regard to clinical description, laboratory studies, follow-up, and family history; and that such markers will delineate the condition from other disorders (Robins and Guze 1970). In the DSM-5, for example, hoarding disorder came to be considered a distinct condition from obsessive-compulsive disorder for the first time. Evidence that was considered relevant included that the phenomenology of hoarding differs from that of obsessive-compulsive disorder, that the conditions seem to respond differently to various drug-treatments, and that the progress of the conditions with aging seems to differ (Mataix-Cols et al. 2010).

In addition to reviewing the empirical evidence, the workgroups that revise the DSM are well aware that changes to the criteria can have implications for the well-being of patients and public policy. When the DSM-5 was revised, those proposing changes were required to consider and minimise the extent to which revisions would likely lead to such problems (Kendler et al. 2009).

The APA is also concerned with ensuring that the diagnostic criteria can be reliably used (although concerns about reliability are less prominent than they were in the 1970s and 80s). Some sets of diagnostic criteria were tested in field trials, where clinicians tried using the draft criteria to ensure they could be understood and employed reliably (Regier et al. 2013).

Finally, the APA is a complex organisation, and prior to publication the DSM-5 had to be approved by various APA committees.

4. Conceptual structure of the DSM

4.1 What does the DSM classify?

The introduction to the DSM includes a definition of mental disorder. The definition was revised for the DSM-5 and currently reads as follows:

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (APA 2013, 20).

As discussed in Cooper (2015b) the current definition is conceptually importantly different from that included in the DSM-IV (which required that an individual suffer harm from symptoms before they could be diagnosed with a mental disorder). The revised definition was produced late in the revision process, with little discussion or debate. There is reason to think that the definition of mental disorder included in the DSM plays little real role in determining the contents of the classification.

Generally, the DSM allows one patient to receive multiple diagnoses. For example, one patient might receive diagnoses of Autism Spectrum Disorder, and Generalized Anxiety Disorder, and Cannabis Use

Disorder. Rates of co-morbidity tend to be high (Andrews et al. 2002) as many patients meet multiple sets of diagnostic criteria.

There are some combinations of diagnoses that are explicitly ruled out. Many sets of diagnostic criteria include exclusion rules that state that the diagnosis can only be made if the symptoms are not better explained by some other mental disorder. For example, Dissociative Amnesia can only be diagnosed if "The disturbance is not better explained by dissociative identity disorder, posttraumatic stress disorder, acute stress disorder, somatic symptom disorder, or major or mild neurocognitive disorder" (APA 2013, 298).

4.2 The structure of the DSM

The extent to which the DSM is intended to be a hierarchical classification is somewhat unclear. The classification is divided up into sections — but it is unclear whether the sections are best understood as mere chapter headings, which group together disorders on any basis that will enable them to be easily located, or whether the section headings should be understood as higher-level groupings in a hierarchical classification. The first section, for example, groups together "Neurodevelopmental Disorders" — these are all conditions that are apparent at birth or develop early in childhood — intellectual disability, stuttering, ADHD, and so on. Disorders in this section seem to be grouped on the basis that they have somewhat similar causes and are all seen in young children. The next section groups together, "Schizophrenia Spectrum and Other Psychotic Disorders". Disorders in this section have similar symptomatology, but a range of causes; the section includes both schizophrenia and Substance/Medication-Induced Psychotic Disorder. Conversely, conditions included in the section "Trauma- and Stressor-Related Disorders" are grouped on the basis of etiology. The introduction to DSM-5 notes that the organization of the classification has not normally been thought scientifically significant (APA 2013, 10), but as detailed below some thought was given to the ordering of disorders in the DSM-5.

4.3 Relation to theory

As previously discussed, the DSM-III (1980) set out to be a purely descriptive, atheoretical classification system (except in the case of conditions with accepted causes, such as the organic mental disorders). In the mid to late 1970s, there was much concern with improving the reliability of diagnosis. Providing explicit criteria for diagnosis, using language that was as descriptive as possible, was seen as a way of dealing with the problem of reliability (see, e.g. Kendell 1975). Making the DSM-III atheoretical was also hoped to be a way of making the classification acceptable to clinicians working under a range of different explanatory paradigms (APA 1980, 7).

Following publication of the DSM-III the claim that the classification was atheoretical came in for criticism. Cooper and Michels (1981) pointed out that many of the diagnostic criteria required theory-laden inferences to be made, for example, "identity disturbance", which is a DSM-III symptom of Borderline Personality Disorder. In the DSM-IV, the claim to be atheoretical was dropped. Still, the structure and contents of the classification remained much as they had been in DSM-III.

Initially the DSM-5 sought to be a classification that would reflect theories about aetiology. A subgroup of the DSM-5 Task Force worked on a "metastructure" for the DSM-5 and a special issue of

Psychological Medicine published their proposals. It was suggested that the DSM-5 might be reorganized into a number of clusters reflecting "aetiological risk factors" (Andrews et al. 2009, 1999). The aim was to enable disorders to be grouped together in a way that provided information about their nature. On publication, the proposals were robustly criticised. The proposed groupings were said to lack adequate empirical support, and there were concerns that the proposals departed radically from clinical tradition (First 2009b; Jablensky 2009; Wittchen et al. 2009). The idea of a radical restructuring of the DSM was abandoned. Still there have been some subtle attempts to reorganise the contents of the DSM so that disorders with similar etiologies can be found together (APA 2013, 13). For example, the chapter on "Disruptive, impulse-control and conduct disorders" has been moved to be next to "Substance-related and addictive disorders", so that these "externalising" disorders are together. Antisocial personality disorder now appears both in the personality disorder section and under "Disruptive, impulse-control and conduct disorders". The effect of such changes will be modest, but they do demonstrate that the DSM now seeks to reflect theoretical knowledge.

4.4. The role of values

When the DSM-5 was developed, guidelines on proposals for new diagnoses required a consideration of whether "the harm that arises from the adoption of the proposed diagnosis exceed[s] the benefit that would accrue to affected individuals" (Kendler et al. 2009, 6). Workgroups developing proposals for the DSM-5 sought to show that their proposals would do more good than harm (e.g. Boelen and Prigerson 2012; Huprich 2012; Mataix-Cols et al. 2010; Selby et al. 2012; Woods et al. 2010). Commonly anticipated benefits included the facilitation of appropriate treatment and other needed services, providing a category useful for future research, and improving clinical communication. Potential harms that were considered included stigmatisation and self-stigmatisation, the inappropriate treatment of false-positives, legal and bureaucratic consequences, and the potential medicalization of normality. The DSM-5 was thus self-consciously developed on the basis of both empirical evidence and considerations of values.

5. Criticisms of the DSM

Criticisms of the DSM are many and various. At the most general level, some think that the DSM fundamentally misunderstands the nature of mental distress. Implicitly, the DSM assumes that psychopathology falls into distinct disease entities. Some take issue with the DSM at this level.

5.1. The DSM is insufficiently scientific

Many critics hold that the DSM is insufficiently scientific and does not accurately represent the domain of psychopathology. Such critics come from a range of orientations. For example, some psychoanalytically-oriented critics see the DSM's focus on observable symptoms as a superficial replacement for true diagnosis, which would require careful attention to internal mental conflicts (for example, Blum 2013).

In recent years, the criticism that the DSM is insufficiently scientific has also commonly been voiced by biologically-oriented researchers (Cuthert 2014; Insel 2014). In 2008 the US National Institute of Mental Health launched the Research Domain Criteria project (RDoC). The aim is start psychiatric classification afresh. The RDoC will "define basic dimensions of functioning (such as fear circuitry or working memory) to be studied across multiple units of analysis, from genes to neural circuits to

behaviors, cutting across disorders as traditionally defined" (NIMH no date). The RDoC system relies far more on dimensions and is more biologically-focussed than the DSM.

5.2 Mental distress should not be classified

Some do not think that it is appropriate to seek to classify mental disorders, and by implication, the people who have them. The slogan — "Labels are for jars, not people" — is commonly seen on posters and T-shirts, and was used in demonstrations against the DSM at the APA annual meeting in 2012 (Davies 2012). On certain accounts of mental distress, "symptoms" should not be understood as manifestations of underlying biological psychopathology. Rather they should be seen as potentially meaningful and best understood within the context of an individual's life. On such accounts, the problems of mentally distressed people are unique and are not types of entity that can be classified.

5.3 Mental disorders are not states of individuals

The DSM thinks of mental disorders as being problems that can arise in individuals. Relational family therapists think that there can be relational disorders, such that family relationships can be dysfunctional even though there is no dysfunction that can be identified "within" a particular individual. Such therapists find the DSM categories inadequate (Kaslow 1993; Denton 2007).

Others critics accept the idea that a categorical classification of types of mental disorder might be legitimate, but still have worries about the DSM.

5.4 Concerns about medicalization

Many critics worry that as the DSM has expanded it has come to include conditions that would be better considered to be normal variations, or in some cases, forms of non-medical deviance (Kirk and Kutchins 1997; Conrad 2007; Frances 2013). There are a variety of pressures that can push towards medicalization. When a condition comes to be thought of as a disorder this can facilitate access to services and support for would-be patients. Patient groups thus sometimes lobby for conditions to be included in the DSM (Young 1997). Sometimes it can be politically and socially expedient to think of a problem as having to do with some inner dysfunction within particular individuals. For example, attributing classroom problems to attention deficit hyperactivity disorder can deflect potential criticism from teaching techniques or educational policies (Conrad 1975).

There are also financial incentives for medicalization. When a new condition comes to be included in the DSM this creates a new potential market for a drug treatment. There are thus incentives for pharmaceutical companies to attempt to influence the DSM. Many of the mental health professionals involved in developing the DSM-5 had financial links with the pharmaceutical industry (Cosgrove and Krimsky 2012). For the DSM-5, the APA introduced limited measures to address potential conflicts of interest (APA no date). However, even if those directly involved in DSM-development are not influenced by links with the pharmaceutical industry, there are concerns that much psychiatric research is now funded by industry and furthers the interests of industry. In so far as the DSM is based on the current research base, if the current research base becomes distorted by industry influence, so too will the DSM (Healy 1997).

5.5 Concerns about cross-cultural adequacy

The DSM is published by the American Psychiatric Association and focusses on conditions seen in the US. In so far as mental disorders take different forms depending on a patient's culture, some worry that the DSM is inadequate for classifying the types of condition that are seen elsewhere around the world (Mellsop et al. 2011; Murphy 2015).

5.6 Concerns about specific conditions

Many critics are happy enough with the DSM in general, but take issue with the way in which some particular condition has been classified. Whether or not a condition is included in the DSM makes a huge difference to patients' lives. Some groups want conditions to be excluded because they do not want to be considered to suffer from a mental disorder. Homosexuality is the classic example where such concerns led to a condition being removed from the DSM. As another example, during the construction of the DSM-III, III-R, and DSM-IV the proposed introduction of premenstrual dysphoric disorder, a mood disorder related to the menstrual period, was blocked by massive protests by feminists, who feared that it would pathologise normal changes in mood associated with the menstrual period (for a history of these debates see Caplan 1995). Premenstrual dysphoric disorder finally came to be included only in the DSM-5. In other cases, groups lobby to retain conditions in the DSM because they worry that essential services will be lost if patients' loose DSM diagnoses. When the DSM-5 was developed changes to autism and related conditions proved controversial for these reasons. There were concerns that proposed changes might lead to children losing a DSM diagnosis and that this would render them ineligible for supportive therapies. Patient groups organised for the APA to be bombarded with emails and phone calls protesting the proposed changes (Greenberg 2013, 296-299), and the DSM-5 criteria were finally published with a footnote that sought to ensure that no patient would lose a diagnosis as a result of the changes that had been made (APA 2013, 51).

6. Conclusion

At time of writing, the APA is soliciting suggestions for how the DSM-5 might be corrected and improved (American Psychiatric Association 2017). Suggestions are invited for changes that might increase the validity, reliability or clinical utility of diagnostic criteria. It is also possible to suggest changes that might reduce any "deleterious consequences" that diagnostic criteria might have. The comments form reflects in miniature the complexities of the DSM. The DSM aims to be "scientific" and to accurately represent the domain of psychopathology. It must be usable in the clinic and capable of enabling reliable diagnoses. At the same time, the APA is concerned with the well-being of patients, and hopes that its classification will do no harm. The processes via which comments can be made are also revealing. The process is open, and anyone who wants to comment is welcome to do so. At the same time, the process is somewhat opaque. It's not possible to view those comments that have been made, and it isn't entirely clear what will happen to suggestions. The economic importance of the DSM is also plain. Those who submit comments must agree to sign over copyright for any revisions that eventuate to the APA (which depends on the DSM for much of its income). There is also a requirement that any potential conflicts of interest (for example, links with the pharmaceutical industry) must be declared. For the foreseeable future the DSM looks set to remain much as it is at present; economically and bureaucratically important, aiming to be scientific and to help patients, controversial and continually revised.

Endnotes

1. First documents the many small differences between DSM-IV and ICD-10. The aim of his paper is to draw attention to the current differences between the systems, which he views as an impediment to research. However, despite the many small differences, overall the two systems are very similar.

2. Personal communication 26 April 2017.

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