History of the Diagnostic and Statistical Manual of the American Psychiatric Association
The initial impetus for developing a classification of mental disorders in the United States was the need to collect statistical information. The first official attempt was the 1840 census which used a single category, "idiocy/insanity". The 1880 census distinguished among seven categories: mania, melancholia, monomania, and epilepsy.
In 1917, a "Committee on Statistics" from what is now known as the American Psychiatric Association (APA), together with the National Commission on Mental Hygiene, developed a new guide for mental hospitals called the "Statistical Manual for the Use of Institutions for the Insane", which included 22 diagnoses.
This was subsequently revised several times by APA over the years. APA, along with the New York Academy of Medicine, also provided the psychiatric nomenclature subsection of the US medical guide, the "Standard Classified Nomenclature of Disease", referred to as the "Standard".
World War II saw the large-scale involvement of US psychiatrists in the selection, processing, assessment and treatment of soldiers. This moved the focus away from mental institutions and traditional clinical perspectives.
A committee headed by psychiatrist and Brigadier General William Menninger developed a new classification scheme called Medical 203, issued in 1943 as a "War Department Technical Bulletin" under the auspices of the Office of the Surgeon General.
The foreword to the DSM – I states the US Navy had itself made some minor revisions but "the Army established a much more sweeping revision, abandoning the basic outline of the Standard and attempting to express present day concepts of mental disturbance."
This nomenclature eventually was adopted by all Armed Forces", and "assorted modifications of the Armed Forces nomenclature [were] introduced into many clinics and hospitals by psychiatrists returning from military duty." The Veterans Administration also adopted a slightly modified version of Medical 203.
In 1949, the World Health Organization published the sixth revision of the International Classification of Diseases (ICD) which included a section on mental disorders for the first time. The foreword to DSM-1 states this "categorized mental disorders in rubrics similar to those of the Armed Forces nomenclature."
An APA Committee on Nomenclature and Statistics was empowered to develop a version specifically for use in the United States, to standardize the diverse and confused usage of different documents.
In 1950 the APA committee undertook a review and consultation. It circulated an adaptation of Medical 203, the VA system and the Standard's Nomenclature, to approximately 10% of APA members. 46% replied, of which 93% approved, and after some further revisions (resulting in it being called DSM-I), the Diagnostic and Statistical Manual of Mental Disorders was approved in 1951 and published in 1952.
The structure and conceptual framework were the same as in Medical 203, and many passages of text identical. The manual was 130 pages long and listed 106 mental disorders.
Although the APA was closely involved in the next significant revision of the mental disorder section of the ICD (version 8 in 1968), it decided to also go ahead with a revision of the DSM. It was also published in 1968, listed 182 disorders, & was 134 pages long. It was similar to the DSM-I. The term “reaction” was dropped but the term “neurosis” was retained.
Both the DSM-I and the DSM-II reflected the predominant psychodynamic psychiatry, although they also included biological perspectives and concepts from Kraeplin's system of classification. Symptoms were not specified in detail for specific disorders.
Many were seen as reflections of broad underlying conflicts or maladaptive reactions to life problems, rooted in a distinction between neurosis and psychosis. Sociological and biological knowledge was also incorporated, in a model that did not emphasize a clear boundary between normality and abnormality.
In 1974, the decision to create a new revision of the DSM was made, and Robert Spitzer was selected as chairman of the task force. The initial impetus was to make the DSM nomenclature consistent with the International Classification of Diseases, published by the World Health Organization. The revision took on a far wider mandate under the influence and control of Spitzer and his chosen committee members.
One goal was to improve the uniformity of psychiatric diagnosis in the wake of a number of critiques, including the famous Rosenhan experiment. There was also a perceived need to standardize diagnostic practices within the US and with other countries. The establishment of these criteria was also an attempt to facilitate the pharmaceutical regulatory process.
The criteria adopted for many of the mental disorders were taken from the Research Diagnostic Criteria (RDC) and Feighner Criteria, which had just been developed by a group of research-orientated psychiatrists based primarily at Washington University and the New York State Psychiatric Institute. Other criteria, and potential new categories of disorder, were established by a consensus during meetings of the committee, as chaired by Spitzer.
A key aim was to base categorization on colloquial English descriptive language (which would be easier to use by Federal administrative offices), rather than assumptions of etiology, although its categorical approach assumed each particular pattern of symptoms in a category reflected a particular underlying pathology.
The psychiatric or physiological view was abandoned, in favor of a regulatory model. A new "multiaxial" system attempted to yield a picture more amenable to a statistical population census, rather than just a simple diagnosis. Spitzer argued, “mental disorders are a subset of medical disorders” but the task force decided on the DSM statement: “Each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome.”
The first draft of the DSM – III was prepared within a year. Many new categories of disorder were introduced; a number of the unpublished documents that aim to justify them have recently come to light. Field trials sponsored by the U.S. National Institute of Mental Health (NIMH) were conducted between 1977 and 1979 to test the reliability of the new diagnoses. A controversy emerged regarding deletion of the concept of neurosis, a mainstream of psychoanalytic theory and therapy but seen as vague and unscientific by the DSM task force.
Faced with enormous political opposition, so the DSM-III was in serious danger of not being approved by the APA Board of Trustees unless “neurosis” was included in some capacity, a political compromise reinserted the term in parentheses after the word “disorder” in some cases. In 1980, the DSM-III was published, at 494 pages long and listing 265 diagnostic categories.
The DSM-III rapidly came into widespread international use by multiple stakeholders and has been termed a revolution or transformation in psychiatry.
In 1987 the DSM – III R has published as a revision of DSM-III, under the direction of Spitzer. Categories were renamed, reorganized, and significant changes in criteria were made. Six categories were deleted while others were added. Controversial diagnoses such as pre-menstrual dysphoric disorder and Masochistic Personality Disorder were considered and discarded. Altogether, DSM-III-R contained 292 diagnoses and was 567 pages long.
In 1994, DSM – IV was published, listing 297 disorders in 886 pages. The task force was chaired by Allen Frances. A steering committee of 27 people was introduced, including four psychologists. The steering committee created 13 work groups of 5–16 members. Each work group had approximately 20 advisers. The work groups conducted a three step process.
First, each group conducted an extensive literature review of their diagnoses. Then they requested data from researchers, conducting analyses to determine which criteria required change, with instructions to be conservative. Finally, they conducted multicenter field trials relating diagnoses to clinical practice.
A major change from previous versions was the inclusion of a clinical significance criterion to almost half of all the categories, which required symptoms cause “clinically significant distress or impairment in social, occupational, or other important areas of functioning”.
A "Text Revision" of the DSM-IV, known as the DSM – IV TR was published in 2000. The diagnostic categories and the vast majority of the specific criteria for diagnosis were unchanged. The text sections giving extra information on each diagnosis were updated, as were some of the diagnostic codes in order to maintain consistency with the ICD.
The Five Axes

- Axis I – Clinical Conditions (V-Codes)
- Axis II – Personality Disorders and Mental Retardation
- Axis III – Health Conditions
- Axis IV – Psychosocial Stressors
- Axis V – Global Assessment of Functioning