Special Articles

Origins of DSM-I: A Study in Appearance and Reality

Gerald N. Grob, Ph.D.

The author traces the history of psychiatric nosology in the United States from its origins in the early nineteenth century to the introduction of DSM-I in 1952. Until World War I, psychiatrists were not interested in systematic classification, although they were concerned with diagnosis. The first official nosology, adopted in 1918, reflected the need to collect mental hospital data. The federal Bureau of the Census had a role in the development of this nosology in that it required such data. The publication of DSM-I marked an internal transformation that mirrored the growing dominance of psychodynamic and psychoanalytic psychiatry and the relative weakness of the biological tradition. This transformation occurred largely as a result of the lessons learned by psychiatrists during World War II. The author’s basic argument is that nosology reflected not only psychiatric ideology but also other, external determinants at any given point in time.


In modern medicine, as in modern society, classification systems play a crucial role, for without such systems the collection and analysis of data are all but impossible. Two symbols perhaps best represent the centrality of taxonomy: the census and the computer. In its origins, the census was but a limited undertaking designed for certain specific purposes: to facilitate the collection of taxes, to measure the strength of the nation-state, or to allocate political representation. In the nineteenth century, however, a radically new concept emerged, namely, that the census could define and describe reality in statistical terms. Similarly, the computer was given legitimacy by the appealing claim that it was both possible and desirable to group data of all varieties into logical and self-evident categories. In turn, the analysis of the relationships among different classes of data could lead to greater knowledge and understanding, whether of the social and physical environment or of human behavioral patterns.

Classification systems are neither inherently self-evident nor given. On the contrary, they emerge from the crucible of human experience; change and variability, not immutability, are characteristic. Indeed, the ways in which data are organized at various times reflect specific historical circumstances. Empirical data, after all, can be presented and analyzed in endless varieties of ways.

The development of psychiatric nosology is a case in point. Although nosological debates dealing with mental disorders were (and are) phrased in scientific and medical language, they were shaped by a variety of factors: the social origins and ideological, political, and moral commitments of psychiatrists; their desire for status and legitimacy; the characteristics of their patients; the nature and location of their practices; and the broader social and intellectual currents prevalent at a given time. Nowhere are these generalizations better illustrated than in the developments that culminated in the publication of the first edition of the Diagnostic and Statistical Manual: Mental Diseases (DSM-I) in 1952.
NOSOLOGY VERSUS DIAGNOSIS

Psychiatrists in nineteenth-century America were for the most part uninterested in elaborate nosologies that systematized mental illnesses in formal and overly rigid ways. Like other physicians, they conceived of disease in individual rather than general terms. Health was a consequence of a symbiotic relationship or balance among nature, society, and the individual (1, 2). Disease, by way of contrast, represented an imbalance that followed the violation of certain natural laws that governed human behavior. To be sure, mental illnesses were indistinguishable from other physical illnesses and occurred when false impressions were conveyed to the mind because the brain or other sensory organs had been impaired. Nevertheless, psychiatrists also believed that mental illnesses were precipitated by a combination of psychological and environmental etiological factors that were mediated by the constitution or predisposition of the individual. Thus, insanity often followed violation of the natural laws that governed human behavior and was linked as well with immorality, improper living conditions, or other stresses that upset the natural balance.

The holistic concept of insanity for American psychiatrists represented both an act of faith and a starting assumption. Except for a few cases in which autopsies revealed the presence of a brain tumor or other physical abnormality, the link between organ and behavior remained shrouded in mystery. Given their inability to demonstrate a relationship between anatomical changes and behavior, psychiatrists identified mental disorders by observing external signs and symptoms. In this respect they were no different from other physicians. Prior to the conceptual changes that began to transform medical thought in the late nineteenth century (symbolized by the specific germ theory of disease), most practitioners defined pathological states in terms of external and visible signs (such as fever). To infer pathology by focusing on signs admitted created serious intellectual and scientific problems; the preoccupation with differentiating among various fevers was but one striking example. Although disagreeing on the diagnosis of signs and symptoms, few physicians questioned this approach, if only because other alternatives were largely lacking. Similarly, nineteenth-century psychiatrists accepted disease as a given; the inability of patients to function, combined with severe behavioral symptoms, was sufficient evidence of the presence of pathology.

Classification systems based on symptoms created grave and perhaps insoluble problems, thus reinforcing psychiatrists' lack of interest, if not hostility, toward nosology. What kind of classification system could possibly encompass the innumerable and protean forms of abnormal behavior? No system of classification, conceded Amariah Brigham in 1843 (3), appeared to be of "much practical utility"; all categories based on symptoms "must be defective, and perhaps none can be devised in which all cases are arranged."

Nor were Brigham's views unique. Samuel B. Woodward (4), Superintendent of the Worcester State Lunatic Hospital and first President of the Association of Medical Superintendents of American Institutions for the Insane (now APA), had observed earlier that insanity was a "unit, indefinable . . . easily recognized . . . [but] not always easily classified." Indeed, he believed that therapy was independent of any nosological system but, rather, had to reflect the unique circumstances presented by each individual case (4–8).

To suggest that American psychiatrists were not persuaded that a systematic nosology was crucial to their practice is not to imply that they were unconcerned with diagnosis. On the contrary, they recognized the importance of classification and even engaged in fierce debates over the validity of such specific categories as moral insanity (9) (a condition in which there was a morbid perversion of the emotions but little or no impairment of the thought process or the intellect) and the relationship of broad psychiatric categories associated with homicidal insanity (10). However, they also were acutely aware of the formidable barriers that blocked the development of all-embracing systems. Hence, their nosologies tended to be general and fluid, and judgments about individual patients represented pragmatic choices that had few practical consequences. In 1838, in his classic treatise on the medical jurisprudence of insanity, for example, Isaac Ray (11) followed J.E.D. Esquirol's classifications and divided insanity into two broad groups. The first—idiocy and imbecility—included individuals with congenital defects. The second encompassed those in whom lesions had impaired the functioning of the mind and included mania (either intellectual or affective) and dementia. Ray, as a matter of fact, denied that any classification could be "rigorously correct, for such divisions have not been made by nature and cannot be observed in practice." Diseases, he added, "are naturally associated into some general groups only; but if these be ascertained and brought into view, the great end of classification is accomplished."

If psychiatrists recognized that nosology was not critical to clinical practice, they were cognizant of its role in the collection of statistical data. After 1800, a number of currents had given rise to a type of social inquiry whose methodological distinctiveness was a commitment to quantitative research. Underlying the application of quantification was the assumption that such a methodology could illuminate and explain social phenomena. Nineteenth-century American psychiatrists were deeply committed to the collection and analysis of such data. In their eyes, statistical inquiry could shed light on recovery rates, uncover the laws governing health and disease, serve the ends of policy advocacy, and enhance the legitimacy of both their specialty and their hospitals (12).

The collection of statistical data, of course, required categories. Most of the categories used by nineteenth-century psychiatrists, however, dealt with the demographic characteristics of patients as well as admission.
and discharge rates; nosology occupied a distinctly subordinate position. At the International Congress of Alienists in 1867 (13), for example, a commission dealing with psychiatric statistics recommended a broad system that involved only seven categories of insanity (simple, epileptic, paralytic, senile dementia, organic dementia, idiocy, and cretinism). The focus of their report, nevertheless, was on demographic rather than nosological variables. When the document was brought before the Association of Medical Superintendents of American Institutions for the Insane in 1869 (14), the focus remained unchanged. Some years later, Clark Bell (President of the New York Medico-Legal Society and a delegate to the International Congress on Psychiatry and Neurology in 1885) asked a group of psychiatrists to prepare an American nosology. In response, a small group (15, pp. 372–377) simply followed their British brethren and identified only eight categories (mania, melancholia, monomania, dementia, general paralysis of the insane, epilepsy, toxic insanity, and congenital mental deficiency); they rejected only moral insanity.

The intellectual and scientific constraints that inhibited the development of psychiatric nosology persisted for much of the nineteenth century. When, toward the close of his long career, the venerable Pliny Earle was approached by Bell in 1886 about the possibility of developing a universally accepted classification of mental diseases, Earle (16) responded in somewhat negative terms. “In the present state of our knowledge,” he wrote, “no classification of insanity can be erected upon a pathological basis, for the simple reason that, with but slight exceptions, the pathology of the disease is unknown. . . . Hence, for the most apparent, the most clearly defined, and the best understood foundation for a nosological scheme for insanity, we are forced to fall back upon the symptoms of the disease—the apparent mental condition, as judged from the outward manifestations.” The oldest, simplest, and most practical classification systems (mania, monomania, dementia, and idiocy), therefore, were still of considerable value.

Recognition of the difficulties that blocked the formulation of a nosology of insanity did not in any way inhibit etiological discussions. To be sure, psychiatrists were aware of their inability to demonstrate meaningful relationships between causal elements and the presence of particular behavioral signs or symptoms. Yet the social and cultural roles of medicine required that all physicians—psychiatrists and others—provide some explanation of disease processes. This was as true for the early part of the nineteenth century as it was for the closing decades, when a new ideal of scientific medicine (symbolized by the introduction of antisepsis in the 1870s and pathogenic specificity in the 1880s) was taking shape.

Nineteenth-century psychiatric etiological concepts reflected broad social perceptions and prevailing cultural norms. Consequently, etiological discussions tended to be protean and nonspecific in character. Insanity, observed Walter Channing (17), involved an internal relationship between the individual and the environment that remained a mystery. Given the immense complexities in understanding the inner life history of a person, he emphasized external predisposing causes. Mental illnesses followed several conditions: the harmful effects of the increasing demands of modern civilization, the migration from abroad of individuals already well on the road to degeneracy, and the role of such factors as marriage and occupation. Nor were Channing’s etiological theories unique; virtually every psychiatrist focused on external elements. The list seemed endless: addiction to alcohol, drugs, and tobacco; sexual excesses; improper nutrition; inadequate housing; misdirected education; uterine and ovarian diseases; and moral or psychological causes such as domestic difficulties, grief, anxiety, adverse circumstances, business failure, financial difficulties, sudden fright, worry, and mental overwork (18–21).

For much of the nineteenth century mental illnesses were loosely classified on the basis of symptoms with unprovable etiology or content. Toward the close of the century, however, interest in psychiatric nosology reawakened. Psychiatrists began to shift their attention to the course and outcome of mental illnesses. Emil Kraepelin (22) in particular singled out groups of signs as evidencing specific disease entities such as dementia praecox and, later, manic-depressive psychosis. Studying thousands of patients at his clinic in Heidelberg, Kraepelin identified the disease entity in terms of its eventual outcome. Dealing with a large mass of data, he sorted out everything that individuals had in common, omitting what he regarded as purely personal data. In this respect he diverted attention away from the unique circumstances of individuals toward more general and presumably universal disease entities. In so doing, he was simply emulating a distinct trend in medical thinking in general.

The Kraepelinian emphasis on classification was not immediately accepted; nosological uncertainty persisted. In 1894 the Committee on Statistical Tables (23) reported that many members regretted the fact that the American Medico-Psychological Association (now APA) lacked a nosology that “would place its members upon common ground.” Six years later, Henry J. Berkley (24), Clinical Professor of Psychiatry at Johns Hopkins, noted that a classification based on clinical symptoms was unsatisfactory “because the indications of one form of disease frequently overlap those of another.” Similarly, an etiological nosology was defective “inasmuch as the fundamental causation is frequently unknown and unascertained.” Berkley fell back on a classification based on morbid anatomy, “for when the pathology of a disease has been once recognized, the course can be predicted with some certainty, and the treatment instituted rests upon a solid foundation.” In another textbook published in 1905, Stewart Paton (25) conceded that classification in psychiatry and medicine differed; the former did not deal with “definite disease entities, such as typhoid fever or
pneumonia,” where a demonstrable causal link was present. Nor had psychiatrists been able to establish a connection between lesions and behavior. The only rational method, Paton suggested, was one that took into consideration “all the possible facts bearing upon the case.” His preferred nosology was a system that divided diseases into the “defect psychoses—idiocy, imbecility, and other degrees of mental debility,” psychoses due to autointoxication (admittedly unproven), and the groups of manic-depressive insanity and dementia praecox. The growing preoccupation with classification led Charles G. Hill (26) in his presidential address before the American Medico-Psychological Association in 1907 to observe that there was little room for addition “unless we add ‘the classifying mania of medical authors.’”

SOCIAL SCIENCES AND THE FEDERAL CENSUS

The impetus to create a psychiatric nosology came largely from outside of psychiatry or medicine. By the end of the nineteenth century a number of new social science disciplines had come into existence. Many of the individuals associated with these new disciplines were concerned not only with developing a scientific understanding of individual and social behavior but also with applying this understanding to a series of pressing social problems that seemed to threaten the very fabric of society.

In its quest for empirical data, social science drew upon the tradition of statistical analysis that had emerged during the first half of the nineteenth century. Ultimately, a general consensus developed around the indispensable utility of the federal census. To those hoping to interpret individual and collective behavior in scientific terms, the census was not merely an undertaking designed to collect data. On the contrary, the census represented a radical faith that quantitative research, when merged with administrative rationality, could replace politics. Statistical knowledge could thus serve as the foundation for social policy and end the pernicious bickering over theory, principles, and politics.

As early as the 1830s, concern with morbidity, mortality, and dependency had stimulated efforts to gather statistical data that could presumably illuminate their causes and thus assist in the development of appropriate policies. The federal census of 1840, for example, attempted to enumerate the insane, but with little success. The obstacles confronting the collection of aggregate data were formidable, and administrative mechanisms were weak or nonexistent (27, 28). The major turning point came with the tenth census in 1880. The scope of this census was evident in its size; it ran to 25 volumes plus a three-volume compendium (compared with two volumes in 1870). More importantly, dependency was the subject of an entirely separate volume prepared under the supervision of Frederick H. Wines, who was already a significant figure in American wel-fare. Wines had been appointed as secretary of the Illinois Board of State Commissioners of Public Charities in 1869 and subsequently became prominent in the National Conference of Charities and Corrections. His stature was such that his views on the care and treatment of a variety of dependent groups, including the mentally ill, the mentally retarded, and imprisoned criminals, received national attention.

Wines’s 581-page volume was published in 1888 under the title Report on the Defective, Dependent, and Delinquent Classes . . . asReturned at the Tenth Cens us (June 1, 1880) (29). That Wines regarded the census as an instrument of policy was indisputable. In his eyes the organization of modern society was intimately related to the increase in dependency, a development he viewed with considerable misgivings. “There is a morphology of evil which requires to be studied,” he wrote. “For the information of legislatures it is important that the whole extent of the evil to be contended against shall be known, and that it shall be accessible in a single report, in order that they may make adequate provision for its care or alleviation” (p. x). Wines’s analysis went beyond mere aggregation of data pertaining to insanity; he began to speculate on the relationship between mental illness and such variables as sex, nativity, race, geographical residence, age, and marital status.

Wines was cognizant that psychiatrists had been unable to agree on a satisfactory nosology. He called attention to the fact that existing nosologies represented a melange of etiology, symptomatology, and description. Some classifications were “based upon symptoms” and some upon “physical causes”; others were “a mixture of the two”; and still others took into account “the complications of insanity.” After consulting with a series of alienists, Wines decided to identify seven forms of insanity: mania, melancholia, monomania, paresis (general paralysis of the insane), dementia, dysomania, and epilepsy (29, p. xlii). A decade later, Dr. John Shaw Billings (30), the physician who created what is today the National Library of Medicine, served as president of the American Public Health Association, and prepared the eleventh census volume dealing with dependency, which followed Wines’s classification but subdivided mania and melancholia into acute and chronic.

After 1900, the Bureau of the Census expanded its coverage of dependent groups in general and the mentally ill in particular. In 1904 and 1910 it conducted two special censuses dealing with the institutionalized insane. The first focused attention on the ethnic and racial characteristics of the institutionalized mentally ill and did not use any psychiatric nosological categories because of the absence of a standard classification. The census officials’ preoccupation with race and ethnicity was related to the growing fear that the alleged racial superiority of the native-born population, whose families were originally from Western and Northern Europe, was being threatened by large-scale immigration of presumably inferior groups from Eastern and
Southern Europe. Eugenical concepts, which posited a relationship between race and culture, enjoyed considerable popularity at the turn of the century. A number of states passed laws regulating marriage for eugenic purposes, mandating the segregation of the feebleminded and providing for the involuntary sterilization of some of the retarded and mentally ill (31–33). Although the data collected in 1904 provided relatively little support for the validity of eugenic concepts, it was evident that the categories used by the Bureau of the Census (34) reflected some of the concerns about the relationship between race and immigration on the one hand and social problems and dependency on the other.

The special census of 1910 was even broader in scope than its predecessor 6 years before and reflected a growing sophistication in the analysis of statistical data. Once again the focus was on the role of demographic characteristics and the relationship between insanity and social factors. With the exception of some brief data on the admission of patients with alcoholic psychosis and paresis (two fairly well-recognized categories) and death rates of those suffering from mental disorders, the census again all but ignored psychiatric nosology. That the compilation reflected the growing importance of the social sciences was evident. Responsibility for its preparation lay with Joseph A. Hill (35), who had received his doctorate in Germany and taught political economy at Harvard before joining the Bureau of the Census in 1898. Hill offered little comfort to those fearful of the new immigration. The claim that insanity was increasing rapidly, he wrote, was dubious. A variety of determinants shaped the statistics of insanity: the growing practice of institutionalizing the insane, the increasing average length of life, new diagnostic methods in psychiatry leading to the detection of mental factors in physical illness, the establishment of dispensaries, provision for "voluntary" and emergency commitment, and better modes of transportation (such as automobiles) that made it possible to bring individuals in poor physical condition to mental hospitals. By correcting for the age distribution of the entire native and foreign-born population, Hill also demonstrated that the allegation that immigrants had higher rates of mental illnesses was in error. "The age difference," he wrote, "probably goes further than any other factor toward explaining the contrast between the native white and the foreign-born in respect to the proportionate numbers admitted to hospitals for the insane." Other differences between the two groups might also be accounted for by sex distribution or residence in urban or rural areas.

STATISTICS AND EPIDEMIOLOGY

The growing involvement of the Bureau of the Census with the statistics of mental illnesses was indicative of the concern outside of psychiatry with policy implications and future trends. The presumption was that demographic data dealing with the institutionalized mentally ill would be useful to public officials responsible for administering large hospital systems. Preoccupation with public policy, however, reinforced the lack of attention given to the imprecise nature of diagnostic categories—an oversight that contradicted generally accepted epidemiologic principles.

Psychiatrists initially manifested relatively little interest in the activities of the Bureau of the Census. This began to change as concern regarding mental hygiene and prevention mounted. When Dr. Thomas W. Salmon became medical director of the recently founded National Committee for Mental Hygiene in 1912, it was clear that the preoccupation with mental hygiene transcended concern with the problems of the institutionalized insane. Indeed, Salmon had a new and radical vision of the role of psychiatry. In the past, he observed in 1917 (36), the isolation of patients in mental hospitals had also isolated psychiatrists. A new kind of psychiatry, on the other hand, would reach beyond hospital confines and play a crucial part "in the great movements for social betterment." He urged his colleagues to undertake research, to help shape public policy, to lay the foundations of mental hygiene, to supervise the care of the retarded, to promote eugenic practices, to control alcoholism, to manage abnormal children, to define the treatment of criminals, and to play crucial roles in the prevention of crime, prostitution, and dependency.

Even if not universally accepted by the specialty, such broad goals helped to move psychiatrists into the community and involve themselves in a broad range of problems not related specifically to the needs of severely mentally ill individuals traditionally found in hospitals. Out of these experiences came a new psychiatric interest in statistics and epidemiology. As early as 1908 the Bureau of the Census had asked the American Medico-Psychological Association to appoint a Committee on Nomenclature of Diseases to facilitate the collection of data (37). In subsequent years the interest of census officials in a standard psychiatric nosology grew even stronger. The Association finally created a Committee on Statistics in 1913. Its members quickly affirmed the need to develop a uniform system to gather data on mental diseases and mental hospitals. In 1917 (38) they reported that the lack of uniformity "makes it absolutely impossible at the present time to collect comparative statistics concerning mental diseases in different states and countries, and extremely difficult to secure comparative data relative to movement of patients, administration, and cost of maintenance and additions." Such data, if collected in a uniform and systematic manner, "would serve as the basis for constructive work in raising the standard of care of the insane, as a guide for preventive effort, and as an aid to the progress of psychiatry." They added, "The present condition with respect to the classification of mental diseases is chaotic. This condition of affairs discredits the science of psychiatry and reflects unfavorably upon our Association."
Cognizant that the Bureau of the Census would continue to expand its data-gathering activities, the members of the Committee on Statistics urged their colleagues to prepare a uniform nomenclature of mental diseases. The Association, with the cooperation of the National Committee for Mental Hygiene, issued the first standardized psychiatric nosology, *Statistical Manual for the Use of Institutions for the Insane* (39) in 1918. This manual divided mental disorders into 22 principal groups. One of these represented undiagnosed psychoses, one represented patients without psychoses, and the remaining 20 categories rested for the most part on the belief that mental disorders had a biological foundation. These categories were traumatic psychoses, senile psychoses, psychoses with cerebral arteriosclerosis, general paralysis, psychoses with cerebral syphilis, psychoses with Huntington's chorea, psychoses with brain tumor, psychoses with other brain or nervous diseases, alcoholic psychoses, psychoses due to drugs and other exogenous toxins, psychoses with pellagra, psychoses with other somatic diseases, manic-depressive psychoses, involution melancholia, dementia praecox (subsequently schizophrenia), paranoia or paranoid conditions, epileptic psychoses, psychoneuroses and neuroses, psychoses with constitutional psychopathic inferiority, and psychoses with mental deficiency.

That American psychiatrists preferred a somatic nosology was hardly surprising. In 1918 the overwhelming majority of those who were identified with psychiatry were employed in mental hospitals; the number in noninstitutional settings was negligible. In public hospitals psychiatrists dealt with patients with severe physical impairments. In 1922, for example, 33.4% of all first admissions represented psychoses of known somatic origins; by 1940 the figure had risen to 42.4%. (The data for this paragraph are taken from the U.S. Bureau of the Census annual compilations of hospital statistics from 1926 to 1946. The first volume was published in 1926 [40].) If we assume that a substantial proportion of individuals in the functional categories also suffered from conditions with a somatic origin—an assumption that may be warranted from present-day data—it is evident that mental hospitals provided care for a patient population with severe physical as well as mental problems. The fact that the somatic group had a higher death rate than the group with functional psychoses suggests that the diagnoses were not inaccurate. In 1940 the somatic group accounted for 19,357 deaths (61.6%) out of a total of 31,417. The somatic nosology adopted in 1918, therefore, mirrored in part the nature of psychiatric practice.

From the point of view of the Bureau of the Census, the adoption of a formal classification system was of major importance. Indeed, in 1920 the Bureau published its own nomenclature of diseases (41), which relied on the *Statistical Manual* (39) in defining psychiatric categories. It conceded its inability to draw a clear line between symptoms and diseases and admitted that many terms used to describe pathological conditions might in the future be regarded as symptoms if the etiology of the disease were discovered. Nevertheless, the collection of statistical data required a formal nomenclature. Three years after the publication of its own nosology, the Bureau of the Census began its annual collection of the statistics of the institutionalized mentally ill population (40), which was continued after World War II by the National Institute of Mental Health (NIMH).

The adoption of a uniform psychiatric nosology was not without controversy. The major opponent was Adolf Meyer. Meyer's genetic-dynamic psychiatry attempted to integrate the life experiences of the individual with physiological and biological data. Training several generations of American psychiatrists at Johns Hopkins between 1910 and 1941, Meyer had never been fond of Kraepelian nosological psychiatry, given his belief that the life history of the individual was the most important element in the etiology of mental disorders. He therefore refused to be identified with the nosology that was prepared by the Committee on Statistics, of which he was a member. The difference, he wrote to E.E. Southard (42, 43), is "that I have no use for the essentially 'one person, one disease' view; that I prefer to speak of an individual *presenting* certain facts that we can do something with in the way of definite demonstration, and, if possible, in the way of some prediction of a type of lesion, and along the lines of attack in the way of some therapeutic activity, and also along the lines of prognosis. Whether a person has a dozen such facts or only one, is to be a matter of demonstration and not of legislation" (42). Meyer told Samuel T. Orton (44, 45) that "statistics will be most valuable if they do not attempt to solve all the problems of administration and psychiatry and sociology under one confused effort of a one-word diagnosis marking the individual . . . . The statistics published annually as they are now are a dead loss to the States that pay for them, and an annual ceremony misdirecting the interests of the staff." Orton (46) was equally critical. The Association's classification, he insisted, was deficient on three counts. First, it was "too narrow in that it excludes all disorders of the nervous system, which do not produce . . . psychoses." Second, it was "illogical" because the categories were based in part on etiology, in part on pathology, and in part on purely clinical data. Third, it was "inconsistent."

Despite such criticisms, the *Statistical Manual* became the definitive nosology of the interwar years and went through no fewer than ten editions between 1918 and 1942. The first seven editions incorporated minor changes; the latter three included more extensive modifications. The tenth edition (47) continued to emphasize the biological basis of most mental disorders but made provision for the psychoneuroses (hysteria, compulsive states, neurasthenia, hypochondriasis, reactive depression, anxiety state, anorexia nervosa, and mixed psychoneuroses) and primary behavior disorders (adult maladjustment and primary behavior dis-
orders in children). As late as 1940, the somatic viewpoint continued to shape psychiatric nosology.

Paradoxically, the classification system incorporated in the *Statistical Manual* was only of marginal concern to psychiatrists and their patients. Its categories were quite general, for the goal was to facilitate the collection of institutional data rather than to provide definitive diagnoses that in turn were related to specific therapies. Psychiatric therapies between the two World Wars, as a matter of fact, were for the most part eclectic and nonspecific; diagnosis was of only marginal significance.

**AFTER WORLD WAR II: PSYCHODYNAMICS AND SOCIAL ACTIVISM**

World War II marked a major watershed in the history of the care and treatment of the mentally ill in the United States. Many psychiatrists who served in the military came to some novel conclusions. They found that neuropyschiatric disorders were a more serious problem than had previously been recognized, that environmental stress associated with combat contributed to mental maladjustment, and that early and purposeful treatment in noninstitutional settings produced favorable outcomes. These beliefs became the basis for claims after 1945 that early identification of symptoms and treatment in community settings could prevent the onset of more serious mental illnesses and thus obviate the need for prolonged institutionalization. The war reshaped psychiatry by attracting into the specialty a substantial number of younger physicians whose outlook, molded by their wartime experiences, was based on psychodynamic and psychoanalytic concepts. After 1945 many of these psychiatrists assumed leadership positions within the specialty, fought to reorganize APA (48), and attempted to forge new policies that broke with the traditional consensus on the need for prolonged hospitalization of mentally ill individuals.

To be sure, the foundation of psychodynamic and psychoanalytic psychiatry had its origins in the early part of the twentieth century. Nevertheless, its triumph within the specialty had to await the transforming experiences of World War II. During that conflict, psychiatrists made major contributions in developing simple but effective means of dealing with large numbers of neuropsychiatric casualties. They found that supportive forms of psychotherapy, when combined with rest, sleep, and food, produced almost instantaneous results. Treatment in a local setting also ensured that soldiers were not separated for any length of time from their units and established social relationships. Overall, about 60% of the soldiers who became neuropsychiatric casualties were returned to duty within 2–5 days. The highest success rates were found in forward combat units; the lowest at rear-echelon hospitals. More than any other element, the success in returning to active duty servicemen who experienced psychological problems renewed a spirit of therapeutic optimism and activism, which was carried back into civilian life after the war (49–52). “Our experiences with therapy in war neuroses have left us with an optimistic attitude,” Roy R. Grinker and John P. Spiegel (53) reported in a chapter for a manual of military psychiatry. “The lessons we have learned in the combat zone can well be applied in rehabilitation at home.”

World War II had other effects as well. In 1941, the status of psychiatrists in military as well as civilian life was marginal. Only 33 members of the Army Medical Corps were assigned to neuropsychiatric sections in hospitals. During the war, psychiatrists slowly increased their presence and importance. At the beginning of 1944 the specialty was raised to the level of a division within the Office of the Surgeon General and placed on an equal organizational level with medicine and surgery. William C. Menninger, who directed the division, was the first psychiatrist to be elevated to the rank of brigadier general. By the end of the war about 2,400 physicians had been assigned to psychiatry, although perhaps less than a third had previous training in the specialty (54, 55). In 1940, by way of comparison, APA had a total membership of only 2,295. The war, in other words, brought into psychiatry hundreds of physicians who might otherwise have selected different medical specialties. Their wartime experiences in successfully treating neurotic symptoms in noninstitutional settings (and allegedly preventing the onset of more serious psychotic symptoms) reinforced the growing importance of a psychodynamic and psychoanalytic model that ultimately became the basis for the postwar transformation of the specialty. More than anything else, the war helped to unify the belief that environmental stress contributed to mental maladjustment and that purposeful human interventions could alter psychological outcomes.

In the postwar era, the traditional preoccupation with the severely mentally ill in public mental hospitals slowly gave way to a concern with the psychological problems of a far larger and more diverse population as well as social problems generally. Persuaded that there was a continuum from mental health to mental illness, psychiatrists increasingly shifted their activities away from the psychoses toward the other end of the spectrum in the hope that early treatment of functional but troubled individuals would ultimately diminish the incidence of the more serious mental illnesses.

Nowhere was the changing outlook of American psychiatry better revealed than in the formation of the Group for the Advancement of Psychiatry (GAP) in 1946. GAP represented a group of “young Turks” determined to reshape APA. Two years before the formation of GAP, the APA Council had authorized its president to appoint a Special Committee on Reorganization to recommend the employment of a medical director for APA and to study the organization’s structure (56–58). Fearful that the heterogeneity of the Association might preclude decisive action, William C. Menninger and a group of colleagues met at the APA meetings in May 1946 to found GAP. There was gen-
eral agreement that GAP would operate as a pressure group within APA to overcome the apathy of its leaders and, in particular, its “incapacity to function.” The new organization was based on the presumption that psychiatry’s responsibilities and functions transcended institutional care and treatment of the mentally ill (59–61). “I do feel,” Menninger (60) told a colleague in early 1947, “that American psychiatry needs renovation in the sense of consideration of social problems and social needs.”

Indeed, the early reports of GAP (issued in final form as published documents) reveal a willingness to engage in a debate on broad social and political issues that bore little direct relationship to the problems of the institutionalized mentally ill. A draft report on the social responsibility of psychiatry (62) urged that psychiatric insights be used in the service of social action (defined as “a conscious and deliberate wish to change society”). Preventive psychiatry, therefore, had to move “out of the hospitals and clinics and into the community” (63). Although GAP’s social activism and emphasis on a psychodynamic social psychiatry quickly aroused hostility within the specialty, in a short time the ideological orientation of GAP prevailed, and its views were shared by the majority of APA members.

In emphasizing the need to focus on nonpsychotic but presumably troubled individuals, psychodynamic psychiatrists tended to blur nosological categories. The changing character of the specialty was reflected in its terminology. Traditionally, diagnoses were expressed in the language of pathology; the presumption was that changes in behavior, which admittedly might be related to environmental factors, had a biological foundation. Postwar psychiatrists, by way of comparison, did not necessarily reject traditional formulations. Their interest in the nature of personality (normal as well as abnormal), the role of childhood and the influence of parenthood, and the ability of the organism to adjust to the environment in ways that were both effective and satisfying, however, led them to use a quite different terminology. Their new language emphasized the need to assist unhappy and neurotic individuals, presumably through different psychotherapies. In emphasizing their ability to deal with such varied concerns as parent-child relationships, marriage, emotional maturity, and occupational roles, the specialty appealed to a broad public eager for assistance in dealing with the problems of ordinary life (64–66).

THE NEW PSYCHIATRIC NOSOLOGY

Nowhere was the change in the nature of postwar psychiatry better illustrated than in the effort to create a new psychiatric nosology. During the 1940s, discontent mounted with the classification system prepared more than two decades earlier. Military and Veterans Administration psychiatrists found themselves using a nomenclature ill-adapted for 90% of their patients. Minor personality disturbances—many of which were of importance only because they occurred within a military context—were placed in the “psychopathic personality” category. The “psychoneurotic” label was given to men who had developed symptoms because of the stress of combat. There was virtually no recognition of psychosomatic disorders. Indeed, by the end of the war the Army and Navy had adopted their own classifications, which subsequently became the basis for revisions of the International Statistical Classification (DSM-I, pp. v–viii).

The nosological confusion, proliferation of nomenclatures, and shift toward psychodynamic and psychoanalytic concepts led the APA Committee on Nomenclature and Statistics in 1948 to postpone further changes in its manual and solicit instead suggestions for change (67). By 1950 it had prepared mimeographed copies of a revised psychiatric nosology, which was widely circulated to various individuals and organizations; a completed version was presented to the APA Council in 1950 for its approval (DSM-I, pp. vii–x). In 1952 APA formally published DSM-I (68).

DSM-I reflected the intellectual, cultural, and social forces that had transformed psychiatry during and after World War II. It divided mental disorders into two major groupings. The first represented cases in which the disturbed mental function resulted from or was precipitated by a primary impairment of brain function. Such brain syndromes were associated with a variety of somatic conditions—infestation; drug, poison, or alcoholic intoxication; trauma; circulatory or metabolic disturbances; intracranial neoplasms; multiple sclerosis; and Huntington’s chorea or other diseases of hereditary origin. The second category encompassed disorders resulting from a more general inability of the individual to adjust, in which brain function disturbance was secondary to the psychiatric illness. DSM-I (pp. 9–43) divided this group into psychotic and psychoneurotic disorders. The former included manic-depressive and paranoid reactions as well as schizophrenia. The latter, in turn, was composed of anxiety, dissociative, conversion, phobic, obsessive-compulsive, and depressive disorders as well as a variety of personality disorders that included emotional instability, compulsiveness, antisocial behavior, sexual deviation, alcoholism, drug addiction, stress, and various reactions associated with different age categories.

The prominence of psychodynamic and psychoanalytic concepts in DSM-I mirrored fundamental changes within psychiatry. The pressure for change, as a matter of fact, was generated largely by analytically oriented psychiatrists who had few ties with public mental hospitals; most of them were in medical schools, clinics, and private practice. By 1956, for example, only about 17% of the 10,000 or so members of APA were employed in hospitals, compared with more than two-thirds in 1940. (Data for 1956 are based on a 10% subgroup [N=943] of the 10,000 members of APA, according to the Biographical Directory for 1957.)
[69.] The clientele of psychiatrists not affiliated with public mental hospitals tended to come from (to use DSM-I categories) the ranks of the psychoneurotic, many of whom seemed to benefit from psychotherapy. Psychodynamic psychiatrists also were more committed to social activism, a commitment mirrored in the activities of GAP.

The growing dominance of psychodynamic and psychoanalytic concepts was reflected in changes in medical and postgraduate education. After 1945 the number of psychodynamic and psychoanalytic psychiatrists affiliated with medical schools increased rapidly. The result was predictable: more and more psychiatry was taught in all 4 years, thus serving as a means of introducing and recruiting young medical students to the specialty. At the same time, psychiatric teaching influenced other departments. NIMH grants, in turn, subsidizing both undergraduate and residency training (70, 71), and the number of psychiatric residencies expanded rapidly. In 1946 there were 155 residency programs; a decade later the total reached 294. The number of actual residencies in this period leaped from 758 to 2,983. The rising prestige and attractiveness of psychiatry was accompanied by a dramatic increase in the proportion of medical school graduates selecting the specialty, which in 1954 peaked at 12.5% (72, 73).

Even more important than the increase in actual numbers was the shift in orientation that marked undergraduate and graduate (i.e., residency) training. A 1942 report on psychiatric education by Franklin G. Ebaugh and Charles A. Rymer (74) had reflected the influence of Meyer. Transitional in character, their work began with the observation that the dominance of the organic point of view in medical education prevented "the proper recognition of the place of psychiatry in the medical curriculum." The concept of organic disease was so pervasive that "functional components are difficult to grasp and appear in the nature of improbability." Other elements contributed to the denigration of psychiatry: a moralistic view of mental disorders, the emotional reaction of medical students to psychiatric concepts, and the seeming hopelessness of mental conditions. Desirable changes, Ebaugh and Rymer concluded, had to rest on three fundamental principles: the concept of man as a whole, the adoption of "a genetic-dynamic concept of mental disorders," and the inseparable relationship of psychiatry and medicine (mediated by the psychosomatic approach) with a recognition of the "emotional factors in disease."

After 1945, by way of contrast, American psychiatry to an unprecedented degree was shaped by psychoanalytic theory, which emphasized the psychological mechanisms that mediated between instinctual biological drives and the pressures of the external environment. Change was already evident by the end of the war. In 1946 the American Board of Psychiatry and Neurology gave its stamp of approval to psychodynamic principles; this anticipated the emergence of a more psychoanalytically oriented psychiatry. Training in the specialty, the Board announced, had to include clinical work with psychoneurotic and psychotic patients (75, 76). Clinical experience had to be integrated "with the study of the basic psychiatric sciences, medical and social psychology, psychopathology, psychotherapy, and the physiological therapies" (75). Psychiatrists had to be taught to collaborate with social workers, clinical psychologists, courts, and other social agencies. Finally, residents had to be exposed to neurology to enable them "to recognize and to evaluate the evidences of organic neurological disease" (75).

In 1951 and 1952 APA and the Association of American Medical Colleges sponsored two important conferences. The first (77) dealt with psychiatry in medical education and the second (75) with residency training. Both were dominated by the psychodynamic perspective. Anxious to alter the marginal role of the specialty, the participants at the first conference urged that all medical students be exposed to psychiatric insights in each of the 4 years. The basic aim was "to equip the student with a reasonably adequate knowledge of the facts of human nature" (77). More specifically, all medical students had to have the ability "to diagnose correctly the condition of patients who are emotionally disturbed and who may be expressing their distress in physical, psychological or social symptoms. This ability implies ... a reasonable understanding of the zones of healthy and sick behavior in our society and, more particularly, the ability to differentiate between normal, neurotic, psychopathic, psychotic, and intellectually defective behavior" (77).

The deliberations at these conferences subsequently led to the preparation of a statement by the APA Committee on Medical Education (77–79). It defined the minimum that all physicians should know about psychiatry and the means by which medical schools could teach such knowledge and skills to their students. The committee recommended that during the first 2 years all medical students be exposed to theories of personality growth, development, structure, and integration; adaptive needs; social and cultural forces affecting personality and behavior; the role of language and meditation; the part played by emotions in physiological functioning; and psychopathology. The curriculum should not attempt to train physicians to become psychiatrists but, rather, to develop "well-rounded physicians, who, in their relationships with all patients, recognize the importance of unconscious motivation, the role of emotional maladjustment in the etiology and chronicity of illness, the emotional and personality problems engendered by various illnesses; and who habitually see the patient in his family and general environmental setting" (78).

That psychodynamic insights quickly dominated the teaching of psychiatry in medical schools was apparent from a GAP survey in 1959–1960 (80). Out of 93 U.S. and Canadian institutions, 88 taught psychodynamics, 87 taught personality growth and development, and 77 taught psychotherapy and clinical syndromes. The number of hours in the curriculum devoted to psychi-
The publication of DSM-I in 1952, therefore, was a visible symbol of the transformation of American psychiatry. Unlike the Statistical Manual, DSM-I elevated the significance of diagnosis. In presenting the new nosology, George N. Raines (68), chairperson of the APA Committee on Nomenclature and Statistics responsible for its publication, observed that “accurate diagnosis is the keystone of appropriate treatment and competent prognosis.” He was critical of the claim that individual differences precluded the use of standardized categories. “Sound diagnosis,” he added, “is possible only with a nomenclature in keeping with current concepts of psychiatric illness.” DSM-I, moreover, was “sufficiently flexible and inclusive to permit the introduction of new and original ideas.”

CONCLUSIONS

Nosologies—psychiatric or otherwise—are rarely etched permanently in stone. DSM-I, like its predecessor and successors, grew out of a specific historical context and reflected the dominance of psychodynamic and psychoanalytic concepts. The shift toward a more biological orientation during and after the 1960s would become the occasion for renewed nosological debate and the creation of new categories.

To contemporary psychiatrists the history of nosology represents a version of the idea of progress; advances in knowledge supposedly lay the foundation for the creation of new categories that describe reality in better and more accurate terms. Within such a perspective, the history of psychiatry is moving on an upward gradient toward an ideal end. In this specific instance, the final goal is a definitive and presumably unchanging nosology of mental illnesses. To more skeptically minded historians, however, the only constant is the process of change itself. The search for a definitive nosology, therefore, may simply be an expression of the perennial human yearning for omniscience—an attribute eagerly sought by many but never yet found.

REFERENCES

3. Utica State Lunatic Hospital Annual Report 1. Utica, NY, Utica State Lunatic Hospital, 1843, p 36
23. Proceedings of the American Medico-Psychological Association 1. Utica, NY, American Medico-Psychological Association, 1894, p 18
39. Statistical Manual for the Use of Institutions for the Insane Prepared by the Committee on Statistics of the American Medico-Psychological Association in Collaboration With the Bureau of Statistics of the National Committee for Mental Hygiene. New York, National Committee for Mental Hygiene, 1918
42. Meyer A: Letter to Southard EE, Dec 16, 1918, in Adolf Meyer Papers. Baltimore, Chesney Medical Archives, Johns Hopkins Medical Institutions
47. Statistical Manual for the Use of Hospitals for Mental Diseases Prepared by the Committee on Statistics of the American Psychiatric Association in Collaboration With the National Committee for Mental Hygiene, 10th ed. Utica, NY, State Hospitals Press, 1942
59. Group for the Advancement of Psychiatry: Minutes of the first informal gathering, May 26, 1946, in GAP Papers. New York, Archives of Psychiatry, New York Hospital-Cornell Medical Center
64. Rennie TAC: Letter to Menninger WC, Jan 20, 1948, in William C Menninger Papers. Topeka, Kan, Menninger Foundation Archives
74. Ebaugh FG, Rymer CA: Psychiatry in Medical Education. New York, Commonwealth Fund, 1942, pp 486–508
76. Group for the Advancement of Psychiatry: Medical Education: Report 3. New York, GAP, 1948
78. APA Committee on Medical Education: An outline for a curriculum for teaching psychiatry in medical schools. J Med Educ 1956; 31:115–128