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DSM and the Death of Phenomenology in America: An Example of Unintended Consequences

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During the 19th century and early 20th century, American psychiatry shared many intellectual traditions and values with Great Britain and Europe. These include principles derived from the Enlightenment concerning the dignity of the individual and the value of careful observation. During the 20th century, however, American psychiatry began to diverge, initially due to a much stronger emphasis on psychoanalytic principles, particularly in comparison with Great Britain. By the 1960s and 1970s, studies such as the US-UK study and the International Pilot Study of Schizophrenia demonstrated that the psychodynamic emphasis had gone too far, leading to diagnostic imprecision and inadequate evaluation of traditional evaluations of signs and symptoms of psychopathology. *Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III)* was developed in this context, under the leadership of representatives from institutions that had retained the more traditional British-European approaches (eg, Washington University, Iowa). The goal of *DSM-III* was to create a comprehensive system for diagnosing and evaluating psychiatric patients that would be more reliable, more valid, and more consistent with international approaches. This goal was realized in many respects, but unfortunately it also had many unintended consequences. Although the original creators realized that *DSM* represented a "best effort" rather than a definitive "ground truth," *DSM* began to be given total authority in training programs and health care delivery systems. Since the publication of *DSM-III* in 1980, there has been a steady decline in the teaching of careful clinical evaluation that is targeted to the individual person's problems and social context and that is enriched by a good general knowledge of psychopathology. Students are taught to memorize *DSM* rather than to learn complexities from the great psychopathologists of the past. By 2005, the decline has become so severe that it could be referred to as "the death of phenomenology in the United States."

Key words: DSM/phenomenology/diagnostic criteria/diagnostic reliability/clinical interviews

Introduction

Any discussion of the "death of phenomenology," probably, needs to begin with a definition of what the word "phenomenology" means in any particular discussion. This is especially necessary because meanings of words change over time and within different contexts, and phenomenology has been used in a variety of ways that have generated considerable controversy.[1] The word phenomenon (plural, phenomena) derives from Greek and refers to outward appearances. It was contrasted with lathomenon, which referred to underlying meanings that might lie hidden beneath the surface. The term was subsequently adopted by Kant and Hegel, who contrasted phenomena with noumena; the former retained a meaning similar to the original Greek, while the latter referred to higher realities and meanings. However, the meaning of phenomena shifted with latter philosophers. In Heidigger, Husserl, and Jaspers, phenomena were understood in terms of internal subjective experiences. Because Jaspers was an influential and thoughtful psychiatrist, his definition has had considerable impact on the usage of the term. Other articles in this series will no doubt use the term phenomenology in the Jasperian sense.

However, the term phenomenology has also acquired a meaning in contemporary psychiatry that is different from that used by Jaspers and other philosophers and that is more similar to the original Greek meaning. In many writings in contemporary psychiatry, the term refers to the study of psychopathology, broadly defined, including signs, symptoms, and their underlying thoughts and emotions. When used in this way, phenomenology provides the basis for nosology, or the development of disease definitions, diagnostic categories, or dimensional classifications. In this discussion, the term phenomenology is used in this contemporary psychiatric context.

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The Origins of Modern Psychiatry: An International Consensus of Shared Values

Although this article is about contemporary psychiatry, it is helpful to understand when and how modern psychiatry came into existence because it illustrates the importance of principles and values about which an international consensus was achieved during the eighteenth century. Psychiatry is among the oldest of the medical specialties. It began when individuals trained as general physicians developed a special interest in the treatment of the seriously mentally ill. This became a widespread movement throughout Britain, Europe, and the United States through the leadership of individuals such as Chiarugi, Pinel, Rush, or the Tukes. The movement arose from the crucible of the dawn of modern science and the philosophy of the Enlightenment.

The dawn of modern science provided early psychiatrists with a framework for generating and testing ideas about the nature and mechanisms of mental illness. Francis Bacon was among the first to articulate the philosophy that would shape the development and methodology of science for the next few hundred years:

> Man can act and understand no further than he has observed, either in operation or in contemplation, of the method and order of nature.
>
> *Novum Organum*[2]

Pursuing this guidance, people worked out new ways to know (science = to know) about the world through observation, testing, and empirical proof. For example, one of the founders of modern psychiatry, Philippe Pinel, stated:

> I, therefore, resolved to adopt that method of investigation which has invariably succeeded in all the departments of natural history, viz. To notice successively every fact, without any other object than that of collecting materials for future use; and to endeavor, as far as possible, to divest myself of the influence, both of my own prepossessions and the authority of others.
>
> *Treatise on Insanity*[3]

Pinel followed those principles faithfully and in the process developed the early principles of epidemiology. He produced case descriptions that are so clear and detailed that his patients can seem to speak in our ears and walk before our eyes. This was phenomenology par excellence, in a prenosological era. As a consequence, the nosology is implicit: the cases are recognizable as classic exemplars of illnesses such as bipolar disorder or paranoid schizophrenia.

The philosophy of the Enlightenment was the second philosophical tradition that shaped the development of modern psychiatry and inspired its early leaders such as Pinel, the Tukes, Rush, or Chiarugi. Its key influence was its emphasis on the dignity of the individual human being and the importance of humanism. There are many famous statements of these principles:

> We hold these truths to be self-evident....that all men are created equal....[4]
>
> Know then thyself, presume not God to scan;
>
> The proper study of mankind is man...[5]
>
> In this system of being, there is no creature so wonderful in its nature, and which so much deserves our particular attention, as man, who fills up the middle space between the visible and invisible world....[6]

Guided by these principles, the early psychiatrists attempted to develop therapies that might help to relieve mental pain in as humane and effective a manner as possible. The picture of Pinel freeing the mentally ill from their chains is perhaps the most famous icon of their therapeutic approach. "Moral therapy" was developed in many countries in Europe, in Britain, and in the United States. In an era when no pharmacological treatments were available, it emphasized a variety of psychotherapeutic techniques that included personalizing the care to the individual's needs, using nonintrusive and compassionate approaches, appealing to reason when possible, and giving the patient some responsibility for improving symptoms and behavior.

Because the philosophy of the Enlightenment encouraged the conceptualization of human beings—including those suffering from mental illness—as endowed with reason and individual dignity, the psychiatric writings of this era did not tend to dissociate the psyche or mind from the brain. Instead, they were seen as integrated. For example, the first editor of *The American Journal of Psychiatry*, Amariah Brigham, stated in 1844[7]:

> ... the brain is the instrument which the mind uses in this life, to manifest itself, and like all other parts of our bodies, is liable to disease, and when diseased, is often incapable of manifesting harmoniously and perfectly the powers of the mind...it is as if, in some very complicated and delicate instrument, as a watch for instance, some slight alteration of its machinery should disturb, but not stop, its action.

Thus, the gifts of modern science and the philosophy of the Enlightenment to the creation of our specialty of psychiatry included stressing the importance of careful observation in order to understand disease mechanisms and progression, an emphasis on the dignity of the individual, the value of "moral treatment," and the integration of "mind," "spirit," and "brain" rather than a dualistic understanding. This has given psychiatry a firm conceptual and moral grounding that it should strive to maintain.

The Rise of Psychoanalysis and the Mid-Atlantic Counterrevolution

The ideas of Sigmund Freud, developed in the early- to mid-20th century, offered an interesting alternative

approach to many psychiatrists, however. They were embraced in many parts of the world and by many individual psychiatrists. The effect was perhaps most striking in the United States. After World War II, psychoanalysis became the dominant conceptual framework in the United States. For a period of 30–40 years, nearly all the major leaders in American psychiatry embraced psychoanalytic principles and used them to shape psychiatric education and training. This created a new and different zeitgeist. A variety of changes occurred as a result of psychoanalytic dominance.

First, psychoanalysis led to a significant de-emphasis on diagnosis and nosology. As a consequence of work by Kraepelin, Bleuler, and others, a system for diagnosing and classifying psychiatric disorders had been developed in parallel with the development of psychoanalysis and was codified in both the *International Classification of Diseases* and the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) of the American Psychiatric Association. In general, the psychoanalytic movement considered diagnosis and classification to be a fruitless endeavor. Defining the nature and source of intrapsychic conflicts was the goal instead.

Second, psychoanalysis, therefore, also led to a significant de-emphasis on careful observation of signs and symptoms—the "bread and butter" of the early humanistic psychiatrists and the basis for developing a phenomenology. In fact, the psychoanalysts taught that the patient's self-report of both symptoms and other internal experiences should be discounted. The analyst must dig beneath self-report to reach the real truth.

While other countries also had prominent psychoanalysts and psychoanalytic movements, the US acceptance of psychoanalysis was extreme. This distanced most of American psychiatry from Anglo-European traditions and approaches, which continued to teach phenomemology and nosology.

However, a few American institutions maintained ties with Anglo-European psychiatry. The institutions have sometimes been called "the Mid-Atlantics." They included Washington University in St Louis, Johns Hopkins in Baltimore, Iowa Psychiatric Hospital in Iowa City, and New York Psychiatric Institute in New York City.

Despite their small numbers and relative isolation from the rest of American psychiatry, the Mid-Atlantics made some significant contributions to psychiatry during the 1970s. These included the development of the first set of diagnostic criteria,[8] the development of the Research Diagnostic Criteria and Schedule for Affective Disorders and Schizophrenia,[9] the development of other rating scales for psychopathology—eg, the Thought, Language, and Communication and Affect Rating Scales,[10–12] and the highly influential article of Robins and Guze on the validation of psychiatric diagnoses.[13]

In parallel, significant work was occurring in Europe and especially Great Britain, making the 1970s a time of reappraisal. The Present State Examination provided the international community with a structured interview that could be used to conduct a variety of epidemiological diagnostic studies.[14] Foremost among these were the International Pilot Study of Schizophrenia[15] and the US-UK study.[16,17] The results of these 2 major studies suggested that American psychiatrists were overdiagnosing mental illnesses in comparison with the rest of the world and not doing systematic clinical assessments and that their diagnoses and clinical assessments were not reliable.

Adding to the rising tide of criticism from the Mid-Atlantics was the publication in *Science* of *Being sane in insane places*.[18] This article reported that 8 sane "pseudopatients" were admitted to psychiatric hospitals with minimal to questionable psychiatric complaints (eg, hearing a voice saying "thud" on a few occasions); after admission, they denied any symptoms at all, behaved normally, rarely met with staff, and nonetheless remained in the hospital for an average of 19 days and were discharged with a diagnosis of schizophrenia in remission. Clearly American psychiatry was in a troubled state. It was time for a change. The Mid-Atlantics had their opportunity and began their charge.

The Development of *Diagnostic and Statistical Manual of Mental Disorders, Third Edition*: Lofty Goals

The changes that seemed to be obviously needed in the principles and practice of American psychiatry were created by the development and publication of a new *DSM*: *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (*DSM-III*). Bob Spitzer, then head of Biometrics at New York Psychiatric Institute, was appointed Chair. He assembled a Task Force comprised primarily of Mid-Atlantics. Their work began in the mid-70s and was culminated by the publication of *DSM-III* in 1980. At their first meeting, there was universal consensus among the Task Force members that *Diagnostic and Statistical Manual of Mental Disorders, Second Edition* (*DSM-II*) should be totally revised. *DSM-III* should be evidence based, use diagnostic criteria instead of general descriptions, and strive for maximal reliability. Principles of validity were also considered important, but much less emphasized; the approach was heavily influenced by the article of Robins and Guze on the validation of schizophrenia.[13] That article suggested that several different methods could be used to determine if a specific psychiatric disorder could be considered valid: familial aggregation, characteristic longitudinal course, response to treatment, and laboratory tests (rarely possible).

The Task Force articulated a group of lofty goals that shaped their efforts:

- To improve communication between clinicians

- To provide reliable diagnoses that would be useful in research
- To enhance teaching: to train psychiatry students in clinical interviewing and differential diagnosis
- To realign American psychiatry with the rest of the world and to be consistent with *International Classification of Diseases, Ninth Revision.*

To achieve these goals, they made major modifications in the old *DSM-II*. An extensive text was written for each of the disorders, expanding the length from 38 pages of *DSM-II* to 295 pages of *DSM-III*. As the writing evolved, Task Force members began to comment to one another that they were writing a new textbook of psychiatry. This new textbook contained a variety of new principles and innovations:

- Atheoretical about etiology (because for most diagnoses etiology is in fact unknown)
- Use of diagnostic criteria
- Dropping of the term "neurosis"
- Provision of a glossary to define the terms used in the criteria
- Multiaxial approach to classification in order to incorporate medical and psychosocial components of a clinical evaluation.

The Task Force members recognized that the increased simplicity and clarity could lead to abuses. Therefore, they filled the introduction with the caveats as follows:

- The problem of using the manual to set policies:

  > The use of this manual for non-clinical purposes, such as determination of legal responsibility, competency or insanity, or justification for third-party payment, must be critically examined in each instance with the appropriate institutional context.[19(p12)]

- The risk that *DSM* would be taken as the ultimate authority on diagnosis:

  > This final version of DSM-III is only one still frame in the ongoing process of attempting to better understand mental disorders.[19(p12)]

- The lack of adequate validation for the criteria:

  > DSM-III provides specific diagnostic criteria as guides for making each diagnosis since such criteria enhance interjudge reliability. It should be understood, however, that for most of the categories the diagnostic criteria are based on clinical judgment, and have not yet been fully validated by data about such important correlates as clinical course, outcome, family history, and treatment response. Undoubtedly, with further study the criteria for many of the categories will be revised.[19(p8)]

- The importance of going beyond *DSM* criteria in history taking:

  > Making a DSM-III diagnosis represents an initial step in a comprehensive evaluation leading to the formulation of a treatment plan. Additional information about the individual being evaluated beyond that required to make a DSM-III diagnosis will invariably be necessary.[19(p11)]

What Went Wrong? The Unintended Consequences

Although the authors of *DSM-III* knew that they were creating a small revolution in American psychiatry, they had no idea that it would become a large one and that it would ultimately change the nature and practice of the field. The American Psychiatric Association, which historically had published *DSM*, was caught completely off guard. Copies sold out immediately, and it took approximately 6 months to catch up with the orders that came flowing in. *DSM* was purchased by psychiatrists, nurses, social workers, lawyers, psychologists—anyone with any connection to psychiatry.

DSM-III and its successors, *Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition* and *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, became universally and uncritically accepted as the ultimate authority on psychopathology and diagnosis. *DSM* forms the basis for psychiatric teaching to both residents and undergraduates throughout most of the United States.

Knowledge of the criteria is the basis for most exams—even the Board Certification examinations taken after residency. As a consequence, classics in psychopathology are now largely ignored.

The ultimate painful paradox: the study of phenomenology and nosology that was so treasured by the Mid-Atlantics who created *DSM* is no longer seen as important or relevant. Research in psychopathology is a dying (or dead) enterprise.

How and why did this occur? What is wrong with *DSM*?

It is not difficult to come up with a list of obvious problems. First, the criteria include only some characteristic symptoms of a given disorder. They were never intended to provide a comprehensive description. Rather, they were conceived of as "gatekeepers"—the minimum symptoms needed to make a diagnosis. Because *DSM* is often used as a primary textbook or the major diagnostic resource in many clinical and research settings, students typically do not know about other potentially important or interesting signs and symptoms that are not included in *DSM*. Second, *DSM* has had a dehumanizing impact on the practice of psychiatry. History taking—the central evaluation tool in psychiatry—has frequently been reduced to the use of *DSM* checklists. *DSM* discourages clinicians from getting to know the patient as an individual person because of its dryly empirical approach. Third, validity has been sacrificed to achieve reliability. *DSM* diagnoses have given researchers a common nomenclature—but probably the wrong one. Although creating standardized diagnoses that would facilitate research was a major goal, *DSM* diagnoses are not useful for research because of their lack of validity.

These concerns led the author to write several editorials for the *American Journal of Psychiatry* about the current problems that have been created by *DSM*. Here are a few of Cassandra's complaints:

> In the United States an older generation of clinical researchers who led the field for many years have died—Eli Robins, Gerry Klerman, George Winokur. Very few younger investigators are emerging to replace them. The word is out—if you want to succeed as a serious scientist, you need to do something relatively basic. Fortunately, the Europeans still have a proud tradition of clinical research and descriptive psychopathology. Someday, in the 21st century, after the human genome and the human brain have been mapped, someone may need to organize a reverse Marshall plan so that the Europeans can save American science by helping us figure out who really has schizophrenia or what schizophrenia really is.[20]

> We need to make a serious investment in training a new generation of real experts in the science and art of psychopathology. Otherwise, we high-tech scientists may wake up in 10 years and discover that we face a silent spring. Applying technology without the companionship of wise clinicians with specific expertise in psychopathology will be a lonely, sterile, and perhaps fruitless enterprise.[21]

The creation of an international conference on phenomenology, as summarized in this issue, may help at least a bit to remedy the present situation.

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