A Cross-National View of DSM-III

Barry J. Gurian, M.B., M.R.C.P., D.P.M.
Lawrence Sharpe, M.B., D.P.M.
Biometrics Research, New York, N.Y.

The current glossary of terms pertaining to the diagnosis of mental disorders (DSM-III) is found inadequate to give clear and concise guidance to psychiatrists within one nation, and is even less adequate as a basis for international agreement. In many cases the British Glossary of Mental Disorders is found to be more precise.

This paper will present a critical assessment of DSM-III from a special viewpoint. The authors have received their psychiatric training in the United Kingdom, and have spent several years, as part of a project entitled Diagnosis of Mental Disorder in the United States and the United Kingdom, following, as a diagnostic guide, the British counterpart to DSM-II. In this article the British counterpart to DSM-II is called the British glossary, but in full it is known as Glossary of Mental Disorders, General Register Office, Studies on Medical and Population Subjects No. 22, Her Majesty’s Stationery Office.

The views expressed in this paper are thus likely to be British in character, and we will make special reference to those aspects of the description of diagnosis in DSM-III that seem at odds with our own view of these diagnoses. Since we do not wish to appear idiosyncratic in our views, we will back up our criticisms by invoking descriptive phrases from the British glossary of diagnostic terms.

We will focus our criticism on the sections of DSM-III covering the affective disorders (including the major affective disorders, reactive depressive psychosis and depressive neurosis) and the schizophrenias together with the paranoid states.

There is a good deal of evidence that American and British psychiatrists differ in their diagnostic usage, at least within the scope of the affective and schizophrenic disorders [1, 2, 4]. This area of disagreement is particularly important partly because in these disorders drug treatment plays a powerful role and the selection of the appropriate drug is determined by diagnosis. Also, the majority of patients hospitalized in state mental hospitals receive these diagnoses.

Affective Disorders

Narrow Concepts of Certain Diagnoses

American psychiatrists are less likely to place a patient in the category of (296.2) Manic-depressive illness, depressed type, than are their British colleagues. The implication that American psychiatrists have a relatively narrow concept of this category is borne out by the DSM-III description.

Only severe depression is mentioned. The protean manifestations of depressive mood change are neglected. No reference is made to the morbid changes of mood that can range from “minimal detectable
change to severe misery, gloom, wretchedness and many more too subtle to be described in a word" (British glossary). Furthermore, the description of this diagnosis in DSM-II omits mention of the physiological concomitants of depression such as sleep disturbance, early morning waking, loss of appetite and weight, and a reduction of libido. These physiological concomitants may be the most prominent indicators of a depressive mood in some patients and, indeed, play a large part in determining that a British psychiatrist diagnoses a major affective disorder rather than depressive neurosis. All in all, a psychiatrist following the guidelines of DSM-II is likely to diagnose fewer cases of manic-depressive illness, depressed type, than a British psychiatrist following his own bent or the guidelines of the British glossary.

A strikingly narrow concept is evident also in the description (296.1) Manic-depressive illness, manic type. Again, DSM-II gives short shrift to the range of moods possible. Only excessive elation is described. No recognition is given to the "infinite number of forms and shadings ranging from quiet, sunny good humor to boisterous elation" (British glossary). Furthermore, although manic-depressive illness, manic type, is easily misdiagnosed as schizophrenia because of the incoherence and paranoid delusions that may arise in both conditions, the frequent exhibition of these symptoms in manic states is not mentioned in the definition. This omission may well reinforce the tendency of American psychiatrists to overlook the diagnosis of manic-depressive illness, manic type, and to diagnose schizophrenia instead. Another factor mitigating against a diagnosis of manic-depressive illness, manic type, is the failure of DSM-II to include the admixture of depressive symptoms that frequently occur in this condition.

**Psychological Stress as a Criterion for Diagnosis**

DSM-II insists on excluding from the manic-depressive, depressive type, those conditions that are precipitated by psychological trauma; similarly, for involutional melancholia, Conditions that would otherwise be included beneath the above two categories of diagnosis are assigned to (296.0) Psychotic depressive reaction if a psychological precipitant has been disclosed. Whereas such firmness in constructing guidelines should lead to more reliable use of these categories, nonetheless it remains notoriously difficult to decide whether a life event has been a cause or an effect of a depressive state. Particularly confusing is the case of patients who have had several attacks of so-called endogenous depression and then become depressed apparently after an unpleasant life experience. It is only the clinician's personal prejudice that would determine whether this lifetime experience is regarded as coincidental or causal to the onset of depression. Probably because it is so difficult to make an assessment of the psychological impact of life events, the British glossary, like the British psychiatrist, minimizes where the DSM-II emphasizes the determining role of psychological stress.

It would be best to relieve the definitions of any dependence on uncertain etiology. Not only is the presence of such etiology difficult to assess but doubts about its relationship to the illness will be hard to settle if assumptions about the etiology are written into the definition of the diagnosis, instead of the etiology being tested as an independent variable.

**Broad Concept of Manic-Depressive Illness, Circular Type**

In contrast to the narrow definition of manic-depressive illness, depressed type, offered by DSM-II, the definition of (296.3)
Manic-depressive illness, circular type, seems far too broad to the British eye. The definition of this diagnosis requires only that a patient should have had "at least one attack of both a depressive episode and a manic episode." With a careful history, a very large number of patients with either a depressive or a manic present state would qualify for this rubric, making it merely a confusing coalition of these states. The British glossary sets rules that are much more circumscribed and easy to apply. According to the British glossary, patients qualify only if "phases of mania or hypomania regularly alternate unbrokenly with or without short intervening periods of normality [and] the intervening periods should not exceed one year." However, this latter definition is too exclusive to fit any but the rare patient so that both DSM-II and the British glossary appear to suffer from opposing evils. The former is too inclusive and the latter too exclusive.

Discouraging the Use of Certain Diagnoses

Favoring or disfavoring one diagnosis or the other may underlie differences in the scope of some of the diagnostic descriptions. These attitudes are, however, more blatant and explicit in the discouraging description of (296.0) Involutional melancholia, where DSM-II advises that "opinion is divided as to whether this psychosis can be distinguished from the other affective disorders" and further recommends "that involutional patients not be given this diagnosis unless all other affective disorders have been ruled out." These instructions are ambiguous, presumptive, and prejudicial, and out of place in a glossary.

Schizophrenia

Prognosis as a Discriminator of Diagnosis

DSM-II gives little space to prognosis as a feature distinguishing the schizophrenias from the major affective disorders. Manic-depressive illness, depressed type, is described merely as having a tendency to remission and recurrence and no mention of prognosis is made in the schizophrenias. British psychiatrists tend to regard the prognosis of major affective disorder as favorable and of schizophrenia (schizo-affective type expected) as decidedly gloomy. This emphasis on prognosis colors the definition of these disorders in the British glossary and might make a psychiatrist hesitate in labeling a patient schizophrenic. The more neutral tone on DSM-II probably unburdens the psychiatrist of scruples about diagnosing patients schizophrenic and allows him to be objective in making his diagnosis.

Differential Diagnosis

Another praiseworthy aspect of DSM-II is the attention paid to differential diagnosis. Such attention is sadly lacking in the British glossary. Guidance given about differential diagnosis is the best way of indicating to the clinician those parts of a description that are most important for identifying a diagnosis.

Examples of differential diagnosis are easy to find in DSM-II, especially in the section on schizophrenia. The introductory section of this category points out that the schizophrenias are "attributable primarily to a thought disorder [and] are to be distinguished from the major illnesses which are dominated by a mood disorder." The (297) Paranoid states, on the other hand, are "distinguished by the narrowness of their distortions of reality and by the absence of other psychotic symptoms." In the definitions of the (295.0) Simple type of schizophrenia a contrast is drawn with hebephrenic, catatonic, and paranoid types, which are more dramatically psychotic, and with schizoid personality, in which there is little or no progression of the symptoms. In

...
the definition of (295.3) Paranoïd type of schizophrenia the relative preservation of personality is given as an aid in differentiation of this diagnosis from the hebephrenic and catatonic types. The acute onset of (295.4) Acute schizophrenic episode is stated to distinguish this diagnosis from the simple type of schizophrenia.

Imprecise Terms
While differential diagnosis in DSM-II helps the diagnosticians, the use of many imprecise terms does nothing but confuse him. The worst offender is the term “psychosis,” which plays a critical role in descriptions of several diagnoses. In (295.5) Schizophrenia, latent type, this category is described as being reserved for patients with “no history of a psychotic schizophrenic episode.” In (295.6) Schizophrenia, residual type, the patients are described as “no longer psychotic.” In addition, a fifth digit may be used to delineate whether an illness is “not psychotic or not presently psychotic”. However, the definition of psychotic seems difficult to apply with any confidence.

“Patients are described as psychotic when their mental functioning is sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life.” Such mental functions appear to include perception, judgment, memory, and “capacity to respond appropriately.” By this token a patient who has an encapsulated paranoïd delusion and is managing to hold down a job might not be regarded as psychotic. If, however, during an economic slump, he were to lose his job, he might then be regarded as psychotic.

These switches in diagnosis, occasioned by the use of the term “psychosis” as a criterion for a diagnosis, appear to be unduly arbitrary. Furthermore, there are other difficulties arising from the imprecise definition given of psychosis. It is hard to judge whether impairment of social functioning is primarily a result of the patient’s “mental functioning” or of socioeconomic factors; no guidance is given as to the recognition of “gross interference” as opposed to lesser levels of interference with the patient’s social functioning; and reference to the “ordinary demands of life” leave unclear whether such demands include, for instance, being kind and loving to one’s wife. The descriptions of diagnosis in the British glossary have been purged of the term “psychotic” and we recommend that DSM-II be similarly exorcised.

There are other terms in DSM-II that are most unlikely to have a precise meaning for psychiatrists from diverse theoretical backgrounds. In the definition of (295.1) Schizophrenia, hebephrenic type, “this psychosis is characterized by ... regressive behavior.” As the form of the regression is not specified, some psychiatrists might be uncertain whether to interpret “regression” as referring, for instance, to childish attention-seeking and pranks, or to some esoterically specific behavior. In (295) Schizophrenia (Introductory paragraph), it is stated that “disturbances in thinking ... may lead ... sometimes to delusion and hallucinations, which frequently appear psychologically self-protective.” The phrase that we underlined may mean so little to some psychiatrists that no damage would be done to the picture he builds up of patients who fit this broad category. Some psychiatrists would, however, be unsure whether it included, for instance, grandiose delusions, such as might appear in manic-depressive illness, manic type. Grandiose delusions might no doubt be construed as protecting the patient’s self-esteem.

Discussion
Even were psychiatrists to use an ideal glossary of diagnoses there would be many sources from which disagreements would arise about diagnosis. Interview style, perception of psychopathology [5, 6], nor-
nate standards, and psychiatric vocabulary
would thereby produce disagreements among
those psychiatrists about the psychopathol-
gy, and consequently the diagnosis, shown
by a patient. A glossary can never overcome
this type of disagreement; but it can and
should provide clear and complete guidance
on assigning patients to the same diagnostic
category when psychiatrists agree about the
psychopathology shown by a patient.

The influence of inadequacies in the noso-
logical system arising largely from the defi-
nitions of diagnostic categories was found
by Ward [7] to account for 62.5 percent of
disagreements in diagnoses. This held true
for psychiatrists who were using the previous
American glossary, DSM-I (Diagnostic and
Statistical Manual: Mental Disorders. First
edition. American Psychiatric Association,
1952), and who had arrived at “consensus
regarding the specific criteria for each of the
nosological entities.” Sixteen years later it
remains doubtful whether the current gloss-
ary, DSM-II, serves the function of clear
and complete guidance, even for psychia-
trists within one nation. Still more doubtful
is whether DSM-II would be satisfactory for
obtaining agreement on an international
scale, on which contrasts in traditions of
psychiatric diagnosis have to be taken into
account.

References
1. Cooper, J. E., R. E. Kendell, B. J. Gurland, N.
Sarkies, and T. Paskas, “Cross-National Study
of Diagnosis of the Mental Disorders: Some Re-
sults from the First Comparative Investigation,”
2. Gurland, B. J., J. L. Fleiss, J. E. Cooper, R. E.
Kendell, and R. Simon, “Cross-National Study of
Diagnosis of the Mental Disorders: Some Com-
parisons of Diagnostic Criteria from the First
Investigation,” American Journal of Psychiatry,
3. Kendell, R. E., J. Goullay, and J. E. Cooper,
“Differences in American and British Usage of
Key Diagnostic Terms,” paper presented at the
annual meeting of the American Psychiatric As-
sociation, May 9, 1969.
Research Suggested by Observations on Differences
in First Admission Rates to Mental Hospitals of
England and Wales and of the United States,” in
Proceedings of the Third World Congress of
Psychiatry (Montreal: University of Toronto
Press/McGill University Press, 1964), Vol. 3,
5. Sandifer, M. C., A. Horrinen, G. C. Timbury, and
L. M. Green, “Psychiatric Diagnosis: A Compara-
tive Study in North Carolina, London and Glas-
Fleiss, “Two-Psychiatric Communication in Psychi-
atriy,” paper presented at the Annual Meeting of
the American Psychiatric Association, May 9,
1969.
MocX, and J. K. Erbaugh, “The Psychiatric No-
menclature: Reasons for Diagnostic Disagreement,”