Diagnostic and Statistical Manual of Mental Disorders

(Third Edition)

DSM-III

American Psychiatric Association

Introduction

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This is the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association, better known simply as DSM-III. The development of this manual over the last five years has not gone unnoticed; in fact, it is remarkable how much interest (alarm, despair, excitement, joy) has been shown in successive drafts of this document. The reasons for this interest are many.

First of all, over the last decade there has been growing recognition of the importance of diagnosis for both clinical practice and research. Clinicians and research investigators must have a common language with which to communicate about the disorders for which they have professional responsibility. Planning a treatment program must begin with an accurate diagnostic assessment. The efficacy of various treatment modalities can be compared only if patient groups are described using diagnostic terms that are clearly defined.

Secondly, from its very beginning, drafts of DSM-III have been widely circulated for critical review and use by clinicians and investigators. This made them aware of the many fundamental ways in which DSM-III differs from its predecessor, DSM-II, and from its international contemporary, the mental disorders chapter of the ninth revision of the *International Classification of Diseases* (ICD-9). For example, DSM-III includes such new features as diagnostic criteria, a multiaxial approach to evaluation, much-expanded descriptions of the disorders and many additional categories (some with newly-coined names); and it does not include several time-honored categories.

Finally, interest in the development of this manual is due to awareness that DSM-III reflects an increased commitment in our field to reliance on data as the basis for understanding mental disorders.

BACKGROUND*

The first edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* appeared in 1952. This was the first official manual of mental disorders to contain a glossary of descriptions of the diagnostic categories. The use of the term "reaction" throughout the classification reflected the influence of Adolf Meyer's psychobiological view that mental disorders represented reactions of the personality to psychological, social, and biological factors. In the development of the second edition (DSM-II), a decision was made to base the classification on the mental disorders section of the eighth revision of the *International Classification of Diseases*, for which representatives of the American Psychiatric Association had provided consultation. Both DSM-II and

* Some readers may wish, for now, to skip *Background* and *The Process of Development of DSM-III* and plunge directly into *Basic Concepts* on p.5.

Other specific affective disorders
301.13 Cyclothymic disorder
300.40 Dysthymic disorder (or Depressive neurosis)

Atypical affective disorders
296.70 Atypical bipolar disorder
296.82 Atypical depression

ANXIETY DISORDERS

Phobic disorders (or Phobic neuroses)
300.21 Agoraphobia with panic attacks
300.22 Agoraphobia without panic attacks
300.23 Social phobia
300.29 Simple phobia

Anxiety states (or Anxiety neuroses)
300.01 Panic disorder
300.02 Generalized anxiety disorder
300.30 Obsessive compulsive disorder (or Obsessive compulsive neurosis)

Post-traumatic stress disorder
308.30 acute
309.81 chronic or delayed

300.00 Atypical anxiety disorder

SOMATOFORM DISORDERS
300.81 Somatization disorder
300.11 Conversion disorder (or Hysterical neurosis, conversion type)
307.80 Psychogenic pain disorder
300.70 Hypochondriasis (or Hypochondriacal neurosis)
300.70 Atypical somatoform disorder (300.71)

DISSOCIATIVE DISORDERS (OR HYSTERICAL NEUROSES, DISSOCIATIVE TYPE)
300.12 Psychogenic amnesia
300.13 Psychogenic fugue
300.14 Multiple personality
300.60 Depersonalization disorder (or Depersonalization neurosis)
300.15 Atypical dissociative disorder

PSYCHOSEXUAL DISORDERS
Gender identity disorders
Indicate sexual history in the fifth digit of Transsexualism code: 1 = asexual, 2 = homosexual, 3 = heterosexual, 0 = unspecified.

302.5x Transsexualism, _____
302.60 Gender identity disorder of childhood
302.85 Atypical gender identity disorder

Paraphilias

302.81 Fetishism
302.30 Transvestism
302.10 Zoophilia
302.20 Pedophilia
302.40 Exhibitionism
302.82 Voyeurism
302.83 Sexual masochism
302.84 Sexual sadism
302.90 Atypical paraphilia

Psychosexual dysfunctions

302.71 Inhibited sexual desire
302.72 Inhibited sexual excitement
302.73 Inhibited female orgasm
302.74 Inhibited male orgasm
302.75 Premature ejaculation
302.76 Functional dyspareunia
306.51 Functional vaginismus
302.70 Atypical psychosexual dysfunction

Other psychosexual disorders

302.00 Ego-dystonic homosexuality
302.89 Psychosexual disorder not elsewhere classified

FACTITIOUS DISORDERS

300.16 Factitious disorder with psychological symptoms
301.51 Chronic factitious disorder with physical symptoms
300.19 Atypical factitious disorder with physical symptoms

DISORDERS OF IMPULSE CONTROL NOT ELSEWHERE CLASSIFIED

312.31 Pathological gambling
312.32 Kleptomania
312.33 Pyromania
312.34 Intermittent explosive disorder
312.35 Isolated explosive disorder
312.39 Atypical impulse control disorder

Psychosexual Disorders

The name for this diagnostic class emphasizes that psychological factors are assumed to be of major etiological significance in the development of the disorders listed here. Disorders of sexual functioning that are caused exclusively by organic factors, even though they may have psychological consequences, are not listed in this classification. For example, impotence due to spinal-cord injury is coded on Axis III as a physical disorder, and the psychological reaction to that condition could be coded as an Adjustment Disorder, or some other suitable category, on Axis I.

The Psychosexual Disorders are divided into four groups. The Gender Identity Disorders are characterized by the individual's feelings of discomfort and inappropriateness about his or her anatomic sex and by persistent behaviors generally associated with the other sex. The Paraphilias are characterized by arousal in response to sexual objects or situations that are not part of normative arousal-activity patterns and that in varying degrees may interfere with the capacity for reciprocal affectionate sexual activity. The Psychosexual Dysfunctions are characterized by inhibitions in sexual desire or the psychophysiological changes that characterize the sexual response cycle. Finally, there is a residual class of Other Psychosexual Disorders that has two categories: Ego-dystonic Homosexuality and a final residual category, Psychosexual Disorders Not Elsewhere Classified.

GENDER IDENTITY DISORDERS

The essential feature of the disorders included in this subclass is an incongruence between anatomic sex and gender identity. Gender identity is the sense of knowing to which sex one belongs, that is, the awareness that "I am a male," or "I am a female." Gender identity is the private experience of gender role, and gender role is the public expression of gender identity. Gender role can be defined as everything that one says and does, including sexual arousal, to indicate to others or to the self the degree to which one is male or female.

Disturbance in gender identity is rare, and should not be confused with the far more common phenomena of feelings of inadequacy in fulfilling the expectations associated with one's gender role. An example would be an individual who perceives himself or herself as being sexually unattractive yet experiences himself or herself unambiguously as a man or woman in accordance with his or her anatomic sex.

302.5x Transsexualism

The essential features of this heterogeneous disorder are a persistent sense of discomfort and inappropriateness about one's anatomic sex and a persistent wish

302.70 Atypical Psychosexual Dysfunction

This category is for Psychosexual Dysfunctions that cannot be classified as a specific Psychosexual Dysfunction. An example would be no erotic sensations or even complete anesthesia despite normal physiological components of sexual excitement and orgasm. Another example would be a female analogue of Premature Ejaculation.

OTHER PSYCHOSEXUAL DISORDERS

302.00 Ego-dystonic Homosexuality

The essential features are a desire to acquire or increase heterosexual arousal, so that heterosexual relationships can be initiated or maintained, and a sustained pattern of overt homosexual arousal that the individual explicitly states has been unwanted and a persistent source of distress.

This category is reserved for those homosexuals for whom changing sexual orientations is a persistent concern, and should be avoided in cases where the desire to change sexual orientations may be a brief, temporary manifestation of an individual's difficulty in adjusting to a new awareness of his or her homosexual impulses.

Individuals with this disorder may have either no or very weak heterosexual arousal. Typically there is a history of unsuccessful attempts at initiating or sustaining heterosexual relationships. In some cases no attempt has been made to initiate a heterosexual relationship because of the expectation of lack of sexual responsiveness. In other cases the individual has been able to have short-lived heterosexual relationships, but complains that the heterosexual impulses are too weak to sustain such relationships. When the disorder is present in an adult, usually there is a strong desire to be able to have children and family life.

Generally individuals with this disorder have had homosexual relationships, but often the physical satisfaction is accompanied by emotional upset because of strong negative feelings regarding homosexuality. In some cases the negative feelings are so strong that the homosexual arousal has been confined to fantasy.

Associated features. Loneliness is particularly common. In addition, guilt, shame, anxiety, and depression may be present.

Age at onset. The most common age at onset is during early adolescence when the individual becomes aware that he or she is homosexually aroused and has already internalized negative feelings about homosexuality.

Course. There is some evidence that in time many individuals with this disorder give up the yearning to become heterosexual and accept themselves as homosexuals. This process is apparently facilitated by the presence of a supportive homosexual subculture. It is not known how often the disorder, without treatment, is self-limited. However, there is a general consensus that spontaneous development of a satisfactory heterosexual adjustment in individuals who previously had a sustained pattern of exclusively homosexual arousal is rare.

The extent to which therapy is able to decrease homosexual arousal, increase heterosexual arousal, or help homosexuals become satisfied with their sexuality is disputed.

Impairment. There is generally no or only mild impairment in social functioning.

Complications. Dysthymic Disorder can be a complication.

Predisposing factors. Since homosexuality itself is not considered a mental disorder, the factors that predispose to homosexuality are not included in this section. The factors that predispose to Ego-dystonic Homosexuality are those negative societal attitudes toward homosexuality that have been internalized. In addition, features associated with heterosexuality, such as having children and socially sanctioned family life, may be viewed as desirable and incompatible with a homosexual arousal pattern.

Prevalence, sex ratio, and familial pattern. No information.

Differential diagnosis. Homosexuality that is ego-syntonic is not classified as a mental disorder. In addition, the attitude that "I guess life would be easier if I were heterosexual" does not warrant this diagnosis. This category is reserved for homosexuals for whom changing sexual orientations is a persistent concern. Similarly, distress resulting simply from a conflict between a homosexual and society should not be classified here.

Individuals with **Inhibited Sexual Desire** may sometimes attribute the lack of sexual arousal to "latent homosexuality." However, Ego-dystonic Homosexuality should be diagnosed only when homosexual arousal is overt, although it may be limited to fantasy.

Homosexuals who develop a Major Depression may then express self-hatred because of their sexual orientation. The diagnosis of Ego-dystonic Homosexuality should not be made if the ego-dystonic quality is judged to be only a transient symptom of a Depressive Disorder.

Diagnostic criteria for Ego-dystonic Homosexuality

A. The individual complains that heterosexual arousal is persistently absent or weak and significantly interferes with initiating or maintaining wanted heterosexual relationships.

B. There is a sustained pattern of homosexual arousal that the individual explicitly states has been unwanted and a persistent source of distress.

302.89 Psychosexual Disorder Not Elsewhere Classified

This is a residual category for disorders whose chief manifestations are psychological disturbances related to sexuality not covered by any of the other