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How one man revolutionized psychiatry.

by Alix Spiegel

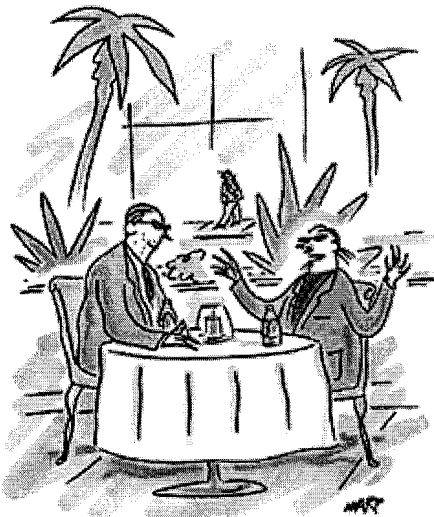
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In the mid-nineteen-forties, Robert Spitzer, a mathematically minded boy of fifteen, began weekly sessions of Reichian psychotherapy. Wilhelm Reich was an Austrian psychoanalyst and a student of Sigmund Freud who, among other things, had marketed a device that he called the orgone accumulator—an iron appliance, the size of a telephone booth, that he claimed could both enhance sexual powers and cure cancer. Spitzer had asked his parents for permission to try Reichian analysis, but his parents had refused—they thought it was a sham—and so he decided to go to the sessions in secret. He paid five dollars a week to a therapist on the Lower East Side of Manhattan, a young man willing to talk frankly about the single most compelling issue Spitzer had yet encountered: women. Spitzer found this methodical approach to the enigma of attraction both soothing and invigorating. The real draw of the therapy, however, was that it greatly reduced Spitzer's anxieties about his troubled family life: his mother was a “professional patient” who cried continuously, and his father was cold and remote. Spitzer, unfortunately, had inherited his mother's unruly inner life and his father's repressed affect; though he often found himself overpowered by emotion, he was somehow unable to express his feelings. The sessions helped him, as he says, “become alive,” and he always looked back on them with fondness. It was this experience that confirmed what would become his guiding principle: the best way to master the wilderness of emotion was through systematic study and analysis.

Robert Spitzer isn't widely known outside the field of mental health, but he is, without question, one of the most influential psychiatrists of the twentieth century. It was Spitzer who took the *Diagnostic and Statistical Manual of Mental Disorders*—the official listing of all mental diseases recognized by the American Psychiatric Association (A.P.A.)—and established it as a scientific instrument of enormous power. Because insurance companies now require a *DSM* diagnosis for reimbursement, the manual is mandatory for any mental-health professional seeking compensation. It's also used by the court system to help determine insanity, by social-services agencies, schools, prisons, governments, and, occasionally, as a plot device on “The Sopranos.” This magnitude of cultural authority, however, is

a relatively recent phenomenon. Although the *DSM* was first published in 1952 and a second edition (*DSM-II*) came out in 1968, early versions of the document were largely ignored. Spitzer began work on the third version (*DSM-III*) in 1974, when the manual was a spiral-bound paperback of a hundred and fifty pages. It provided cursory descriptions of about a hundred mental disorders, and was sold primarily to large state mental institutions, for three dollars and fifty cents. Under Spitzer's direction—which lasted through the *DSM-III*, published in 1980, and the *DSM-III-R* ("R" for "revision"), published in 1987—both the girth of the *DSM* and its stature substantially increased. It is now nine hundred pages, defines close to three hundred mental illnesses, and sells hundreds of thousands of copies, at eighty-three dollars each. But a mere description of the physical evolution of the *DSM* doesn't fully capture what Spitzer was able to accomplish. In the course of defining more than a hundred mental diseases, he not only revolutionized the practice of psychiatry but also gave people all over the United States a new language with which to interpret their daily experiences and tame the anarchy of their emotional lives.



"But in my screenplay, the young female P.O.W. is in the shower when her rescuers arrive."

The Biometrics Department of the New York State Psychiatric Institute at Columbia Presbyterian Medical Center is situated in an imposing neo-Gothic building on West 168th Street. I met Spitzer in the lobby, a sparsely decorated and strangely silent place that doesn't seem to get much use. Spitzer, a tall, thin man with well-cut clothes and a light step, was brought up on the Upper West Side. He is in his seventies but seems much younger; his graying hair is dyed a deep shade of brown. He has worked at Columbia for more than forty years, and his office is filled with the debris of decades. Calligraphed certificates with seals of red and gold cover the walls, and his desk is overwhelmed by paper.

Spitzer first came to the university as a resident and student at the Columbia Center for Psychoanalytic Training and Research, after graduating from N.Y.U. School of Medicine in 1957. He had had a brilliant medical-school career, publishing in professional journals a series of well-received papers about childhood schizophrenia and reading disabilities. He had also established himself outside the academy, by helping to discredit his erstwhile hero Reich. In addition to his weekly sessions on the Lower East Side, the teen-age Spitzer had persuaded another Reichian doctor to give him free access to an orgone accumulator, and he spent many hours sitting hopefully on the booth's tiny stool, absorbing healing orgone energy, to no obvious avail. In time, he became disillusioned, and in college he wrote a paper critical of the therapy, which was consulted by the Food and Drug Administration when they later prosecuted Reich for fraud.

At Columbia Psychoanalytic, however, Spitzer's career faltered. Psychoanalysis was too abstract, too theoretical, and somehow his patients rarely seemed to improve. "I was always unsure that I was being helpful, and I was uncomfortable with not knowing what to do with their messiness," he told me. "I don't think I was uncomfortable listening and empathizing—I just didn't know what the hell to do." Spitzer managed to graduate, and secured a position as an instructor in the psychiatry department (he has held some version of the job ever since), but he is a man of

tremendous drive and ambition—also a devoted contrarian—and he found teaching intellectually limiting. For satisfaction, he turned to research. He worked on depression and on diagnostic interview techniques, but neither line of inquiry produced the radical innovation or epic discovery that he would need to make his name.

As Spitzer struggled to find his professional footing in the nineteen-sixties, the still young field of psychiatry was also in crisis. The central issue involved the problem of diagnosis: psychiatrists couldn't seem to agree on who was sick and what ailed them. A patient identified as a textbook hysteric by one psychiatrist might easily be classified as a hypochondriac depressive by another. Blame for this discrepancy was assigned to the *DSM*. Critics claimed that the manual lacked what in the world of science is known as "reliability"—the ability to produce a consistent, replicable result—and therefore also lacked scientific validity. In order for any diagnostic instrument to be considered useful, it must have both. The S.A.T., for example, is viewed as reliable because a person who takes the test on a Tuesday and gets a score of 1200 will get a similar score if he takes the test on a Thursday. It is considered valid because scores are believed to correlate with an external reality—"scholastic aptitude"—and the test is seen as predictive of success in an academic setting. Though validity is the more important measure, it is impossible to achieve validity without reliability: if you take the S.A.T. on a Tuesday and get a 1200 and repeat it on a Thursday and get a 600, the test is clearly not able to gauge academic performance. Reliability, therefore, is the threshold standard.

Problems with the reliability of psychiatric diagnosis became evident during the Second World War, when the military noticed that medical boards in different parts of the country had dramatically different rejection rates for men attempting to enlist. A draft board in Wichita, say, might have a twenty-per-cent exclusion rate, while Baltimore might find sixty per cent of its applicants unfit for service. Much of the disparity was on psychiatric grounds, and this was puzzling. It seemed implausible that the mental stability of potential recruits would vary so greatly from one area to another. A close study of the boards eventually determined that the psychiatrists responsible for making the decisions had widely divergent criteria. So a hypothesis emerged: perhaps it was not the young men but the doctors who were the problem.

In 1949, the psychologist Philip Ash published a study showing that three psychiatrists faced with a single patient, and given identical information at the same moment, were able to reach the same diagnostic conclusion only twenty per cent of the time. Aaron T. Beck, one of the founders of cognitive behavioral therapy, published a similar paper on reliability in 1962. His review of nine different studies found rates of agreement between thirty-two and forty-two per cent. These were not encouraging numbers, given that diagnostic reliability isn't merely an academic issue: if psychiatrists can't agree on a patient's condition, then they can't agree on the treatment of that condition, and, essentially, there's no relationship between diagnosis and cure. In addition, research depends on doctors' ability to form homogeneous subject groups. How can you test the effectiveness of a new drug to treat depression if you can't be sure that the person you're testing is suffering from that disorder? Allen Frances, who worked under Spitzer on the *DSM-III* and who, in 1987, was appointed the director of the *DSM-IV*, says, "Without reliability the system is completely random, and the diagnoses mean almost nothing—maybe worse than nothing, because they're falsely labelling. You're better off not having a diagnostic system."

Spitzer had no particular interest in psychiatric diagnosis, but in 1966 he happened to share a lunch table in the Columbia cafeteria with the chairman of the *DSM-II* task force. The two struck up a conversation, got along well, and by the end of the meal Spitzer had been offered the job of note-taker on the *DSM-II* committee. He accepted it, and served ably. He was soon promoted, and when gay activists began to protest the designation of homosexuality as a pathology Spitzer brokered a compromise that eventually resulted in the removal of homosexuality from the *DSM*. Given the acrimony surrounding the subject, this was an impressive feat of nosological diplomacy, and in the early seventies, when another revision of the *DSM* came due, Spitzer was asked to be the chairman of the task force.

Today, the chair of the *DSM* task force is a coveted post—people work for years to position themselves as candidates—but in the early nineteen-seventies descriptive psychiatry was a backwater. Donald Klein, a panic expert at Columbia, who contributed to the *DSM-III*, says, "When Bob was appointed to the *DSM-III*, the job was of no consequence. In fact, one of the reasons Bob got the job was that it wasn't considered that important. The vast majority of psychiatrists, or for that matter the A.P.A., didn't expect anything to come from it." This attitude was particularly prevalent among Freudian psychoanalysts, who were the voice of the mental-health profession for much of the twentieth century. They saw descriptive psychiatry as narrow, bloodless, and without real significance. "Psychoanalysts dismiss symptoms as being unimportant, and they say that the real thing is the internal conflicts," Klein says. "So to be

interested in descriptive diagnosis was to be superficial and a little bit stupid.”

Spitzer, however, managed to turn this obscurity to his advantage. Given unlimited administrative control, he established twenty-five committees whose task it would be to come up with detailed descriptions of mental disorders, and selected a group of psychiatrists who saw themselves primarily as scientists to sit on those committees. These men and women came to be known in the halls of Columbia as *dops*, for “data-oriented people.” They were deeply skeptical of psychiatry’s unquestioning embrace of Freud. “Rather than just appealing to authority, the authority of Freud, the appeal was: Are there studies? What evidence is there?” Spitzer says. “The people I appointed had all made a commitment to be guided by data.” Like Spitzer, Jean Endicott, one of the original members of the *DSM-III* task force, felt frustrated with the rigid dogmatism of psychoanalysis. She says, “For us *dops*, it was like, Come on—let’s get out of the nineteenth century! Let’s move into the twentieth, maybe the twenty-first, and apply what we’ve learned.”

There was just one problem with this utopian vision of better psychiatry through science: the “science” hadn’t yet been done. “There was very little systematic research, and much of the research that existed was really a hodgepodge—scattered, inconsistent, and ambiguous,” Theodore Millon, one of the members of the *DSM-III* task force, says. “I think the majority of us recognized that the amount of good, solid science upon which we were making our decisions was pretty modest.” Members of the various committees would regularly meet and attempt to come up with more specific and comprehensive descriptions of mental disorders. David Shaffer, a British psychiatrist who worked on the *DSM-III* and the *DSM-III-R*, told me that the sessions were often chaotic. “There would be these meetings of the so-called experts or advisers, and people would be standing and sitting and moving around,” he said. “People would talk on top of each other. But Bob would be too busy typing notes to chair the meeting in an orderly way.” One participant said that the haphazardness of the meetings he attended could be “disquieting.” He went on, “Suddenly, these things would happen and there didn’t seem to be much basis for it except that someone just decided all of a sudden to run with it.” Allen Frances agrees that the loudest voices usually won out. Both he and Shaffer say, however, that the process designed by Spitzer was generally sound. “There was not another way of doing it, no extensive literature that one could turn to,” Frances says. According to him, after the meetings Spitzer would retreat to his office to make sense of the information he’d collected. “The way it worked was that after a period of erosion, with different opinions being condensed in his mind, a list of criteria would come up,” Frances says. “It would usually be some combination of the accepted wisdom of the group, as interpreted by Bob, with a little added weight to the people he respected most, and a little bit to whoever got there last.”

Because there are very few records of the process, it’s hard to pin down exactly how Spitzer and his staff determined which mental disorders to include in the new manual and which to reject. Spitzer seems to have made many of the final decisions with minimal consultation. “He must have had some internal criteria,” Shaffer says. “But I don’t always know what they were.” One afternoon in his office at Columbia, I asked Spitzer what factors would lead him to add a new disease. “How logical it was,” he said, vaguely. “Whether it fit in. The main thing was that it had to make sense. It had to be logical.” He went on, “For most of the categories, it was just the best thinking of people who seemed to have expertise in the area.”

Not every mental disorder made the final cut. For instance, a group of child psychiatrists aspired to introduce a category they called “atypical child”—an idea that, according to Spitzer, didn’t survive the first meeting. “I kept saying, ‘O.K., how would you define “atypical child”?’ And the answer was ‘Well, it’s very difficult to define, because these kids are all very different.’” As a general rule, though, Spitzer was more interested in including mental disorders than in excluding them. “Bob never met a new diagnosis that he didn’t at least get interested in,” Frances says. “Anything, however against his own leanings that might be, was a new thing to play with, a new toy.” In 1974, Roger Peele and Paul Luisada, psychiatrists at St. Elizabeths Hospital, in Washington, D.C., wrote a paper in which they used the term “hysterical psychoses” to describe the behavior of two kinds of patients they had observed: those who suffered from extremely short episodes of delusion and hallucination after a major traumatic event, and those who felt compelled to show up in an emergency room even though they had no genuine physical or psychological problems. Spitzer read the paper and asked Peele and Luisada if he could come to Washington to meet them. During a forty-minute conversation, the three decided that “hysterical psychoses” should really be divided into two disorders. Short episodes of delusion and hallucination would be labelled “brief reactive psychosis,” and the tendency to show up in an emergency room without authentic cause would be called “factitious disorder.” “Then Bob asked for a typewriter,” Peele says. To Peele’s surprise, Spitzer drafted the definitions on the spot. “He banged out criteria sets for factitious

disorder and for brief reactive psychosis, and it struck me that this was a productive fellow! He comes in to talk about an issue and walks away with diagnostic criteria for two different mental disorders!" Both factitious disorder and brief reactive psychosis were included in the *DSM-III* with only minor adjustments.

The process of identifying new disorders wasn't usually so improvisatory, though, and it is certain that psychiatric treatment was significantly improved by the designation of many of the new syndromes. Attention-deficit disorder, autism, anorexia nervosa, bulimia, panic disorder, and post-traumatic stress disorder are all examples of diseases added during Spitzer's tenure which now receive specialized treatment. But by far the most radical innovation in the new *DSM*—and certainly the one that got the most attention in the psychiatric community—was that, alongside the greatly expanded prose descriptions for each disorder, Spitzer added a checklist of symptoms that should be present in order to justify a diagnosis. For example, the current *DSM* describes a person with obsessive-compulsive personality disorder as someone who:

- is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost. . . .
- is unable to discard worn-out or worthless objects even when they have no sentimental value. . . .
- adopts a miserly spending style towards both self and others.

Five other criteria are listed in a box beneath the description of the disorder, and clinicians are cautioned that at least four of the eight must be present in order for the label to be applied.

Finally, Spitzer and the dops argued, here was the answer to the problem of reliability, the issue that had bedevilled psychiatry for years. As they understood it, there were two reasons that doctors couldn't agree on a diagnosis. The first was informational variance: because of rapport or interview style, different doctors get different information from the same patient. The second was interpretive variance: each doctor carries in his mind his own definition of what a specific disease looks like. One goal of the *DSM-III* was to reduce interpretive variance by standardizing definitions. Spitzer's team reasoned that if a clear set of criteria were provided, diagnostic reliability would inevitably improve. They also argued that the criteria would enable mental-health professionals to communicate, and greatly facilitate psychiatric research. But the real victory was that each mental disorder could now be identified by a foolproof little recipe.

Spitzer labored over the *DSM-III* for six years, often working seventy or eighty hours a week. "He's kind of an idiot savant of diagnosis—in a good sense, in the sense that he never tires of it," Allen Frances says. John Talbott, a former president of the American Psychiatric Association, who has been friends with Spitzer for years, says, "I remember the first time I saw him walk into a breakfast at an A.P.A. meeting in a jogging suit, sweating, and having exercised. I was taken aback. The idea that I saw Bob Spitzer away from his suit and computer was mind-shattering." But Spitzer's dedication didn't always endear him to the people he worked with. "He was famous for walking down a crowded hallway and not looking left or right or saying anything to anyone," one colleague recalled. "He would never say hello. You could stand right next to him and be talking to him and he wouldn't even hear you. He didn't seem to recognize that anyone was there."

Despite Spitzer's genius at describing the particulars of emotional behavior, he didn't seem to grasp other people very well. Jean Endicott, his collaborator of many years, says, "He got very involved with issues, with ideas, and with questions. At times he was unaware of how people were responding to him or to the issue. He was surprised when he learned that someone was annoyed. He'd say, 'Why was he annoyed? What'd I do?'" After years of confrontations, Spitzer is now aware of this shortcoming, and says that he struggles with it in his everyday life. "I find it very hard to give presents," he says. "I never know what to give. A lot of people, they can see something and say, 'Oh, that person would like that.' But that just doesn't happen to me. It's not that I'm stingy. I'm just not able to project what they would like." Frances argues that Spitzer's emotional myopia has benefitted him in his chosen career: "He doesn't understand people's emotions. He knows he doesn't. But that's actually helpful in labelling symptoms. It provides less noise."

What may have been a professional strength had disruptive consequences in Spitzer's personal life. In 1958, he married a doctor, and they had two children. As the demands of his project mounted, he spent less and less time with his family, and eventually fell in love with Janet Williams, an attractive, outspoken social worker he had hired to help edit the manual. In 1979, he and his wife separated, and several years later Spitzer and Williams were married. Williams became a professor at Columbia, and she and Spitzer went on to have three children. Spitzer remained close

to his oldest son, but his relationship with his daughter from his first marriage was initially strained by the divorce.

The *DSM* was scheduled to be published in 1980, which meant that Spitzer had to have a draft prepared in the spring of 1979. Like any major American Psychiatric Association initiative, the *DSM* had to be ratified by the assembly of the A.P.A., a decision-making body composed of elected officials from all over the country. Spitzer's anti-Freudian ideas had caused resentment throughout the production process, and, as the date of the assembly approached, the opposition gathered strength and narrowed its focus to a single, crucial word—"neurosis"—which Spitzer wanted stricken from the *DSM*.

The term "neurosis" has a very long history, but over the course of the twentieth century it became inseparable from Freudian psychoanalytic philosophy. A neurosis, Freud believed, emerged from unconscious conflict. This was the bedrock psychoanalytic concept at the height of the psychoanalytic era, and both the *DSM-I* and the *DSM-II* made frequent use of the term. Spitzer and the *dops*, however, reasoned that, because a wide range of mental-health professionals were going to use the manual in everyday practice, the *DSM* could not be aligned with any single theory. They decided to restrict themselves simply to describing behaviors that were visible to the human eye: they couldn't tell you why someone developed obsessive-compulsive personality disorder, but they were happy to observe that such a person is often "over-conscientious, scrupulous, and inflexible about matters of morality."

When word of Spitzer's intention to eliminate "neurosis" from the *DSM* got out, Donald Klein says, "people were aghast. 'Neurosis' was the bread-and-butter term of psychiatry, and people thought that we were calling into question their livelihood." Roger Peele, of St. Elizabeths, was sympathetic to Spitzer's work, but, as a representative of the Washington, D.C., branch of the A.P.A., he felt a need to challenge Spitzer on behalf of his constituency. "The most common diagnosis in private practices in Washington, D.C., in the nineteen-seventies was something called depressive neurosis," Peele says. "That was what they were doing day after day." Psychoanalysts bitterly denounced the early drafts. One psychiatrist, Howard Berk, wrote a letter to Spitzer saying that "the *DSM-III* gets rid of the castle of neurosis and replaces it with a diagnostic Levittown."

Without the support of the psychoanalysts, it was possible that the *DSM-III* wouldn't pass the assembly and the entire project would come to nothing. The A.P.A. leadership got involved, instructing Spitzer and the *dops* to include psychoanalysts in their deliberations. After months of acrimonious debate, Spitzer and the psychoanalysts were able to reach a compromise: the word "neurosis" was retained in discreet parentheses in three or four key categories.

With this issue resolved, Spitzer presented the final draft of the *DSM-III* to the A.P.A. assembly in May of 1979. Roughly three hundred and fifty psychiatrists gathered in a large auditorium in Chicago. Spitzer got up onstage and reviewed the *DSM* process and what they were trying to accomplish, and there was a motion to pass it. "Then a rather remarkable thing happened," Peele says. "Something that you don't see in the assembly very often. People stood up and applauded." Peele remembers watching shock break over Spitzer's face. "Bob's eyes got watery. Here was a group that he was afraid would torpedo all his efforts, and instead he gets a standing ovation."

The *DSM-III* and the *DSM-III-R* together sold more than a million copies. Sales of the *DSM-IV* (1994) also exceeded a million, and the *DSM-IV TR* (for "text revision"), the most recent iteration of the *DSM*, has sold four hundred and twenty thousand copies since its publication, in 2000. Its success continues to grow. Today, there are forty *DSM*-related products available on the Web site of the American Psychiatric Association. Stuart Kirk, a professor of public policy at U.C.L.A., and Herb Kutchins, a professor emeritus of social work at California State University, Sacramento, have studied the creation of the modern *DSM* for more than seventeen years, and they argue that its financial and academic success can be attributed to Spitzer's skillful salesmanship. According to Kirk and Kutchins, immediately after the publication of the *DSM-III* Spitzer embarked on a P.R. campaign, touting its reliability as "far greater" and "higher than previously achieved" and "extremely good." "For the first time . . . claims were made that the new manual was scientifically sound," they write in "Making Us Crazy: *DSM*—The Psychiatric Bible and the Creation of Mental Disorders" (1997). Gerald Klerman, a prominent psychiatrist, published an influential book in 1986 that flatly announced, "The reliability problem has been solved."

It was largely on the basis of statements like these that the new *DSM* was embraced by psychiatrists and psychiatric institutions all over the globe. "The *DSM* revolution in reliability is a revolution in rhetoric, not in reality," Kutchins and Kirk write. Kirk told me, "No one really scrutinized the science very carefully." This was owing, in part, to the manual's imposing physical appearance. "One of the objections was that it appeared to be more authoritative than it was. The way it was laid out made it seem like a textbook, as if it was a depository of all known facts," David Shaffer

says. "The average reader would feel that it carried great authority and weight, which was not necessarily merited."

Almost immediately, the book started to turn up everywhere. It was translated into thirteen languages. Insurance companies, which expanded their coverage as psychotherapy became more widespread in the nineteen-seventies, welcomed the *DSM-III* as a standard. But it was more than that: the *DSM* had become a cultural phenomenon. There were splashy stories in the press, and TV news magazines showcased several of the newly identified disorders. "It was a runaway success in terms of publicity," Allen Frances says. Spitzer, Williams, and the rest of the *dops* were surprised and pleased by the reception. "For us it was kind of like being rock stars," Williams says. "Because everyone saw that it was the next big thing, everyone knew us and wanted to talk to us. It was like suddenly being the most popular kid on the block."

A year and a half after the publication of the *DSM-III*, Spitzer began work on its revision. Emboldened by his success, he became still more adamant about his opinions, and made enemies of a variety of groups. "I love controversy," Spitzer admits, "so if there was something that I thought needed to be added that was controversial, so much the better." He enraged feminists when he tried to include a diagnosis termed "masochistic personality disorder," a nonsexual form of masochism which critics claimed implied that some abused wives might be responsible for their own mistreatment. He angered women's groups again when he attempted to designate PMS as a mental disorder ("premenstrual dysphoric disorder"). "A lot of what's in the *DSM* represents what Bob thinks is right," Michael First, a psychiatrist at Columbia who worked on both the *DSM-III-R* and *DSM-IV*, says. "He really saw this as *his* book, and if he thought it was right he would push very hard to get it in that way." Thus, despite the success of Spitzer's two editions, and despite extensive lobbying on his part, the American Psychiatric Association gave the chairmanship of the *DSM-IV* task force to Allen Frances. "The American Psychiatric Association decided that they had had enough of Spitzer, and I can understand that," Spitzer says with a note of regret in his voice. "I think that there was a feeling that if the *DSM* was going to represent the entire profession—which obviously it has to—it would be good to have someone else." This certainly was part of the reason. But Spitzer's colleagues believe that the single-mindedness with which he transformed the *DSM* also contributed to his eclipse. "I think that Spitzer looked better in *III* than he did in *III-R*," Peele says. "*III-R*, for one reason or another, came across as more heavy-handed—'Spitzer wants it this way!'"

As chair of the *DSM-IV*, Frances quickly set about constructing a more transparent process. Power was decentralized, there were systematic literature reviews, and the committees were put on notice that, as Frances says, "the wild growth and casual addition" of new mental disorders were to be avoided. Spitzer was made special adviser to the *DSM-IV* task force, but his power was dramatically reduced. He found the whole experience profoundly distressing. "I had the feeling that this wonderful thing that I created was going to be destroyed," he says.

The official position of the American Psychiatric Association is that the reliability of the *DSM* is sound. Darrel Regier, the director of research at the A.P.A., says, "Reliability is, of course, improved. Because you have the criteria, you're not depending on untestable theories of the cause of a diagnosis." He says that psychiatric practice was so radically changed by Spitzer's *DSM*—it was, for the first time, at least nominally evidence-based—that it's impossible to compare reliability before and after. One consequence of the addition of diagnostic criteria was the creation of long, structured interviews, which have allowed psychiatrists successfully to assemble homogeneous research populations for clinical trials. In this context, the *DSM* diagnoses have been found to be reliable.

But structured interviews don't always have much in common with the conversations that take place in therapists' offices, and since the publication of the *DSM-III*, in 1980, no major study has been able to demonstrate a substantive improvement in reliability in those less formal settings. During the production of the *DSM-IV*, the American Psychiatric Association received funding from the MacArthur Foundation to undertake a broad reliability study, and although the research phase of the project was completed, the findings were never published. The director of the project, Jim Thompson, says that the A.P.A. ran out of money. Another study, whose primary author was Spitzer's wife, Janet Williams, took place at six sites in the United States and one in Germany. Supervised by Williams and some of the most experienced diagnostic professionals in the world, the participating clinicians were given extensive special training before being split into pairs and asked to interview nearly six hundred prospective patients. The idea was to determine whether clinicians faced with the same client could agree on a diagnosis using the *DSM*. Although Williams claims that the study supported the reliability of the *DSM*, when the investigators wrote up their results they admitted that they "had expected higher reliability values." In fact, Kutchins and Kirk point out, the results were "not that different from those statistics achieved in the 1950s and 1960s—and in some cases were worse."

Reliability is probably lowest in the place where the most diagnoses are made: the therapist's office. As Tom Widiger, who served as head of research for the *DSM-IV*, points out, "There are lots of studies which show that clinicians diagnose most of their patients with one particular disorder and really don't systematically assess for other disorders. They have a bias in reference to the disorder that they are especially interested in treating and believe that most of their patients have." Unfortunately, because psychiatry and its sister disciplines stand under the authoritative banner of science, consumers are often reluctant to challenge the labels they are given. Diagnoses are frequently liberating, helping a person to understand that what he views as a personal failing is actually a medical problem, but they can in certain cases become self-fulfilling prophecies. A child inappropriately given the label of attention-deficit/hyperactivity disorder can come to see himself as broken or limited, and act accordingly. And there are other problems with the *DSM*. Critics complain that it often characterizes everyday behaviors as abnormal, and that it continues to lack validity, whether or not the issue of reliability has been definitely resolved.

Even some of the manual's early advocates now think that the broad claims of reliability were exaggerated. "To my way of thinking, the reliability of the *DSM*—although improved—has been oversold by some people," Allen Frances says. "From a cultural standpoint, reliability was a way of authenticating the *DSM* as a radical innovation." He adds, "In a vacuum, to create criteria that were based on accepted wisdom as a first stab was fine, as long as you didn't take it too seriously. The processes that happened were very limited, but they were valuable in their context." And Frances believes that both psychiatry and the public have benefitted in a less tangible way from the collective fantasy that the *DSM* was a genuine scientific tool. "In my view, if I had been doing the *DSM-III* it would never have been as famous a document, because I'm a skeptic," he says. "But it was good for the world at large. Good for psychiatry, good for patients. Good for everyone at that point in time to have someone whose view may have been more simpleminded than the world really is. A more complex view of life at that point would have resulted in a ho-hum 'We have this book and maybe it will be useful in our field.' The revolution came not just from the material itself, from the substance of it, but from the passion with which it was introduced."

Spitzer, too, has grown more circumspect. "To say that we've solved the reliability problem is just not true," he told me one afternoon in his office at Columbia. "It's been improved. But if you're in a situation with a general clinician it's certainly not very good. There's still a real problem, and it's not clear how to solve the problem." His personal investment in the *DSM* remains intense. During one of our conversations, I asked Spitzer if he ever feels a sense of ownership when troubled friends speak to him of their new diagnoses, or perhaps when he comes across a newspaper account that features one of the disorders to which he gave so much of his life. He admitted that he does on occasion feel a small surge of pride. "My fingers were on the typewriter that typed those. They might have been changed somewhat, but they all went through my fingers," he said. "Every word." ♦

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