

Whither DSM and ICD, Chapter V?

Hugh Middleton

*Associate Professor, School of Sociology and Social Policy, University of Nottingham
Honorary Consultant Psychiatrist, Nottinghamshire Healthcare NHS Trust*

Abstract

Consideration is given to the extent to which the DSM and ICD approach to psychiatric case definition and treatment supports clinical activity. Their validity as a way of defining 'mental illness' is found wanting and they do not, in themselves, usefully guide treatment. These conclusions are set in a critical realist approach to 'mental illness', which draws attention to the legitimacy of several differing perspectives, each reflecting their own sets of interests and allegiances. DSM-V and ICD-11 are due to be published in 2012 and 2014 respectively, and their architects are called upon to be clear about which of these constituencies they are representing.

Key words

Classification, DSM, ICD, mental illness

It is widely argued that a significant proportion of the population suffers from mental illness, that this amounts to a significant economic burden, and that there is a strong case for investing in improved mechanisms of detection and treatment (Layard, 2006). Not everyone is in full agreement (Moncrieff, 1999; Healy, 2000; Middleton & Shaw, 2001; Double, 2002; Horowitz & Wakefield, 2007; Pilgrim, 2007; Shaw & Taplin, 2007; Bolton, 2008).

Contemporary approaches to detection and classification reflect the American Psychiatric Association's third diagnostic and statistical manual, DSM-III, published in 1980 and revised in 1987 (American Psychiatric Association, 1987). Less systematic manuals, DSM-I and DSM-II, had been published in 1952 and 1968 and the current version, DSM-IV was published in 1992. Work is under way to release a finally approved DSM-V in 2012 (American Psychiatric Association, 2008).

Mental health difficulties can be considered from several viewpoints, including their lived experience, neuroscience, public policy, professional practice, commerce and the media. Attempts to authoritatively define 'mental illness' from any one of them all prove wanting in one way or another (Zachar & Kendler, 2007; Bolton, 2008). An alternative is to accept the independent legitimacy of each and acknowledge multiple purposive definitions. This is a critical realist (Bhaskar, 1975) approach, and it is proving to be popular (Ellis, 1992; Pilgrim & Bentall, 1999; Houston, 2001; Littlejohn, 2003; Fulford &

Columbo; 2004, Pilgrim & Rogers, 2005; Stickley, 2006; McEvoy & Richards, 2007; Middleton & Shaw, 2007). The purpose of this paper is to consider the 'DSM project' and its sister 'ICD project' (World Health Organization (WHO), 1992) from that perspective. It reflects upon their contributions to ordinary clinical practice. Clearly DSM and ICD have other constituencies but these differ from the clinician's, and vary among themselves. A critical approach accepts that all are legitimate expressions of differing purposes and interests, and each may be examined in its own right.

From a clinical viewpoint it is reasonable to expect a scheme of diagnostic classification to determine whether or not a particular set of symptoms reflects 'mental illness' (case definition), provides an effective way of improving public health by detecting 'hidden' cases for treatment (case detection), and identifies indications for particular forms of treatment (guide treatment). This paper examines how well DSM and ICD achieve these.

Case definition

The years leading up to DSM-III heard calls for more reliable approaches to psychiatric case definition. Academic psychiatrists were criticised for a lack of rigour, funding organisations sought clearer definition of their liabilities, the pharmaceutical industry sought diagnostic criteria to support clinical trials and Rosenhan's vivid illustration of the unreliability of psychiatric diagnosis (Rosenhan 1973) threatened

professional credibility. Early responses were publication of the Feighner Criteria (Feighner *et al*, 1972) and the Present State Examination (PSE) (Wing *et al*, 1974). The Feighner Criteria formed the basis of DSM-III and the PSE became the basis of Chapter V of the Ninth Edition of the International Classification of Diseases, ICD-9 (WHO, 1978).

Prior editions of DSM were both descriptive and interpretive, basing case definition upon symptomatology and presumptive interpretations. The DSM-II definition of 'Depressive Neurosis' (American Psychiatric Association (APA), 1968) is:

'This disorder is manifested by an excessive reaction of depression due to an internal conflict or identifiable event such as the loss of a love object or cherished possession.'

It is not difficult to see the opportunity this gave those keen to criticise psychiatry as 'unscientific'.

The architects of DSM-III rose to this. Conditions were defined in terms of detailed and explicitly defined sets of symptoms. DSM-III-R defines 'Major Depressive Episode', the term used in place of 'Depressive Neurosis', as a state of affairs in which (APA, 1987):

A:

At least five of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure. (Do not include symptoms that are clearly due to a physical condition, mood-incongruent delusions or hallucinations, incoherence, or marked loosening of associations.)

- (1) Depressed mood (or can be irritable mood in children and adolescents) most of the day, nearly every day, as indicated either by subjective account or observation by others*
- (2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation by others of apathy most of the time)*
- (3) Significant weight loss or weight gain when not dieting (eg more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (in children, consider failure to make expected weight gains)*
- (4) Insomnia or hypersomnia nearly every day*
- (5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)*
- (6) Fatigue or loss of energy nearly every day*

(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B:

(1) It cannot be established that an organic factor initiated and maintained the disturbance

(2) The disturbance is not a normal reaction to the death of a loved one (Uncomplicated Bereavement)

Note: *Morbid preoccupation with worthlessness, suicidal ideation, marked functional impairment or psychomotor retardation, or prolonged duration suggest bereavement complicated by Major Depression*

C:

At no time during the disturbance have there been delusions or hallucinations for as long as two weeks in the absence of prominent mood symptoms (ie before the mood symptoms developed or after they have remitted)

D:

Not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS.

This is an exacting definition and successive revisions have continued to refine it, and similar definitions of other disorders. DSM-IV defines some 400 distinct conditions in this way, and ICD-10 some 350 (APA, 1992; WHO, 1992).

Individual items such as 'diminished ability to think or concentrate' or 'markedly diminished interest or pleasure' can be explicitly defined, allowing structured interviews to be developed. These include the Clinical Interview Schedule (CIS) (Goldberg *et al*, 1970), the Diagnostic Interview Schedule (DIS) (Robins *et al*, 1981), the Composite International Diagnostic Interview (CIDI) (WHO, 1990), and a revised Clinical Interview Schedule (CIS-R) (Lewis *et al*, 1992). Criticisms of earlier approaches to psychiatric diagnosis made much of the part played by clinicians' judgments and assumptions. These were seen to distinguish psychiatric diagnosis from other medical judgements, and discredit it (Kramer, 1969). The development of structured interviews which reliably generate diagnoses, in many cases by computer algorithm, addressed this.

Case detection Epidemiology

These techniques have supported major surveys in the US, the UK and Australia. In the US the Epidemiologic Catchment Area (ECA) programme surveyed psychiatric morbidity across three sites between 1980 and 1985, and the National Co-morbidity Study (NCS) surveyed psychiatric morbidity in a nationally representative sample between 1990 and 1992. Using DIS the former returned lifetime prevalence rates of DSM-III defined disorders of 28.8%, 38% and 31% respectively from each of three districts (Robins *et al*, 1984). In the NCS some 8,000 15 to 54-year-olds were interviewed using a modification of the CIDI. Nearly half fulfilled one or another set of diagnostic criteria at some time in their life, and 30% within the previous 12 months (Kessler *et al*, 1994).

The first UK survey was conducted in 1993 (Jenkins *et al*, 1997): 10,108 people aged 16 to 64 and drawn from 18,000 households were interviewed using CIS-R. They answered screening questions designed to detect the possibility of psychosis, 12 questions designed to detect alcohol dependency and five questions designed to detect dependence upon other drugs. Those screening positive for psychosis were interviewed by psychiatrists using a structured assessment (Wing *et al*, 1990). The survey established

a prevalence of 23.3% for one or more conditions meeting ICD-10 criteria.

The second UK survey was conducted in 2000 (Singleton *et al*, 2001). It used essentially the same methods and obtained essentially the same findings.

During 1997, 10,641 Australian residents were interviewed using the CIDI to generate non-psychosis diagnoses, and screened to detect psychosis, personality disorder, cognitive impairment and neurasthenia. Twelve-month and one-month prevalence estimates of 20.3% and 13.2% were obtained for any one of 16 DSM-IV-defined conditions (Andrews *et al*, 2001a).

Table 1 gives the lifetime and 12-month prevalence of DSM-III-R defined conditions detected by the NCS survey. More than half of the identified disorders were found in the 14% of the population whose symptoms fulfilled criteria for three or more distinct conditions, 13% of the population fulfilled lifetime criteria for two disorders and 21% for only one. Singly or together, 25% were instances of alcohol or drug misuse of one sort or another and 30% were instances of Major Depression, Dysthymia or Generalised Anxiety Disorder.

Table 2 gives the 12 and one-month prevalence of DSM-IV conditions detected in the Australian survey. Again these are reported as frequencies of conditions rather than afflicted individuals: 26.5% were

Table 1 Frequencies of disorder detected in the US National Co-morbidity Study, after Kessler *et al* 1994

DSM-III-R diagnosis	Lifetime prevalence (%)	Twelve-month prevalence (%)
Major Depression	17.1	10.3
Manic Episode	1.6	1.3
Dysthymia	6.4	2.5
Panic Disorder	3.5	2.3
Agoraphobia without Panic Disorder	5.3	2.8
Social Phobia	13.3	7.9
Simple Phobia	11.3	8.8
Generalised Anxiety Disorder	5.1	3.1
Alcohol Abuse without Dependence	9.4	2.5
Alcohol Dependence	14.1	7.2
Drug Abuse without Dependence	4.4	0.8
Drug Dependence	7.5	2.8
Antisocial Personality Disorder	3.5	N/A
Non-affective Psychosis	0.7	0.5
Any	48	29.5

Table 2 Frequencies of disorder detected in the Australian National Mental Health Survey after Andrews et al 2001

DSM-IV diagnosis	Twelve-month prevalence (%)	One-month prevalence (%)
Major Depression	6.3	3.2
Dysthymia	1.1	0.9
Panic Disorder with/without Agoraphobia	1.1	0.5
Agoraphobia without Panic Disorder	0.5	0.2
Social Phobia	1.3	1.0
Obsessive Compulsive Disorder	0.7	0.5
Generalised Anxiety Disorder	2.6	2.0
Post-traumatic Stress Disorder	1.3	0.9
Alcohol Abuse without Dependence	1.9	0.7
Alcohol Dependence	4.1	1.7
Drug Abuse without Dependence	1.0	0.3
Drug Dependence	2.0	0.9
Neuraesthesia	1.5	1.2
Any Personality Disorder	6.5	5.3
Cognitive Impairment	1.3	1.3
Non-affective Psychosis	0.7	0.5
Any	20.3	13.2

instances of alcohol or drug misuse of one sort or another, and 29.4% were instances of Major Depression, Dysthymia or Generalised Anxiety Disorder.

Table 3 gives the prevalence of ICD-10-defined conditions identified in the earlier UK survey. This adopted a hierarchical view of functional disorders,

which specifies a priority when two or more sets of diagnostic criteria are fulfilled (Meltzer *et al*, 1995). Thus these figures are estimates of the detected condition's prevalence if only one set of criteria were met, or that of the primary diagnosis if more than one. Another methodological point is that the CIS-R used in the UK surveys is semi-structured whereas

Table 3 Frequencies of disorder detected in the first National Psychiatric Morbidity Household Survey of Great Britain, after Jenkins et al 1997

ICD-10 diagnosis	One-year prevalence (%)	One-week prevalence (%)
Mixed Anxiety and Depressive Disorder		7.7
Generalised Anxiety Disorder		3.1
Panic Disorder		0.8
Depressive Episode		2.1
All Phobias		1.1
Obsessive Compulsive Disorder		1.2
Alcohol Dependence	4.7	
Drug Dependence	2.2	
Functional Psychosis	0.4	
Any	23.3	

the CIDI used in the US and Australia is fully structured, determining the presence of symptoms on the basis of 'Yes/No/Don't know' answers to specific questions. The former generates an estimate of severity, as well as determining whether or not particular symptoms are present in a diagnostic combination. As a result it identifies instances of 'Non-specific Neurosis' or 'Mixed Anxiety and Depressive Disorder', where severity exceeds a threshold but symptoms are not present in a combination that fulfils formal diagnostic criteria. This 'diagnosis' accounted for a third of those identified as 'cases'. Thirteen per cent were instances of Generalised Anxiety Disorder and nearly a third (30%) were cases of drug or alcohol misuse.

Guiding public health measures

Across the several surveys only a third of those identified as suffering a mental health problem sought professional help (Shapiro *et al*, 1984; Kessler *et al*, 1994; Bebbington *et al*, 2000a; Andrews *et al*, 2001b). Help-seeking was more likely where symptoms were severe, and among married, older, wealthier and more educated individuals, and less likely among those from ethnic minorities and males (Pollard *et al*, 1989; Dew *et al*, 1991; Olfson & Klerman, 1992; Gallo *et al*, 1995; Bebbington *et al*, 2000a; Bebbington *et al*, 2000b).

This was interpreted as unsatisfactory case detection, provision and treatment, conceivably due to public and professional ignorance. There are references to 'a large reservoir of untreated psychiatric disorder' and 'an education gap ... likely to be shared by primary care physicians and the general public' (Bebbington *et al*, 2000b). In the UK the Royal College of Psychiatrists and Royal College of General Practitioners launched their Defeat Depression campaign (Paykel & Priest, 1992). It was intended to raise public awareness of depression, reduce stigma, train general practitioners in recognition and treatment, and make specialist advice and support more readily available. It focused upon depression because an appropriate treatment could readily be made available in the form of antidepressant medication.

The Defeat Depression campaign and related US initiatives provide an opportunity to review the effects of public health interventions. All of three formal evaluations of education and the introduction of treatment guidelines in the UK failed to detect significant improvements in clinical outcome. In the first (Thompson *et al*, 2000) general practitioners were provided with an educational package designed to improve their detection and treatment of

depression. It was well received and 80% of the participants felt that it would improve their skills. Unfortunately there were no significant effects upon detection rate or changes in the Hospital Anxiety and Depression rating scale (Zigmond & Snaith, 1983). In the second (King *et al*, 2002) general practitioners were provided with a four-and-a-half day course of instruction in recognising depression, and using cognitive behaviour therapy to treat it. The intervention made no difference to practitioners' ratings of their understanding of the condition, or to changes in patients' Beck Depression Inventory (Beck *et al*, 1961). The third (Croudace *et al*, 2003) investigated the use of practice guidelines based upon the ICD-10 WHO Primary Care Guidelines for the Diagnosis and Management of Mental Disorders (WHO, 1996). Guidelines were adapted for local relevance and made available to intervention practices which were encouraged to make use of them. There were no significant differences between intervention practices and controls in their abilities to detect cases or in patients' General Health Questionnaire (Goldberg *et al*, 1997) scores at follow-up.

A different organisational environment in the US has led to more managerially focused interventions. A recent follow-up of 1,131 clients attending practices that were part of the Quality Improvement for Depression (QID) collaboration (Rost *et al*, 2001) has shown that practitioners adhered well to guidelines concerning detection and the initiation of treatment, but poorly to those concerning longer-term management and attention to ancillary issues such as alcohol misuse. Client outcomes reflected practitioners' overall adherence to guidelines (Hepner *et al*, 2007). This suggests differences between interventions narrowly intended to improve practitioners' skills, and more complex interventions involving audit, re-aligned professional roles, altered relationships between primary and specialist services and monitoring. A systematic review of 36 studies providing information about client outcome, organisational changes and/or economic outcomes confirms this; that improved outcomes can follow more complex and organisationally directed interventions but not simple educational strategies or the passive introduction of clinical guidelines (Gilbody *et al*, 2003). The situation appears to be the same in relation to the use of screening questionnaires (Pignone *et al*, 2002).

Guiding treatment

In identifying a condition as a disease or illness by diagnosis the physician implicitly professes some

knowledge of the mechanism responsible for it, from which specific recommendations about treatment automatically follow.

Of the drug treatments used for mental illness there are four principal groups: major tranquillisers (also known as antipsychotic agents), antidepressants, minor tranquillisers and hypnotic agents, and mood-stabilising agents (Middleton, 1996a). Major tranquillisers or antipsychotic agents are considered to exert their therapeutic effects by altering neurotransmission mediated by dopamine, antidepressants by altering neurotransmission mediated by noradrenaline and/or serotonin, and minor tranquillisers by altering neurotransmission mediated by gamma-amino-butyric acid. Even at these basic levels of distinction there are few clear and direct links between DSM/ICD diagnosis and treatment specificity. Although they are primarily used in the treatment of clearly psychotic or seriously agitated individuals various antipsychotic agents have also been advocated for the treatment of depression (Ostroff & Nelson, 1999), anxiety disorders (Hollander *et al*, 2003; Sagud *et al*, 2003) and bipolar affective disorder (Tohen *et al*, 2003). Similarly, compounds marketed primarily as antidepressants are also widely used in the treatment of anxiety disorders (Taylor *et al*, 2005).

The same is essentially true for psychological treatments. The importance of 'non-specific' factors reflecting the quality of relationship between client and therapist has long been recognised (Rosenzweig, 1936; Luborsky & Singer, 1975; Frank & Frank, 1991). In a recent review of some 5,613 cases treated in a variety of NHS settings only a very small proportion of the variance in outcome could be attributed to psychotherapeutic technique, as opposed to non-specific effects of the therapeutic relationship (Stiles *et al*, 2008). These conclusions have been questioned (Clark *et al*, 2008) and there are occasions when more detailed 'diagnosis' usefully informs treatment, although in this context the term 'formulation' tends to be used (Roth & Fonagy, 2004). Panic Disorder, Agoraphobia, Social Phobia and Obsessive Compulsive Disorder involve systematic patterns of avoidance and/or ritualised behaviour that maintain identifiable sets of anxiety-provoking concerns and misunderstandings (Clark & Ehlers, 1993; Middleton, 1996b; Middleton, 1998). Therapies based on an ideographic formulation of these, and directed at disrupting such 'safety behaviours' do have therapeutic effects attributable to the technique, but this is due to the application of a detailed and individualised formulation of that

particular person's psychological difficulties (Clark *et al*, 1999).

DSM and ICD as clinical tools

Given these facts, how well do DSM and ICD fulfil a clinician's reasonable expectations of case definition, case detection and a guide to therapy?

Case definition

Standardised instruments based upon DSM/ICD detect unrealistically high rates of disorder. In common usage, 'psychiatric disorder' (UK and US terminology) and 'mental disorder' (Australian terminology) are robust terms. To suggest that 20% of the population is disordered in this way is discrediting because it is counter-intuitive. If 20% has a serious illness, then why is that not more publicly evident, and where is the massive public health effort that would be deployed if 20% of the population had influenza? If what 20% of the population have is not a serious illness, then why call it 'psychiatric disorder' or 'mental disorder', which in the eyes of most, are serious conditions?

Clearly there are major differences between commonly held views of what is and what is not mental illness, and commonly encountered DSM/ICD 'diagnoses'. In the US and Australian surveys about a quarter of detected cases were instances of drug or alcohol misuse, and a slightly higher proportion were instances of either Depression, Dysthymia or Generalised Anxiety Disorder. In the UK survey drug or alcohol misuse accounted for 30%, and 50% cases were instances of Mixed Anxiety and Depressive Disorder, Depression and Generalised Anxiety Disorder.

Similar methods were used to detect alcohol or drug misuse in all three surveys; questions were asked about illicit drug use, loss of control, symptomatic behaviour and binge drinking (Jenkins *et al*, 1997). Although such questions probe for socially unaccepted and habitually harmful patterns of drug and alcohol use, they do not explore whether or not the respondent feels a need for help with altering their behaviour, or whether or not they feel disabled by it (Ewing, 1984). Without that information it is difficult to distinguish between occurrences of unwise drug or alcohol consumption that might be appropriately considered a 'disorder', and those that might be better considered part of a deviant subculture. Political ambivalence about the 'pathological' status of unwise intoxicant use is reflected in proscription of drug or alcohol dependency from conditions that merit detention in hospital under the Mental Health Act.

Similar questions arise in relation to depression (Horowitz & Wakefield, 2007). DSM criteria for Major Depressive Episode are met by depressed mood or sadness most of the day nearly every day; loss of energy, feelings of worthlessness, insomnia and indecisiveness. ICD-10 criteria for 'Depressive Episode' are similar. If this state of affairs follows the death of a loved one DSM acknowledges it could be an uncomplicated bereavement but, as Horowitz and Wakefield argue, understandable sadness due to a much wider range of causes can also result in this state of affairs.

DSM criteria for Generalised Anxiety Disorder are six months' 'unrealistic or excessive anxiety and worry about two or more life circumstances' and at least six of 18 possible symptoms of anxiety such as restlessness, dry mouth or irritability. Although this represents an uncomfortable state, the 'normal' population includes a wide range of measurable levels of trait anxiety which overlap with some of these qualities (Spielberger *et al*, 1983) and challenge what is meant by 'unrealistic or excessive'. Without knowledge of an individual's prior levels of trait anxiety and the context in which the assessment is being conducted it is insufficient to base diagnosis and identification of an illness solely upon 'unrealistic or excessive worry' and a number of autonomic symptoms. It has to be established that these amount to a departure from habitual state, and that there is no evidence of an stressor playing upon a vulnerable person.

ICD-10 uses the term 'Mixed Anxiety and Depressive Disorder' where 'symptoms of anxiety and depression are both present, but neither type of symptom is present to the extent that justifies a diagnosis if considered separately'. In other words, a state of emotional or psychological distress which lacks the pattern of symptoms signifying Depression or an Anxiety Disorder. Mixed Anxiety and Depressive Disorder accounted for some 30% of all cases of 'psychiatric disorder' detected in the UK survey. Without contextual information these cannot be differentiated from instances of understandable distress arising from life's vagaries.

Although DSM and ICD classifications do include conditions such as psychosis, recurrent panic attacks, severe depression or disabling behavioural problems such as anorexia nervosa that would all be considered a 'disorder' under most conceivable circumstances, they also routinely identify a number of common conditions that cannot be distinguished from understandable distress or unwise behaviour. Without external validation, usually in the form of 'this is independent of context', they lack specificity when

compared with other equally legitimate ways of defining 'mental illness'.

Case detection

Results from the three UK studies explicitly designed to hone general practitioners' psychiatric skills were disappointing. On the other hand the QID collaboration and related reviews suggest that improvements can be made. The interventions associated with these appear to be those that addressed more than just clinical skills. They included role changes, organisational developments, multidisciplinary management programmes and monitoring. Given DSM/ICD's inclusion of individuals better understood as victims of life's vagaries it is not surprising to find that providing a more supportive environment brings results, but this is not the same as improved condition-specific detection and treatment.

Guide treatment

DSM and ICD discriminate very credibly between conditions that a consensus of professionals, public and academics would distinguish; for instance, psychosis, melancholic depression, mania, phobias, learning difficulties and addictions, and thus their related treatment strategies. However, these distinctions are present in DSM-I which itself acknowledges their even greater antiquity (APA, 1952). Thus the ability of later revisions of DSM and ICD to make such distinctions cannot be attributed to the schemes themselves, but to the fact that they have incorporated much more longstanding consensus over the forms different types of disabling human distress can take. Broad and consensually agreed distinctions between different types of disabling human distress guide practitioners and contribute to mental health policy, but there are few if any instances of a finely nuanced DSM-IV or ICD-10 diagnosis clearly indicating a particular treatment. Where, as is the case in applying some psychological therapies, detailed 'diagnostic' assessment does inform treatment, this is in ways that are not directly informed by DSM/ICD.

Discussion

DSM/ICD measure up poorly against expectations of clinical utility. This is counter-intuitive, but no surprise. Brown (1987) considered the use of DSM-III in a community mental health centre. He identified tensions between differing constituencies and interests at play in the organisation, and acknowledged that 'pressure to refine diagnostic procedures in this clinic is less directed to patient

care than to other goals'. In themselves DSM/ICD add little to the therapeutic endeavour other than expert terminology.

Manning (2002) has considered the development and activities of several interest groups concerned with 'personality disorder'. He discusses how the process of identifying 'personality disorder' as a defined set of DSM/ICD diagnoses, the language which goes with them and the development of services to treat them can all be understood as an outcome of opportunistic collaborations between interested stakeholders. He refers to actor network theory (Callon 1986) and policy networks (Marsh & Richards, 1992) as competing ways of understanding this. Pilgrim (2007) draws attention to the differing perspectives of interest groups in relation to diagnoses of 'schizophrenia' and 'depression', emphasising the importance of recognising interests. Given the limited part DSM/ICD play in clinical work, these references to the influences of competing and collaborating interests in shaping knowledge, and the fact that there are several legitimate ways of viewing 'mental illness', it is worth considering whose interests they do serve.

It is an agreed and understandable convention that patients' interests are the focus of health care endeavours. However, they are not passive recipients. A number of findings illustrate how patients do or do not develop views of their psychological condition as 'illness' meriting professional intervention (Pescosolido *et al*, 1998; Biddle *et al*, 2007), and there is considerable literature illustrating that even when they do, their views may not conform to those of the professionals (Kangas, 2001; Thomas-MacLean & Stoppard, 2004; Nettleton, 2006). From the patient's perspective, distress, discomfort and disability are circumstances that have to be negotiated with or without professional assistance and in ways that reflect their individual circumstances. This can include negotiating a diagnosis in order to legitimise a claim for treatment or welfare but in general, rather than comfortably seeing themselves as 'cases of ...', most mental health service users prefer to see themselves and their difficulties in individual, ideographic terms (Repper & Perkins, 2003; Conroy & Wilson, 2006). The use of services is not a rational process neatly respecting professionally determined diagnostic criteria, and the wide disparity between the prevalence of DSM/ICD defined conditions and rates of help-seeking reflects this. Patients, their behaviours and their use of services do not conform to DSM/ICD criteria and are not directly served by them.

Public agencies have different requirements. They have a responsibility to mitigate the risks of harm

that the 'mentally disordered' inevitably generate, and so there have to be judicially determined definitions of 'mental illness'. Health insurance organisations and other funding agencies have a legitimate interest in costs. These require well defined criteria that determine what conditions qualify. Finally 'being ill' is a socially endorsed role with identifiable implications for financial and other forms of responsibility; a plea of 'mental disorder' can mitigate the consequences of murder, and a sick certificate can be a source of income.

For these and related purposes 'mental illness' has to be defined in a politically acceptable manner. There is a long history of related procedures and practices. The second Elizabethan Poor Law Act of 1601 established a distinction between 'the deserving and the undeserving poor'. Paupers were allocated to one of three categories: the able-bodied poor, for whom work would be provided; the 'impotent poor' – the elderly, children, the handicapped or sick, and lunatics, who were provided with support; and 'sturdy beggars' – those thought to be able, but unwilling, to earn a living for themselves, who were criminalised. Welfare provision, including health care, still functions on essentially the same principle more than 400 years later. Whether or not public opinion fully endorses 'illness status' for Mixed Anxiety and Depressive Disorder, Mild to Moderate Depression, all cases of Generalised Anxiety and all cases of drug or alcohol misuse is debatable.

The pharmaceutical industry has an interest in illness of all kinds. It exists to maximise profit from the development and sale of pharmaceuticals by identifying as wide as possible a range of indications for any one product, and by introducing new compounds for established indications in order to benefit from highly profitable early years of sale. Licensing and marketing depend heavily upon clinical trials requiring discrete diagnostic categories of the sort DSM/ICD so readily provide. Furthermore, by defining progressively more and more 'conditions' DSM/ICD provide marketing opportunities. Between 1992 and 2006 the yearly number of UK NHS prescriptions for antidepressant medication rose from some nine million to 31 million (Department of Health, 2008). During very much the same period (1995 to 2005) the proportion of incapacity benefit claims for mental and behavioural disorders rose from 22% to 39%, to become the single most common reason to claim (Department of Work and Pensions, 2008). It is worth considering which of these constituencies – patients, public agencies or the pharmaceutical industry – has benefited most.

A fourth constituency is the academic community. In the UK performance in the Research Assessment Exercise is a strong determinant of professional preferment, and similar forces operate in the US and elsewhere. These reward intellectual rigour and successful fundraising. The DSM/ICD 'project' has been a laudable response to criticisms of intellectual flaccidity in psychiatry but more recent years have seen concern about the part played by the pharmaceutical industry in funding and shaping mental health research (Healy & Cattell, 2003; Cooper, 2004; Moncrieff *et al*, 2005), and this is reflected in how research activity is recognised. The American Psychiatric Association has published a series of papers that considers the DSM-V research agenda (Kupfer *et al*, 2002). One of these 'white papers' is a proposal to develop a pathophysiologically based classification system (Charney *et al*, 2002). Another develops the need to understand mental disorders in their cultural context (Alarcón *et al*, 2002). Of the 187 citations supporting the former, 75 were published in one of the ten 2003 highest impact mental health journals (Sci-Bites, 2008); of the 300 citations supporting the latter, 36 were published in the same journals.

There are other constituencies with a legitimate interest in 'mental illness' which might include carers, whose interests do not always coincide with those of the one they care for; the media and other elements of the entertainment industry; religious bodies and campaigning organisations. It is clear that DSM and ICD cannot serve all of them, and it would be unrealistic for them to attempt to. For these reasons the architects of DSM-V and ICD-11 have to be explicit with their purpose. Cooper (2003) has drawn attention to the advantages of developing ICD-11 for a clinical rather than a research constituency. Among published submissions to the DSM-V debate there is a plea to consider conceptual issues (Kendler *et al*, 2008). It addresses the question of how to define 'mental illness' but the assumption remains, that this can be achieved to everyone's satisfaction by a panel of experts. A critical realist approach, actor network theory and interests work all suggest that it is more realistic to accept a set of context-dependent definitions, and the DSM/ICD project has to be clear which is theirs. Are they to be a valid clinical aid, an organ of social control, a framework for remuneration, or a biomedical research tool? They cannot please all of these, all of the time.

References

- Alarcón RD, Bell CC, Kirmayer LJ *et al* (2002) Beyond the funhouse mirrors. Research agenda on culture and psychiatric diagnosis. In Kupfer DJ, First MB & Regier DA (Eds) *A Research Agenda for DSM-V*. Washington, DC: American Psychiatric Association.
- American Psychiatric Association (1952) *Diagnostic and Statistical Manual: Mental Disorders*. Washington, DC: APA.
- American Psychiatric Association (1968) *Diagnostic and Statistical Manual of Mental Disorders*. Second edition. Washington, DC: APA.
- American Psychiatric Association (1987) *Diagnostic and Statistical Manual of Mental Disorders*. Third edition – revised. Washington, DC: APA.
- American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders*. Fourth edition. Washington, DC: APA.
- American Psychiatric Association (2008) *DSM-V: The Future Manual*. www.psych.org/MainMenu/Research/DSMIV/DSMV.aspx (Last accessed: October 30 2008.)
- Andrews G, Henderson S & Hall W (2001a) Prevalence, comorbidity, disability and service utilisation. Overview of the Australian National Mental Health Survey. *British Journal of Psychiatry* **178** 145-153.
- Andrews G, Issakidis C & Carter G (2001b) Shortfall in mental health service utilisation. *British Journal of Psychiatry* **179** 417-425.
- Balon R, Segraves RT & Clayton A (2007) Issues for DSM-V: sexual dysfunction, disorder or variation along normal distribution: toward rethinking DSM criteria of sexual dysfunctions. *American Journal of Psychiatry* **164** 198-200.
- Bebbington PE, Brugha TS, Meltzer H *et al* (2000a) Neurotic disorders and the receipt of psychiatric treatment. *Psychological Medicine* **30** 1369-1376.
- Bebbington PE, Meltzer H, Brugha TS *et al* (2000b) Unequal access and unmet need: neurotic disorders and the use of primary care services. *Psychological Medicine* **30** 1359-1367.
- Beck AT, Ward CH, Mendelson M *et al* (1961) An inventory for measuring depression. *Archives of General Psychiatry* **4** 561-571.
- Bhaskar R (1975) *A Realist Theory of Science*. Second edition. London: Verso.
- Biddle L, Donovan J, Sharp D *et al* (2007) Explaining non-help-seeking amongst young adults with mental distress: a dynamic interpretive model of illness behaviour. *Sociology of Health & Illness* **29** 983-1002.
- Block JJ (2008) Issues for DSM-V: internet addiction. *American Journal of Psychiatry* **165** 306-307.
- Bolton D (2008) *What is Mental Disorder? An Essay in Philosophy, Science and Values*. Oxford: Oxford University Press.
- Brown P (1987) Diagnostic conflict and contradiction in psychiatry. *Journal of Health and Social Behaviour* **28** 37-50.
- Callon M (1986) Some elements of a sociology of translation: domestication of the scallops and the fishermen of St Briec Bay. In Law J (Ed) *Power, Action and Belief: A New Sociology of Knowledge?* London: Routledge and Kegan Paul.

- Charney DS, Barlow DH, Botteron K *et al* (2002) Neuroscience research agenda to guide development of a pathophysiologically based classification system. In Kupfer DJ, First MB & Regier DA (Eds) *A Research Agenda for DSM-V*. Washington, DC: American Psychiatric Association.
- Clark DM & Ehlers A (1993) Empirical status of the cognitive theory and treatment of panic disorder. *Applied and Preventative Psychology* **2** 151–159.
- Clark DM, Fairburn CG *et al* (2008) Psychological treatment outcomes in routine NHS services: a commentary on Stiles *et al* (2007). *Psychological Medicine* **38** 629–634.
- Clark DM, Salkovskis PM, Hackmann A *et al* (1999) Brief cognitive therapy for panic disorder: a randomised controlled trial. *Journal of Consulting and Clinical Psychology* **4** 583–589.
- Connor SL & Wilson R (2006) It's important that they learn from us for mental health to progress. *Journal of Mental Health* **15** 461–474.
- Cooper JE (2003) Prospects for Chapter V of ICD-11 and DSM V. *British Journal of Psychiatry* **183** 379–381.
- Cooper R (2004) What is wrong with the DSM? *History of Psychiatry* **15** 5–25.
- Croudace T, Evans J, Harrison G *et al* (2003) Impact of the ICD-10 Primary Health Care (PHC) diagnostic and management guidelines for mental disorders on detection and outcome in primary care. *British Journal of Psychiatry* **182** 20–30.
- Department of Health (2008) *Pharmacies and Prescriptions*. www.dh.gov.uk/en/PublicationsAndStatistics/Statistics/StatisticalWorkAreas/StatisticalHealthCare/DH_4086488 (Last accessed: October 30 2008.)
- Department of Work and Pensions (2008) *Incapacity Benefit and Severe Disablement Allowance: Quarterly Summary of Statistics*. www.dwp.gov.uk/asd/ib_sda.asp (Last accessed: October 30 2008.)
- Dew MA, Bromet EJ, Schulberg HC *et al* (1991) Factors affecting service utilization for depression in a white collar population. *Social Psychiatry and Psychiatric Epidemiology* **26** 230–237.
- Double D (2002) The limits of psychiatry. *British Medical Journal* **324** 900–904.
- Ellis A (1992) My current views on rational-emotive therapy (RET) and religiousness. *Journal of Rational-Emotive and Cognitive Therapy* **10** 37–40.
- Ewing JA (1984) Detecting alcoholism: the CAGE Questionnaire. *Journal of the American Medical Association* **252** 1905–1907.
- Feighner JP, Robins E, Guze SB *et al* (1972) Diagnostic criteria for use in psychiatric research. *Archives of General Psychiatry* **26** 57–63.
- Frank JD & Frank JB (1991) *Persuasion & Healing. A Comparative Study of Psychotherapy*. Third edition. Baltimore: Johns Hopkins University Press.
- Fulford KW & Colombo A (2004) Professional judgement, critical realism, real people, and, yes, two wrongs can make a right! *Philosophy, Psychiatry and Psychology* **11** 165–173.
- Gallo JJ, Marino S, Ford D *et al* (1995) Filters on the pathway to mental health care, II. Sociodemographic factors. *Psychological Medicine* **25** 1149–1160.
- Gilbody S, Whitty P, Grimshaw J *et al* (2007) Educational and organizational interventions to improve the management of depression in primary care. A systematic review. *Journal of the American Medical Association* **299** 3145–3151.
- Goldberg DP, Cooper B, Eastwood MR *et al* (1970) A standardised psychiatric interview for use in community surveys. *British Journal of Preventive and Social Medicine* **24** 18–23.
- Goldberg DP, Gater R, Sartorius N *et al* (1997) The validity of two versions of the GHQ in the WHO study of mental illness in general health care. *Psychological Medicine* **27** 191–197.
- Healy D (2000) The case for an individual approach to the treatment of depression. *Journal of Clinical Psychiatry* **61** (suppl 6) 18–23.
- Healy D & Cattell D (2003) Interface between authorship, industry and science in the domain of therapeutics. *British Journal of Psychiatry* **183** 22–27.
- Hepner KA, Rowe M, Rost K *et al* (2007) *Annals of Internal Medicine* **147** 320–329.
- Hollander E, Rossi NB, Sood E *et al* (2003) Risperidone augmentation in treatment-resistant obsessive-compulsive disorder: a double-blind, placebo-controlled study. *International Journal of Neuropsychopharmacology* **6** 397–401.
- Horowitz AV & Wakefield JC (2007) *The Loss of Sadness. How Psychiatry Transformed Normal Sorrow into Depressive Disorder*. New York: Oxford University Press.
- Houston S (2001) Beyond social construction: critical realism and social work. *British Journal of Social Work* **31** 845–861.
- Jenkins R, Lewis G, Bebbington P *et al* (1997) The national psychiatric morbidity surveys of Great Britain – initial findings from the household survey. *Psychological Medicine* **27** 775–789.
- Kangas I (2001) Making sense of depression: perceptions of melancholia in lay narratives. *Health* **5** 76–92.
- Kendler KS, Appelbaum PS, Bell CC *et al* (2008) Issues for DSM-V: DSM-V should include a conceptual issues working group. *American Journal of Psychiatry* **165** 174–175.
- Kessler RC, McGonagle KA, Zhao S *et al* (1994) Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the national comorbidity survey. *Archives of General Psychiatry* **51** 8–19.
- King M, Davidson O, Taylor F *et al* (2002) Effectiveness of teaching general practitioners skills in brief cognitive behaviour therapy to treat patients with depression: randomised controlled trial. *British Medical Journal* **324** 947–953.
- Kramer M (1969) Cross-national study of diagnosis of the mental disorders: origin of the problem. *American Journal of Psychiatry* **10** suppl 1–11.
- Kupfer DJ, First MB & Regier DA (2002) *A Research Agenda for DSM-V*. Washington, DC: American Psychiatric Association.
- Layard R (2006) The case for psychological treatment centres. *British Medical Journal* **332** 1030–1032.
- Lewis G, Pelosi AJ, Araya R *et al* (1992) Measuring psychiatric disorder in the community: a standardised assessment for use by lay interviewers. *Psychological Medicine* **22** 465–486.
- Littlejohn C (2003) Critical realism and psychiatric nursing: a philosophical inquiry. *Journal of Advanced Nursing* **43** 449–456.

- Luborsky L & Singer B (1975) Comparative studies of psychotherapies: is it true that everyone has won and all must have prizes? *Archives of General Psychiatry* **32** 995-1008.
- Manning N (2002) Actor networks, policy networks and personality disorder. *Sociology of Health & Illness* **24** 644-666.
- Marsh D & Richards D (1992) *Policy Networks in British Government*. Oxford: Oxford University Press.
- McEvoy P & Richards D (2007) Gatekeeping access to community mental health teams: a qualitative study. *International Journal of Nursing Studies* **44** 387-395.
- Meltzer H, Gill B & Petticrew M (1995) *OPCS Surveys of Psychiatric Morbidity in Great Britain. Report No 1. The Prevalence of Psychiatric Morbidity Among Adults aged 16-64 Living in Private Households in Great Britain*. London: HMSO.
- Middleton HC (1996a) Drugs and psychiatry. In Reid JL, Rubin PC, Whiting B (Eds) *Lecture Notes on Clinical Pharmacology*. Oxford: Blackwell Science.
- Middleton H (1996b) Non-random associations between fears, beliefs and behaviours among panic patients. *Anxiety* **2** 265-278.
- Middleton HC (1998) Panic disorder: a theoretical synthesis of medical and psychological approaches. *Journal of Psychosomatic Research* **44** 121-132.
- Middleton H & Shaw I (2000) Distinguishing mental illness in primary care. *British Medical Journal* **320** 1420-1421.
- Middleton H & Shaw I (2007) A utilitarian perspective of social and medical contributions to three illustrative conditions, and recent UK NHS policy initiatives. *Journal of Mental Health* **16** 291-305.
- Moncrieff J, Hopker S & Thomas P (2005) Psychiatry and the pharmaceutical industry: who pays the piper? *Psychiatric Bulletin* **29** 84-85.
- Nettleton S (2006) 'I just want permission to be ill': towards a sociology of medically unexplained symptoms. *Social Science and Medicine* **62** 1167-1178.
- Olfson M & Klerman GL (1992) Depressive symptoms and mental health service utilization in a community sample. *Social Psychiatry and Psychiatric Epidemiology* **27** 161-167.
- Ostroff RB & Nelson JC (1999) Risperidone augmentation of selective serotonin reuptake inhibitors in major depression. *Journal of Clinical Psychiatry* **60** 256-259.
- Paykel ES & Priest RG (1992) Recognition and management of depression in general practice: consensus statement. *British Medical Journal* **305** 1198-1202.
- Pescosolido BA, Brooks Gardner C & Lubell KM (1998) How people get into mental health services: stories of choice, coercion and 'muddling through' from 'first timers'. *Social Science and Medicine* **46** 275-286.
- Pignone MP, Gaynes BN, Rushton JL *et al* (2002) Screening for depression in adults: a summary of the evidence for the US preventive services task force. *Annals of Internal Medicine* **136** 756-776.
- Pilgrim D (2007) The survival of psychiatric diagnosis. *Social Science and Medicine* **65** 536-547.
- Pilgrim D & Bental R (1999) The medicalisation of misery: a critical realist analysis of the concept of depression. *Journal of Mental Health* **8** 261-274.
- Pilgrim D & Rogers A (2005) The troubled relationship between psychiatry and sociology. *International Journal of Social Psychiatry* **51** 228-241.
- Pollard CA, Henderson JG, Frank M *et al* (1989) Help-seeking patterns of anxiety-disordered individuals in the general population. *Journal of Anxiety Disorders* **3** 131-138.
- Repper J & Perkins R (2003) *Social Inclusion and Recovery. A Model for Mental Health Practice*. London: Baillière Tindall.
- Robins LN, Helzer J.E, Croughan J *et al* (1981) The NIMH Diagnostic Interview Schedule. Its history, characteristics and validity. *Archives of General Psychiatry* **38** 381-389.
- Robins LN, Helzer JE, Weissman MM *et al* (1984) Lifetime prevalence of specific psychiatric disorders in three sites. *Archives of General Psychiatry* **41** 949-958.
- Rosenhan R (1973) On being sane in insane places. *Science* **179** 251-258.
- Rosenzweig S (1936) Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry* **6** 412-415.
- Rost KM, Duan N, Rubenstein LV *et al* for the Quality Improvement for Depression Consortium (2001) The Quality Improvement for Depression Collaboration: general analytic strategies for a coordinated study of quality improvement in depression care. *General Hospital Psychiatry* **23** 239-253.
- Roth A & Fonagy P (2004) *What Works For Whom? A Critical Review of Psychotherapy Research*. Second edition. New York: Guilford Publications.
- Sagud JM, Sagud M & Peles M (2003) Olanzapine in the treatment of treatment-resistant, combat-related PTSD – a series of case reports. *Acta Psychiatrica Scandinavica* **107** 394-396.
- Sci-Bites (2008) http://in-cites.com/research/2004/november_22_2004-2.html (Last accessed: October 30 2008.)
- Shapiro S, Skinner EA, Kessler LG *et al* (1984) Utilization of health and mental health services. Three epidemiologic catchment area sites. *Archives of General Psychiatry* **41** 971-978.
- Shaw I & Taplin S (2007) Happiness and mental health policy: a sociological critique. *Journal of Mental Health* **16** 359-373.
- Singleton N, Bumpstead R, O'Brien M *et al* (2001) *Psychiatric Morbidity Among Adults Living in Private Households, 2000*. London: Stationery Office.
- Spielberger CD, Gorsuch RL, Lushene R *et al* (1983) *Manual for the State-Trait Anxiety Inventory*. Pao Alto, California: Consulting Psychologists Press.
- Stickley T (2006) Should service user involvement be consigned to history? A critical realist perspective. *Journal of Psychiatric and Mental Health Nursing* **13** 570-577.
- Stiles WB, Barkham M, Mellor-Car J *et al* (2008) Effectiveness of cognitive-behavioural, person-centred, and psychodynamic therapies in UK primary-care routine practice: replication in a larger sample. *Psychological Medicine* **38** 677-688.
- Stunkard A, Allison K & Lundgren J (2008) Issues for DSM-V: night eating syndrome. *American Journal of Psychiatry* **165** 424.
- Taylor D, Paton C & Kerwin R (2005) *The South London and Maudsley NHS Trust 2005-2006 Prescribing Guidelines*. London: Taylor and Francis.

- Thomas-MacLean R & Stoppard JM (2004) Physicians' constructions of depression: inside/outside the boundaries of medicalization. *Health* **8** 275-293.
- Thompson C, Kinmonth AL, Stevens L *et al* (2000) Effects of a clinical-practice guideline and practice-based education on detection and outcome of depression in primary care: Hampshire Depression Project randomised controlled trial. *Lancet* **355** 185-191.
- Tohen M, Ketter TA, Zarate CA *et al* (2003) Olanzapine versus divalproex sodium for the treatment of acute mania and maintenance of remission: a 47-week study. *American Journal of Psychiatry* **160** 1263-1271.
- Volkow ND & O'Brien CP (2007) Issues for DSM-V: should obesity be included as a brain disorder? *American Journal of Psychiatry* **164** 708-710.
- Wing J, Babor T, Brugha T *et al* (1990) Schedules for clinical assessment in neuropsychiatry. *Archives of General Psychiatry* **47** 589-593.
- Wing JK, Cooper JE & Sartorius N (1974) *The Measurement and Classification of Psychiatric Symptoms*. London: Cambridge University Press.
- World Health Organisation (1978) *Mental Disorders: Glossary and Guide to their Classification in Accordance with the Ninth Revision of the International Classification of Diseases*. Geneva: WHO.
- World Health Organisation (1990) *The Composite International Diagnostic Interview (CIDI) Version 1.0*. Geneva: WHO.
- World Health Organisation (1992) *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. Geneva: WHO.
- World Health Organisation (1996) *Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version*. Göttingen: Hogrefe and Huber.
- Zachar P & Kendler KS (2007) Psychiatric disorders: a conceptual taxonomy. *American Journal of Psychiatry* **164** 557-565.
- Zigmond AS & Snaith RP (1983) The hospital anxiety and depression rating scale. *Acta Psychiatrica Scandinavica* **67** 361-370.