The need for a classification of mental disorders has been clear throughout the history of medicine, but until recently there was little agreement on which disorders should be included and the optimal method for their organization. The many different classification systems that were developed over the past two millennia have differed in their relative emphasis on phenomenology, etiology, and course as defining features. Some systems included only a handful of diagnostic categories; others included thousands. Moreover, the various systems for categorizing mental disorders have differed with respect to whether their principle objective was for use in clinical, research, or statistical settings. Because the history of classification is too extensive to be summarized here, this summary focuses briefly only on those aspects that have led directly to the development of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and to the "Mental Disorders" sections in the various editions of the International Classification of Diseases (ICD).

Pre-World War II

In the United States, the initial stimulus for developing a classification of mental disorders was the need to collect statistical information. What might be considered the first official attempt to gather information about mental health in the United States was the recording of the frequency of "idiocy/insanity" in the 1840 census. By the 1880 census, seven categories of mental health were distinguished: mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy.

In 1917, the American Medico-Psychological Association, together with the National Commission on Mental Hygiene, formulated a plan that was adopted by the Bureau of the Census for gathering uniform statistics across mental hospitals. Although this system devoted more attention to clinical utility than did previous systems, it was still primarily a statistical classification. The American Psychiatric Association subsequently collaborated with the New York Academy of Medicine to develop a nationally acceptable psychiatric nomenclature that would be incorporated within the first edition of the American Medical Association's Standard Classified Nomenclature of Disease. This nomenclature was designed primarily for diagnosing inpatients with severe psychiatric and neurological disorders.

In 1921, the American Medico-Psychological Association changed its name to the American Psychiatric Association.
Association.

Post-World War II

A much broader nomenclature was later developed by the U.S. Army (and modified by the Veterans Administration) in order to better incorporate the outpatient presentations of World War II servicemen and veterans (e.g., psychophysiological, personality, and acute disorders). Concurrently, the World Health Organization (WHO) published the sixth edition of *International Classification of Diseases* (ICD), which, for the first time, included a section for mental disorders. ICD-6 was heavily influenced by the Veterans Administration nomenclature and included 10 categories for psychoses and psychoneuroses and seven categories for disorders of character, behavior, and intelligence.

The American Psychiatric Association Committee on Nomenclature and Statistics developed a variant of the ICD-6 that was published in 1952 as the first edition of *Diagnostic and Statistical Manual: Mental Disorders (DSM-I)*. DSM-I contained a glossary of descriptions of the diagnostic categories and was the first official manual of mental disorders to focus on clinical utility. The use of the term “reaction” throughout DSM-I reflected the influence of Adolf Meyer's psychobiological view that mental disorders represented reactions of the personality to psychological, social, and biological factors.

In part because of the lack of widespread acceptance of the mental disorder taxonomy contained in ICD-6 and ICD-7, WHO sponsored a comprehensive review of diagnostic issues, which was conducted by the British psychiatrist Erwin Stengel. His report can be credited with having inspired many advances in diagnostic methodology—most especially the need for explicit definitions of disorders as a means of promoting reliable clinical diagnoses. However, the next round of diagnostic revisions, which led to DSM-II and ICD-8, did not follow Stengel's recommendations to any great degree. DSM-II was similar to DSM-I but eliminated the term “reaction.”

Development of DSM-III

As had been the case for the *Diagnostic and Statistical Manual of Mental Disorders, First Edition* and *Second Edition* (DSM-I) and (DSM-II), the development of the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III) was coordinated with the development of the next version of the *International Classification of Diseases* (ICD), ICD-9, which was published in 1975 and implemented in 1978. Work began on DSM-III in 1974, with publication in 1980.

DSM-III introduced a number of important methodological innovations, including explicit diagnostic criteria, a multiaxial system, and a descriptive approach that attempted to be neutral with respect to theories of etiology. This effort was facilitated by extensive empirical work on the construction and validation of explicit diagnostic criteria and the development of semistructured interviews.

ICD-9 did not include diagnostic criteria or a multiaxial system largely because the primary function of this
international system was to outline categories for the collection of basic health statistics. In contrast, DSM-III was developed with the additional goal of providing a medical nomenclature for clinicians and researchers. Because of dissatisfaction across all of medicine with the lack of specificity in ICD-9, a decision was made to modify it for use in the United States, resulting in ICD-9-CM (for Clinical Modification). The ICD-9-CM is still in use today.

**DSM-III-R and DSM-IV**

Experience with *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III) revealed a number of inconsistencies in the system and a number of instances in which the criteria were not entirely clear. Therefore, the American Psychiatric Association appointed a work group to revise DSM-III, which developed the revisions and corrections that led to the publication of DSM-III-R in 1987.

Several years later, in 1994, the last major revision of DSM, DSM-IV, was published. It was the culmination of a six-year effort that involved more than 1000 individuals and numerous professional organizations. Much of the effort involved conducting a comprehensive review of the literature to establish a firm empirical basis for making modifications. Numerous changes were made to the classification (e.g., disorders were added, deleted, and reorganized), to the diagnostic criteria sets, and to the descriptive text based on a careful consideration of the available research about the various mental disorders. Developers of DSM-IV and the 10th Edition of the *International Classification of Diseases* (ICD-10) worked closely to coordinate their efforts, resulting in increased congruence between the two systems and fewer meaningless differences in wording. ICD-10 was published in 1992.