

THE INFLUENCE OF A CHARTER

DOCUMENT IN PSYCHIATRY

LUCILLE PARKINSON McCARTHY

In 1979, the 34,000 members of the American Psychiatric Association voted to approve the third edition of its *Diagnostic and Statistical Manual of Mental Disorders*. In this 500-page book, referred to as *DSM-III*, some 200 mental disorders are named, described, and defined with specific operational criteria. This classification system differs from its predecessors in fundamental ways and has been called a landmark achievement in the history of American psychiatry (Rutter and Shaffer) and the central document of the new scientific psychiatry (Maxmen). In the seven years following its publication in 1980 *DSM-III* sold 600,000 copies worldwide, and it is now used not only by psychiatrists but also by professionals in related health care fields, and in government, insurance, and legal agencies.

DSM-III was developed between 1974 and 1979 by a 130-member task force of the American Psychiatric Association in response to a concern in psychiatry about the lack of diagnostic reliability (Klerman). Before the publication of this manual there were no standardized definitions of mental disorders, and thus schizophrenia, for example, meant something different in New York than it did in Baltimore or London. In essence, psychiatrists used a variety of definitions of mental disorders, and this made research and clinical conversations very difficult. This concern about the absence of an objective and reliable system of diagnosis arose in large part because of the development in the 1950s of drugs that acted specifically on particular mental disorders. Before the advent of such drugs, when treatment for all disorders was either talk-based psychotherapy or institutionalization, the patient's diagnosis mattered very little. However, these medications required accurate description of the patient's symptoms and

accurate diagnoses, both for treatment planning and for studying treatment results.

The *DSM-III* descriptions of 200 mental disorders which were created to meet these needs of the profession are not considered final. That is, most of *DSM-III*'s diagnostic categories are not fully validated by research. In fact, the definitions of many of the disorders were established on the basis of the developers' clinical experience and thus are controversial and have been called arbitrary and incomplete. The developers of *DSM-III* concede that these allegations are true (Spitzer, Williams, and Skodol), and the manual is being revised as research adds to what is now known. The first revision of *DSM-III* appeared in 1987, and *DSM-IV* is expected in the mid-1990s.

In this essay, I will explore the influence of *DSM-III* in a very limited sphere: the rhetorical universe of a single child psychiatrist, Dr. Joan Page. Put differently, I will examine how this 500-page classification system of psychiatric disorders shapes reality for Dr. Page, that is, shapes what she knows about mental illness and how she communicates that knowledge. I will limit my study to an exploration of the influence of this text on Dr. Page's diagnostic work; I will not examine how *DSM-III* influences her therapy, research, or teaching. More specifically, I focus on Dr. Page's diagnostic evaluation reports, five-page documents that she writes for each child admitted to her unit in the hospital. In her diagnostic evaluations, Dr. Page creates a full picture of the child's psychosocial adjustment, and she then diagnoses any mental illnesses that are present. My central question in this essay is how does the *DSM-III* manual shape Dr. Page's diagnostic work: her information gathering, her analyses, and her writing? That is, what are the epistemological and textual consequences of *DSM-III*? How is it linked to what Dr. Page knows about mental illness and how she writes about it?

The metaphor of a charter document has proven useful in looking at the meaning of *DSM-III* for Dr. Page. The charter document of a social or political group establishes an organizing framework that specifies what is significant and draws people's attention to certain rules and relationships. In other words, the charter defines as authoritative certain ways of seeing and deflects attention from other ways. It thus stabilizes a particular reality and sets the terms for future discussions. *DSM-III* is a charter document in psychiatry, and the particular reality that it stabilizes is the biomedical conceptual model of mental illness. More specifically, *DSM-III* provides a diagnostic framework for psychiatry, and diagnosis is central in modern medicine. As Feinstein says, "Diagnosis is the focal point of thought in the treatment of a patient. From diagnosis, which gives a name to the patient's ailment, thinking goes chronologically backward to

explore the mechanisms and causes of the ailment . . . and chronologically forward to predict prognosis and choose therapy. . . . *The taxonomy used for diagnosis will inevitably establish the patterns in which clinicians observe, think, remember, and act*" (73, emphasis mine). How the *DSM-III* charter document influences the ways in which Dr. Page observes, thinks, and writes about mental disorder is what I will explore in this essay.

Models of Mental Illness

In order to understand the nature of the *DSM-III* charter framework and the view of mental illness that underlies it, it is necessary to sketch the two independent and competing conceptual models that dominate contemporary psychiatry. The first of these, the one that is invoked in *DSM-III*, is the biomedical model. The second is the interpretation of meaning model (McHugh and Slavney).

The biomedical model in psychiatry is familiar to us from medicine where it so dominates theory and practice that it is, as Mishler argues, "often treated as *the* representation or picture of reality rather than understood as *a* representation" (Mishler et al., 1). Two assumptions from the biomedical model underlie *DSM-III*. The first concerns the nature of mental disorders. This assumption is that there are real, discrete entities to which disease labels such as "schizophrenia" or "major depressive episode" or "attention deficit disorder" ought properly to be applied. These disorders are seen as generic and universal across cultures.

A second assumption of the biomedical model, found in modified form in psychiatry, relates to the causation of disease. It is what Dubos calls the doctrine of specific etiology. In medicine it is widely assumed that diseases are caused by a single specific biological factor and can be cured or prevented with chemical drugs. This is an assumption that developed in the nineteenth and twentieth centuries from work with the infectious diseases, diseases such as pneumonia, tuberculosis, typhoid fever, and syphilis. However, the notion of specific etiology has had to be modified in psychiatry for most (but not all) mental disorders. The assumption of specific etiology has been replaced in psychiatry with the assumption of multiple, interacting etiological factors: biological, psychological, genetic, environmental, and/or social. In fact, it is widely acknowledged in psychiatry that there is not yet much known about the actual causes of most disorders. Further, though there are some drugs that do act specifically on particular disorders, the treatment for most psychiatric disorders is still not "one diagnosis-one drug," as it is for many physical disorders, and it may never be (Rapoport and Ismond, 33). Rather, psychiatric treatment

generally consists of some combination of drugs and individual or family psychotherapy and is likely to vary from case to case, even among patients with the same *DSM-III* diagnosis.

Just as the assumptions of the biomedical model about the nature and causation of mental disorders are familiar to us from medicine, so is its mode of reasoning: identification and then explanation. Patients are first identified by their reported or observed symptoms. Their symptoms are clustered and a disorder then is diagnosed by the psychiatrist. A disease may be known for centuries before its mechanisms and etiology, the how and why of the disease, are explained. In the biomedical model explanation is a cumulative affair, with later research building on earlier. Explanation begins with a search for correlations in populations of patients with the same diagnosis, and the discovery of a correlation can be the first step toward a hypothesis, theory, or law. This familiar hypothetico-deductive approach of medical science, with its stages of identification and explanation, underlies the biomedical perspective in psychiatry and its charter document, *DSM-III*.

The *DSM-III* taxonomy of mental disorders reflects, as I have said, biomedical assumptions, defining mental disorders as real, generic entities which cause distress or impairment in functioning. Further, there is an implication of underlying behavioral, psychological, or biological dysfunction; that is, the disturbance is not just in the relationship between the individual and society (*DSM-III*, 6). However, in defining psychiatric disorders, *DSM-III* avoids speculation about etiology because so little is yet actually known about the causes of most disorders. Rather, *DSM-III* adopts a fully descriptive approach: each of the 200 *DSM-III* disorders is defined with specific operational criteria which are either observable or verifiable clinical findings. The operational criteria for the disorders include such clinical features as type and quantity of symptoms, age of onset, quality of onset (abrupt or gradual), course, impairment, familial patterns of transmission, sex ratio, and complications. The diagnostic criteria for mental disorders do not yet include lab tests, treatment response, or autopsy findings, the biologic criteria which are commonly used to verify diagnoses of physical diseases. Neither does *DSM-III* recommend treatment. Rather, it attempts to describe comprehensively the *manifestations* of mental disorders. It is, then, *DSM-III* categories of mental disorder which control diagnosis, the identification stage of the identification-explanation process of reasoning in the biomedical model.

By contrast, the second conceptual model in contemporary psychiatry, interpretation of meaning, represents a very different set of assumptions about mental illness. The interpretation of meaning model reflects the tradition in which each mentally ill patient is seen as an individual whose

symptoms have meaning particular to him or her. Interpretation is usually guided by the comprehensive constructs of intrapsychic workings and theories of etiology developed by Freud, Adler, or Jung. Generally, symptoms are interpreted as symbolic attempts to express and resolve unconscious conflicts. That is, a patient's unconscious conflicts result in the symptoms. The attitude toward diagnosis in the interpretation of meaning perspective is very different than that in the biomedical perspective. The focus is less on distinguishing, describing, and classifying symptoms than it is on what lies behind these superficial manifestations, that is, on the meaning of the symptoms to the individual patient. Generalizations are less certain in this perspective because insights are drawn from a small number of particular life stories rather than from population samples. In fact, psychiatrists who share this perspective have made little effort to derive refutable principles, because their all-inclusive theoretical constructs of unconscious mechanisms are not susceptible to disproof. Rather, because this type of knowing is based on intuition and empathy, effort has been expended in developing skills in communication and persuasion for use with individual patients (Frank, 173-78).

In summary, those psychiatrists who work within the interpretation of meaning perspective understand the patient as an individual with a story to tell. Those who work within the biomedical perspective see the patient as a member of a group with impairments to be explained. For psychiatrists in the interpretation of meaning perspective each patient presents "an exercise in hermeneutics: a reading of the books of consciousness and behavior for their hidden meanings" (McHugh and Slavney, 133). For psychiatrists who share the biomedical perspective each patient exhibits a form of human activity which can be correlated with biological, psychological, and sociological variables (15). (For more detailed discussions of concepts of mental and physical disease, see Caplan, Engelhardt, and McCartney; Dixon; Fleck; Grob; and Szasz.)

A psychiatrist's choice of perspective, which is often unacknowledged, is the result of his or her personality, education, interests, and particular work situation. And there may be some switching between perspectives as when, for example, a psychiatrist whose perspective is interpretation of meaning must designate a *DSM-III* diagnosis for insurance purposes. Or a psychiatrist whose perspective is biomedical may at times during therapy interpret a patient's symptoms in psychoanalytic terms. However, it is certain that the dominant perspective of virtually all of the 130 members of the American Psychiatric Association task force which developed *DSM-III* was biomedical. These people were chosen on the basis of their clinical and research experience, and most had made "significant contributions" to the literature in diagnosis (*DSM-III*, 2).

Research Methods

To answer my questions about the epistemological and textual consequences of *DSM-III* for the diagnostic work of one child psychiatrist, I used a triangulated approach, examining Dr. Page's writing activities and texts from several angles (Denzin). First, in order to illuminate *DSM-III's* role in shaping Dr. Page's understanding of what constitutes significant information and how to collect that information, I observed her in the hospital and interviewed her frequently over a two year period (1984-1986). I was guided in my procedures and analyses by the work of Spradley and Odell, Goswami, and Herrington. I also had Dr. Page keep a log in which she recorded all her data-gathering activities as she prepared to write one of her diagnostic evaluations.

Second, in order to illuminate *DSM-III's* role in shaping Dr. Page's analysis of her patient data, I audiotaped her as she composed and dictated the diagnostic evaluations of four patients. I also studied the resulting evaluation texts, paying special attention to the ways Dr. Page analyzed the data to reach her diagnosis.

Finally, in order to elucidate the role *DSM-III* played in the social functioning of Dr. Page's evaluation texts, I interviewed her readers, that is, her colleagues on the hospital unit. I asked them how they perceived and used Dr. Page's evaluations and what for them were the evaluations' sources of authority and persuasion. I also questioned Dr. Page in this regard.

These multiple data sources worked together, adding to, refining, and cross-checking each other, as I worked to establish the influence of the *DSM-III* charter document on Dr. Page's knowing and writing. The role I played as I observed and interviewed Dr. Page and her colleagues was that of Dr. Page's friend and coresearcher. Thus, as I began my research in the hospital, Dr. Page introduced me to various informants, and because she is a person who is respected and trusted, I was granted immediate access to that setting.

THE SETTING AND THE PARTICIPANTS

The hospital in which Dr. Page works is a large, university-affiliated, evaluation, research, and treatment hospital for handicapped children. She is the child psychiatrist member of the rehabilitation team, a group of eighteen professionals from ten disciplines. This team runs an eight-bed rehabilitation unit for children who have suffered brain injuries from accidents or illnesses.

The rehabilitation ward is comprised of two large adjoining rooms, each

with four beds. At the end of one of the rooms is a glass-enclosed nursing station with three desks, medicine cabinets, and a shelf where patients' notebook-like charts stand side by side. At the time I observed the ward, there were four children in the first room, two of whom were still in their beds in coma. A third child was walking unsteadily with a cane, and the fourth was in a wheel chair. Three of these children had been struck by cars while on foot or bicycle, and one was thrown from a three-wheel motor bike. On the wall beside each child's bed was a bulletin board covered with get well cards and posters. Also on each bulletin board was a recent school photograph of the child. According to Dr. Page, the photograph of the pre-injury child is useful to parents and staff. The healthy child in the photograph looks very different than the injured one, the healthy child's face animated and vital, eyes focused on the viewer, muscles relaxed. The photo reminds staff and parents of the goal of rehabilitation, a goal that at times seems terribly remote.

The child in the wheel chair was five-year-old Eddie Farnham who, the nurse told me, was responding to simple commands, saying a few words, and beginning to regain muscle control. Eddie was hit by a car when he ran into the street, and he suffered severe closed head trauma and was in a coma for six weeks. At the end of four weeks, as he was emerging from coma, he was admitted to the rehab unit from a neighboring hospital's intensive care unit. In the two months since Eddie's admission to the rehab unit, he had been evaluated and/or treated by all of the eighteen specialists on the rehabilitation team, and his family had been counselled about accepting and managing what were certain to be permanent disabilities and long-term care needs. It is on Dr. Page's diagnostic evaluation of Eddie, conducted and written during his first two weeks on the unit, that I will focus in this essay.

In Dr. Page's diagnostic evaluations she constructs a full picture of the child's behavior and functioning before the accident and diagnoses any mental disorders that were present at that time. These psychiatric evaluation documents help the team plan treatment and deliver care because it is known that the emotional and behavior problems that children have before such disabling accidents are likely to reappear in exaggerated form during the long recovery period. When Dr. Page completes her diagnostic evaluation text, she gives one copy to the rehab unit director and one to the unit social worker. A third copy goes into the patient's chart for other team members to read. Dr. Page keeps the original for her own clinical and research needs and for patients' future therapists and school personnel who may request it.

Dr. Page's workplace, the rehabilitation unit, is, obviously, medically rather than psychiatrically oriented. And because the hospital is university-

affiliated, it is also research oriented. In fact, this institution is well known for its research on the correlation of biologic factors and particular psychiatric disorders and on the effects of drug therapies: types of research commonly conducted within the biomedical model. Thus, the biomedical perspective, rather than the interpretation of meaning perspective, is likely to be adopted by psychiatrists working in this setting. This is the case with Dr. Page. In addition, she told me, her training influenced her biomedical understanding of mental illness. She spent four years after medical school learning a medical specialty, pediatrics, before she decided to enter a five-year training program in psychiatry. Although she was, during her training in psychiatry, exposed to psychoanalytic interpretation, she chose not to undergo analysis herself, and she never really abandoned her medical ways of thinking. Eight years ago she came to this university medical center where she now does both clinical and research work. It is not surprising then that the rehab unit director, Dr. John Van Zante, a surgeon/rehabilitation specialist, described Dr. Page's evaluation as taking "the standard medical approach to illness." He explained, "Joan takes a complete history. She examines the symptoms and then groups them to see if mental disorder is present. We must know the sort of thing that Joan finds: the emotional and social factors of the case. We need to know these if we're to help our patients and their families reconstruct their lives. The challenge of rehabilitation is not just physical. Relieving pain and suffering on this unit requires both physical *and* emotional work."

Results and Discussion

The *DSM-III* charter document had epistemological and textual consequences for Dr. Page's diagnostic work in two general areas. The first is *DSM-III selectivity*. That is, the *DSM-III* diagnostic classification system determined the type and amount of information that Dr. Page gathered about her patients. Put differently, this manual defined what Dr. Page chose, tacitly and explicitly, to observe and to know. *DSM-III* selectivity was particularly evident in Dr. Page's interview with the parent, an extremely important source of information for the child psychiatrist (Rapoport and Ismond, 37). And because *DSM-III* selectivity controlled what Dr. Page chose to find out about her patients, it is also evident in her final evaluation text.

The second area in which *DSM-III* influenced Dr. Page's diagnostic evaluations was in her analysis of the information she gathered about her patients. *DSM-III* controlled not only the information Dr. Page selected as significant, but also how she analyzed that information, how she

reasoned from her data to reach a diagnosis. The source of Dr. Page's confidence in her diagnostic judgments lies in her *DSM-III-backed analysis* of the appropriate information. *DSM-III-backed analysis* is particularly evident in the two final sections of her evaluation text, "Summary and Recommendations" and "*DSM-III Diagnoses*."

DSM-III SELECTIVITY: THE PARENT INTERVIEW

Underlying Dr. Page's interview with Eddie Farnham's mother was the *DSM-III* assumption that mental disorders are real, discrete entities that can be identified in patients by their clinical features. Dr. Page spent one and a half hours with Mrs. Farnham eliciting information about the clinical features designated by *DSM-III* as constituting criteria for various disorders. Dr. Page did not attempt to interpret the underlying meaning of Eddie's symptoms nor to speculate about the etiology of those symptoms.

Dr. Page structured her questioning of Mrs. Farnham with an interview schedule, a set of questions based on *DSM-III* diagnostic categories. This interview schedule, the "Kiddie/SADS" (the Children's Schedule of Affective Disorders and Schizophrenia), is designed to lead directly to a *DSM-III* diagnosis of mental disorder. The Kiddie/SADS moves from one diagnosis to the next, with each question referring to one of the operational criteria defining a disorder. If, during her questioning of Mrs. Farnham about Eddie, Dr. Page found no symptoms for a particular disorder, she moved on quickly. However, when her questioning revealed the presence of some of the diagnostic criteria for a disorder, she questioned Mrs. Farnham further. If Dr. Page found all of the required criteria for a disorder to be present, she made a diagnosis. In Eddie's case, as we'll see below, criteria were partially fulfilled for one disorder (attention deficit disorder with hyperactivity) and completely fulfilled for another (delirium).

Mrs. Farnham cooperated fully during the interview, answering Dr. Page's questions calmly and thoughtfully. Many diagnoses were passed over quickly when no symptoms were found. For example, Eddie manifested no evidence of such disorders as depression, mania, thought disorder, autism, eating disorder, or panic disorder. Movement through the interview schedule slowed down, however, when Dr. Page reached the questions concerning the clinical features of the *DSM-III* disorder, attention deficit disorder with hyperactivity (ADD). These questions concerned Eddie's behavior, activities, attention span at home and school, his sleep patterns, his interactions with others, and the age of onset and duration of various behaviors. The *DSM-III* criteria for attention deficit disorder with hyperactivity are reproduced in table 15.1. The manual requires that eleven of the nineteen criteria be present if a diagnosis of ADD is to be made.

Diagnostic Criteria for Attention Deficit Disorder with Hyperactivity

The child displays, for his or her mental and chronological age, signs of developmentally inappropriate inattention, impulsivity, and hyperactivity. The signs must be reported by adults in the child's environment, such as parents and teachers. Because the symptoms are typically variable, they may not be observed directly by the clinician. When the reports of teachers and parents conflict, primary consideration should be given to the teacher reports because of greater familiarity with age-appropriate norms. Symptoms typically worsen in situations that require self-application, as in the classroom. Signs of the disorder may be absent when the child is in a new or a one-to-one situation.

The number of symptoms specified is for children between the ages of eight and ten, the peak age range for referral. In younger children, more severe forms of the symptoms and a greater number of symptoms are usually present. The opposite is true of older children.

A. Inattention. At least three of the following:

- (1) often fails to finish things he or she starts
- (2) often doesn't seem to listen
- (3) easily distracted
- (4) has difficulty concentrating on schoolwork or other tasks requiring sustained attention
- (5) has difficulty sticking to a play activity

B. Impulsivity. At least three of the following:

- (1) often acts before thinking
- (2) shifts excessively from one activity to another
- (3) has difficulty organizing work (this not being due to cognitive impairment)
- (4) needs a lot of supervision
- (5) frequently calls out in class
- (6) has difficulty awaiting turn in games or group situations

C. Hyperactivity. At least two of the following:

- (1) runs about or climbs on things excessively
- (2) has difficulty sitting still or fidgets excessively
- (3) has difficulty staying seated
- (4) moves about excessively during sleep
- (5) is always "on the go" or acts as if "driven by a motor"

D. Onset before the age of seven.**E. Duration of at least six months.****F. Not due to Schizophrenia, Affective Disorder, or Severe or Profound Mental Retardation.**

Table 15.1.

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In 1987, one year after the present study was completed, revised criteria for ADD were published in *DSM-III-R* (revised). The revised criteria for this disorder, which was renamed attention-deficit hyperactivity disorder (ADHD), are appended at the end of this chapter.

In her interview with Mrs. Farnham, Dr. Page elicited a large amount of information about Eddie's emotions, behaviors, impairments, family history, and patterns of interaction. These verifiable clinical features constitute the operational criteria required for a diagnosis of mental disorder. Although the large amount of information that Dr. Page elicited with her *DSM-III*-based interview schedule will serve her clinical and research endeavors very well, she said that at times she feels frustrated by what the manual selects to *leave out*. Her *DSM-III*-based interview schedule, she said, requires her to structure the parent interview more tightly than she used to do, more tightly, in fact, than she considers ideal. "Time is the problem," she said. "I just can't let the parent go off on tangents. Which is too bad, because sometimes by following the parent's lead you get the richest material. Now I go in and get lots of information as quickly as possible. The hour and a half it takes me to get all that information and the diagnosis is really very quick. But at times I feel like a parent might tell me that her husband committed suicide last week by walking in front of a truck, and I'd go to the next question on the schedule and ask, 'What's your place of employment?'"

Thus, for Dr. Page *DSM-III* selectivity is not wholly satisfying. But apparently its limitation, the fact that it permits no time to "let people ramble on about their situations," is compensated for by Dr. Page's certainty that she has elicited the type and amount of information she needs to make an accurate *DSM-III* diagnosis. (For an analysis of physician-patient discourse that examines the issues of structure and control in medical interviews, see Mishler.)

DSM-III SELECTIVITY: THE EVALUATION TEXT

Bazerman argues that certain textual features reveal the writer as a "statement-maker coming to terms with reality from a distinctive perspective" (363). Features of Dr. Page's texts which reveal her biomedical orientation and, more particularly, her *DSM-III* selectivity are her headings, her citations of her data sources, and her patterns of reporting and organizing her data.

Six of Dr. Page's eight headings in her evaluation of Eddie Farnham reflect *DSM-III* assumptions about what counts as relevant knowledge in defining mental disorder. These six headings all focus on the clinical features of the case and Dr. Page's sources of information about these features. Because *DSM-III* takes a descriptive approach to mental illness, the clinical features of the case are, as I have said, the *sine qua non* of diagnosis. And Dr. Page's focus on the sources of her data reflects the assumption that psychiatric disorders are generic and universal and are known by objective signs and symptoms. Knowledge lies in verifiable data,

not in the individual psychiatrist's interpretation of particular cases. Moreover, Dr. Page's focus on the sources of her data emphasizes the reliability of her diagnoses, the concern which initiated the development of *DSM-III*, as I explained earlier. The first six headings in Dr. Page's diagnostic evaluation text are:

1. "Identifying Information" (Basic facts about the patient)
2. "Information Sources"
3. "History" (of the present physical illness)
4. "Kiddie/SADS" (review of psychiatric symptoms)
5. "Observation of Patient"
6. "Information about Family"

Like the headings of Dr. Page's text, her patterns of reporting and organizing of her data also reveal her biomedical perspective and *DSM-III* selectivity. In the evaluation's central section, "Kiddie/SADS," found on pages 2-4 of the five-page evaluation, Dr. Page presents the clinical data from the parent interview. She reports her clinical findings at the lowest possible level of inference, presenting them in the same order in which she elicited them in the interview: first, the facts about the child's psychosocial adjustment and, second, the child's psychiatric symptoms organized by *DSM-III* categories of mental disorder. This *DSM-III*-based review of psychiatric symptoms is modelled on the review of symptoms (or systems) which forms an essential part of the medical history. Dr. Page's Kiddie/SADS review of psychiatric symptoms forms the core of her evaluation and provides the grounds for her subsequent analysis and diagnostic conclusions.

The assumptions about knowledge which underlie Dr. Page's reporting and organizing of her data are very different than those which underlie the psychoanalytic case study, the best-known written form of the interpretation of meaning perspective. Unlike Dr. Page's evaluation text which describes and classifies clinical findings, the psychoanalytic case study presents a narrative which attempts to explain them. The aim of the psychoanalytic case study is to construct the most coherent, plausible, and therapeutic story of the patient's symptoms and their relationship to his or her unconscious conflicts. As Spence puts it, the psychoanalytic case study is less interested in "historical" events than it is in "narrative" events. In fact the psychoanalytic narrative may leave out, and eventually take the place of, the patient's original "raw" data and the analyst's original "basic" observations. And clinical findings which don't fit the prevailing narrative order of the psychoanalytic case story may receive no attention at all (Spence, 23-24). By contrast, Dr. Page avoids interpreting the meaning or etiology of the patient's symptoms with psychoanalytic constructs. Rather, she describes all of the clinical facts that she

has elicited or observed, facts generated and organized by the biomedical constructs of *DSM-III*.

In addition to reporting all of her clinical findings at the lowest possible level of inference, Dr. Page reports the source of nearly every one of her findings. The sources she cites in Eddie's evaluation include his mother, his teacher, the social worker, the nurse, the hospital chart, and the Achenbach Child Behavior Checklist that Eddie's mother filled out. In the following quote, taken from the middle of the "Kiddie/SADS" section's review of symptoms, Dr. Page rules out several *DSM-III* diagnoses because no symptoms are present. She then reports the symptoms that Eddie exhibits which fulfill some (but not all) of the operational criteria for a *DSM-III* diagnosis of attention deficit disorder with hyperactivity. This section of Dr. Page's evaluation text illustrates her patterns of reporting and organizing her data and her citing of her information sources. These are all shaped by *DSM-III* selectivity.

Mrs. Farnham denies any symptoms suggestive of depression or mania. Symptoms of psychosis are also denied. Since age 4, Eddie has had an imaginary companion whose name is Edward. Since age 4, his occupation with the imaginary companion has lessened and is now only an occasional thing. Symptoms of delusions are denied. Symptoms of thought disorder are denied. Autistic behavior is denied. Symptoms of eating disorder are denied.

The teacher complains that Eddie does not listen in the classroom. He has difficulty paying attention and keeping his mind on school work. The mother denies symptoms of impulsivity; however, it is important to note that the school is holding the child back for a very short attention span.

It is difficult for Eddie to sit still. He appears always on the go. He likes to run about and climb about on things a lot. His mother states that he enjoys doing the busier things.

DSM-III selectivity, then, determines the type, amount, and sources of data that Dr. Page gathers during the evaluation process, and it shapes her presentation of that data. That *DSM-III* selectivity plays a central role in Dr. Page's confidence in her diagnostic conclusions is suggested by her response to a question in a text-based interview. I asked her if she would be willing to delete the second section of the evaluation, "Information Sources," where she lists all her data sources before she begins her presentation. She said she would not and offered this explanation: "In the 'Information Sources' section I show how reliable the evaluation is, if it's based on enough data from the right sources to make an accurate diagnosis, a diagnosis that other psychiatrists will agree with."

DSM-III selectivity, then, shapes several features of Dr. Page's evaluation text. These textual features include her headings, which focus on the clinical features established by the manual as defining mental disorders, her careful citing of the sources of her information, her reporting of her data at the lowest level of inference, and her organizing of the patient data according to *DSM-III* diagnostic categories.

DSM-III-BACKED ANALYSIS: "SUMMARY AND RECOMMENDATIONS"

In Dr. Page's "Summary and Recommendations" near the end of her evaluation text, we see the second way in which *DSM-III* influences her work: *DSM-III*-backed analysis. In this section of her evaluation Dr. Page's analysis of her data is shaped by rules of diagnosis outlined in *DSM-III*. As she works with the information she gathered on Eddie Farnham, she applies the rules of diagnosis specified by the manual for attention deficit disorder with hyperactivity. She is aware, of course, of *DSM-III*'s stipulation that a patient, in order to be diagnosed ADD, must fulfill eleven of the nineteen diagnostic criteria for that disorder.

Dr. Page told me in an interview following her dictation of Eddie's evaluation, "In planning my Summary and Recommendations I summarize the criteria I've identified that suggest a possible diagnosis in the patient. I then ask myself, 'What do I have here? Can I make this claim?' " In the first paragraph of her "Summary and Recommendations," which is quoted below, Dr. Page makes a limited "claim," explaining that though many of the criteria for a diagnosis of ADD are present in Eddie's case, some of the required criteria—those providing evidence for impulsivity—are not. The mother did not report impulsivity, and the teacher's report, always an important source of information for the child psychiatrist, had not yet arrived.

Eddie is a 5 and 1/2 year old white child with a history of prematurity, rocking, head banging, and bruxism. From the mother's account, he fulfills many diagnostic criteria for attention deficit disorder with hyperactivity. The mother, however, does not describe impulsivity. So a school report of observation from the teacher would be helpful in conclusively making the *DSM-III* diagnosis. Because of this prior behavioral problem, Eddie is at high risk for the development of a post-traumatic psychiatric disorder.

Because Dr. Page did not have the evidence of impulsivity required for a diagnosis of ADD, she recorded in the final section of Eddie's evaluation, "*DSM-III* Diagnoses": "Rule out attention deficit disorder with hyper-

activity." This statement both alerts her readers that it is a likely diagnosis and works to control future diagnostic discussions of this patient.

Dr. Page's *DSM-III*-backed analysis of her data also resulted in a second diagnosis. Principles outlined in the manual for reasoning from clinical data to diagnostic conclusions state that more than one disorder may be diagnosed in a patient if the required criteria are met. In the second paragraph of Dr. Page's "Summary and Recommendations" she diagnoses in one sentence the obvious second diagnosis of delirium. "Being still comatose, Eddie fulfills diagnostic criteria for delirium." Delirium is one of ten *DSM-III* disorders in which psychological or behavioral abnormality is due to brain dysfunction of known cause. The diagnostic criteria for delirium are reproduced in table 15.2.

Diagnostic Criteria for Delirium

- A. Clouding of consciousness (reduced clarity of awareness of the environment), with reduced capacity to shift, focus, and sustain attention to environmental stimuli.
- B. At least two of the following:
 - (1) perceptual disturbance: misinterpretations, illusions, or hallucinations
 - (2) speech that is at times incoherent
 - (3) disturbance of sleep-wakefulness cycle, with insomnia or daytime drowsiness
 - (4) increased or decreased psychomotor activity
- C. Disorientation and memory impairment (if testable).
- D. Clinical features that develop over a short period of time (usually hours to days) and tend to fluctuate over the course of a day.
- E. Evidence, from the history, physical examination, or laboratory tests, of a specific organic factor judged to be etiologically related to the disturbance.

Table 15.2.

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In her "Summary and Recommendations" Dr. Page refers briefly to "diagnostic criteria" and "*DSM-III* diagnosis," making no effort to explain them. She assumes that her readers know and value this way of defining and reasoning about mental illness. And she is right. The interviews with the readers of Dr. Page's evaluation texts revealed that *DSM-III* is indeed a powerful source of persuasion for them. All three of her audiences—rehab unit clinicians, mental health researchers, and insurance/legal personnel—expect, indeed require, *DSM-III* diagnostic analysis in Dr. Page's evaluations. However, a full exploration of the manual's role in the social functioning of Dr. Page's texts (and in enhancing her own professional self-esteem) lies beyond the scope of this essay. The point to be made here

is that Dr. Page's clinical and diagnostic judgments in her "Summary and Recommendations" are those of a professional speaking authoritatively, a professional confident of her conclusions. The evidence on which her claims are grounded and the analysis that produces them are shaped by *DSM-III*.

DSM-III-BACKED ANALYSIS: "*DSM-III* DIAGNOSES"

In the final section of Eddie Farnham's evaluation text, "*DSM-III* Diagnoses," Dr. Page lists her diagnostic conclusions. Here, in addition to ADD and delirium, the two disorders that she argues for in her "Summary and Recommendations," Dr. Page makes the four other diagnostic statements required by *DSM-III*'s "multi-axial" framework.

The developers of *DSM-III* departed from earlier, unitary diagnostic systems in order to include as much information about the patient as possible. It was argued that several types of information are needed in order to understand the complexity of individual patients. Thus a psychiatrist makes diagnostic statements about the patient on five "axes," each of which records a different kind of information. On Axis I are recorded the diagnoses of mental disorders such as those discussed above, delirium and attention deficit disorder, as well as schizophrenia, paranoia, manic depressive illness, major depression, the anxiety disorders, and many more. Fewer diagnoses are recorded on Axis II: only the adult personality disorders and the specific childhood developmental disorders of language, reading, math, and articulation. The reason for separating out these Axis II diagnoses was to highlight them; they tend to be overlooked when attention is paid to the more obvious Axis I disorders. Multiple diagnoses may be made on both axes. On Axis III the psychiatrist describes any physical illness the patient may have, and on Axis IV he or she judges the severity of psychological stressors in the patient's environment. Finally, on Axis V, the psychiatrist records a judgment about the patient's highest level of functioning in the past year. The first three axes, the mental and physical diagnoses, are typological, and require statements involving categories. Axes IV and V, levels of stressors and functioning, require dimensional judgments. Dr. Page's diagnostic judgments about Eddie Farnham conclude her evaluation:

DSM-III Diagnoses

- Axis I: 293.00 Delirium
314.01 Rule out attention deficit disorder with hyperactivity.
- Axis II: 799.90 Diagnosis deferred on Axis II.
- Axis III: History of severe closed head injury on 3/13/86 with

multiple skull fractures and cerebral contusion, followed by persistent coma.

Axis IV: Severity of psychosocial stressor – unspecified.

Axis V: Highest level of adaptive functioning in past year – fair. Moderate impairment in school functioning necessitating being held back for a second year.

The diagnostic conclusions about Eddie that Dr. Page makes on Axes II–V, like those on Axis I, are based on the clinical data reported in the evaluation and are controlled by *DSM-III*-backed rules of analysis. Dr. Page made these latter diagnostic statements quickly as she dictated, without pausing to study her notes and her manual as she did during her formulation of the diagnoses on Axis I. This relative speed is explained by the fact that she decided to put off making statements on Axes II and IV because of inadequate information and lack of immediate relevance to treatment planning. And on Axes III and V she briefly summarizes the evaluation's clinical data and makes the judgment that Eddie's functioning during the preceding year was fair.

DSM-III's multiaxial diagnostic system thus provides several kinds of information about the patient – physical, socio-familial, and behavioral – without implying that these are the causes of the mental disorders diagnosed on Axes I and II. In this way, *DSM-III* has satisfied the need of clinicians and researchers for a full picture of the patient while keeping the psychiatric diagnoses free from unproven theories of etiology. For example, the patient's physical condition and social situation, recorded on Axes III and IV, are important pieces of information for treatment planning. But the role these play in causing most mental disorders is not yet known.

DSM-III-backed analysis, then, shapes Dr. Page's reasoning as she moves from clinical data to diagnostic conclusions. That is, *DSM-III* provides the diagnostic principles she uses, principles such as numbers of criteria required for a diagnosis and ways of splitting the data into discrete parts, the five "axes." *DSM-III*-backed analysis is most obvious in the final two sections of the evaluation, "Summary and Recommendations" and "DSM-III Diagnoses," where Dr. Page refers specifically to it in her text and final heading.

Conclusion

To summarize, in this essay I have argued that the American Psychiatric Association's third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (1980) can be understood as a charter document for contemporary psychiatry. That is, it provides a framework for diagnosing mental illness that has epistemological and textual consequences

for the discipline. The *DSM-III* diagnostic taxonomy is based on the assumptions of the biomedical model about what disease is and how it can be known.

To examine the epistemological and textual consequences of the *DSM-III* charter document for psychiatrists, I studied the diagnostic processes and texts of one child psychiatrist, Dr. Joan Page, a staff psychiatrist in a large university hospital. I found that her diagnostic thinking and writing is profoundly influenced by *DSM-III*. First, this manual shapes Dr. Page's understanding of what counts as relevant information about her patients and thus controls her gathering of data. Second, its diagnostic principles control her analysis of that information. In its role as charter document, the *DSM-III* manual of mental disorders is closely linked to what Dr. Page knows about mental illness and how she writes about it.

DSM-III is, then, an extremely important document in Dr. Page's diagnostic work, work which lies at the heart of both her clinical and research endeavors. *DSM-III* is also an important document in the history of American psychiatry and has, apparently, resulted in one of the main purposes for which it was developed, achieving "a noticeable increase in the reliability of diagnostic judgments and a facilitation of communication among clinicians and researchers" (Klerman, 18). The manual's specific operational definitions of mental disorders have also played an important role in suggesting the questions that psychiatric researchers are now asking. Because so many of the statements made in *DSM-III* about the various disorders are not based on research data, this text has spotlighted the gaps in factual information in psychiatry. That is, it has pointed to areas of needed research. As Maxmen explains, before *DSM-III*, when mental disorders were only vaguely defined, "the profession could conceal its ignorance" (58). However, in *DSM-III* "areas of ignorance" are now clear, and, according to Robert Spitzer, the manual's chief developer, *DSM-III* has resulted in an "explosion" of research (pers. com., February 1987). Some 2000 articles were published between 1980 and 1987 reporting research that used or directly investigated the manual's diagnostic categories and criteria. By providing a matrix and forms for discourse, the *DSM-III* text has proven to be a powerful heuristic for psychiatric inquiry and writing, generating a large number of additional texts.

Besides informing the work of psychiatric researchers and clinicians, *DSM-III* now plays an important role in the education of most young psychiatrists. Students read and learn *DSM-III*, and the manual's diagnostic categories provide the organizing framework for most textbooks of psychiatry. Moreover, *DSM-III*-based activities inform at least part of students' clinical training. This text thus shapes students' knowledge and articulation of mental disorder from the beginning. The implications of this are clear. Various kinds of *DSM-III*-based documents produced for these students, and eventually by them, will proliferate, further increas-

ing the web of this discourse system. The influence of the *DSM-III* charter document on thinking and writing in psychiatry is thus likely to become more and more pervasive.

APPENDIX

Diagnostic criteria for 314.01 Attention-deficit Hyperactivity Disorder

Note: Consider a criterion met only if the behavior is considerably more frequent than that of most people of the same mental age.

A. A disturbance of at least six months during which at least eight of the following are present:

- (1) often fidgets with hands or feet or squirms in seat (in adolescents, may be limited to subjective feelings of restlessness)
- (2) has difficulty remaining seated when required to do so
- (3) is easily distracted by extraneous stimuli
- (4) has difficulty awaiting turn in games or group situations
- (5) often blurts out answers to questions before they have been completed
- (6) has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension), e.g., fails to finish chores
- (7) has difficulty sustaining attention in tasks or play activities
- (8) often shifts from one uncompleted activity to another
- (9) has difficulty playing quietly
- (10) often talks excessively
- (11) often interrupts or intrudes on others, e.g., butts into other children's games
- (12) often does not seem to listen to what is being said to him or her
- (13) often loses things necessary for tasks or activities at school or at home (e.g., toys, pencils, books, assignments)
- (14) often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g., runs into street without looking

Note: The above items are listed in descending order of discriminating power based on data from a national field trial of the *DSM-III-R* criteria for Disruptive Behavior Disorders.

B. Onset before the age of seven.

C. Does not meet the criteria for a Pervasive Developmental Disorder.

Criteria for severity of Attention-deficit Hyperactivity Disorder:

Mild: Few, if any, symptoms in excess of those required to make the diagnosis and only minimal or no impairment in school and social functioning.

Moderate: Symptoms or functional impairment intermediate between "mild" and "severe."

Severe: Many symptoms in excess of those required to make the diagnosis and significant and pervasive impairment in functioning at home and school and with peers.

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