UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

JAMES L. RADTKE, JR.,	)	
	)	
Plaintiff,	)	
	)	
v.	)	No. 4:13 CV 213 ERW
	)	
REBECCA MARIE WINZEN, et al.,	)	
	)	
Defendants.	)	

MOTION FOR LEAVE TO FILE BRIEF IN EXCESS OF 15 PAGES

Defendant American Psychiatric Association ("APA") moves for leave to file its Memorandum in Support of its Motion to Dismiss in excess of 15 pages.

In support, APA states:

Plaintiff's Complaint raises three claims against APA, and APA believes those claims are invalid for multiple reasons, including lack of constitutional standing, deficiencies under general tort principles, unconstitutionality under the First Amendment, failure to meet the requirements of the Civil Rights Act, and failure to satisfy federal pleading requirements.

APA has attempted to succinctly set forth its authorities on behalf of its motion to dismiss, but because of the important issues involved, including constitutional First Amendment issues, APA requires more than 15 pages. APA therefore respectfully seeks leave to file the attached Memorandum, of 23 pages, in support of its motion.

Respectfully submitted,

THOMPSON COBURN LLP

By */s/ Mark Sableman*
Mark Sableman, 36276MO
Anthony Blum, 60993MO
One US Bank Plaza

St. Louis, Missouri 63101
314-552-6000
FAX 314-552-7000
msableman@thompsoncoburn.com
ablum@thompsoncoburn.com

Attorneys for Defendant American Psychiatric Association

Certificate Of Service

I hereby certify that on May 20, 2013, the foregoing was filed electronically with the Clerk of Court to be served by operation of the Court's electronic filing system upon the following:

S. Randolph Kretchmar
1170 Michigan Avenue
Wilmette, IL 60091
srandolphk@gmail.com

James C. Thoele
Brinker & Doyen, LLP
34 N. Meramec Ave. 5th Floor
Clayton, MO 63105
jthoele@brinkerdoyen.com

Kenneth W. Bean
Sandberg, Phoenix & von Gontard, P.C.
600 Washington Ave. 15th Floor
St. Louis, MO 63101-1313
kbean@sandbergphoenix.com

Michael E. Hughes
St. Louis County Counselor's Office
41 S. Central Avenue
Clayton, MO 63105
mhughes2@stlouisco.com

I further certify that on May 20, 2013, a true and correct copy of the foregoing was served on Defendant Allen Frances, M.D., by mail to:

Dr. Allen Frances, M.D.
1820 Avenida Del Mundo
Coronado, CA 92118
allenfrances@vzw.blackberry.net

/s/ Mark Sableman
Mark Sableman
Attorney for American Psychiatric Association
Thompson Coburn LLP
One US Bank Plaza
St. Louis, MO 63101
(314) 552-6000

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

JAMES L. RADTKE, JR.,	)	
	)	
Plaintiff,	)	
	)	
v.	)	No. 4:13 CV 213 ERW
	)	
REBECCA MARIE WINZEN, et al.,	)	
	)	
Defendants.	)	

MEMORANDUM OF LAW IN SUPPORT OF MOTION TO DISMISS

The Amended Complaint's allegations against American Psychiatric Association ("APA"), a non-profit medical specialty society that works to promote the highest quality of care for individuals with mental disorders, are based solely upon APA's publication of its *Diagnostic and Statistical Manual of Mental Disorders* ("*DSM*"). These activities are fully protected under the First Amendment, and not actionable in tort.

Initially, because Plaintiff's alleged chain of causation linking APA to his alleged injury is extremely speculative and fanciful, he lacks the requisite constitutional standing to bring claims against APA. Thus, the APA claims should be dismissed for lack of subject-matter jurisdiction under Federal Rule of Civil Procedure 12(b)(1).

Further, Plaintiff's products liability and negligence claims fail as a matter of law under both general tort principles and the First Amendment. The conspiracy claim also fails a matter of law under Title 42 and the First Amendment because APA is not a state actor, there is no causal link, no true conspiracy can be alleged, and Plaintiff cannot allege class-based invidious discriminatory animus. Accordingly, Plaintiff's complaint against APA should be dismissed with prejudice.

STATEMENT OF ALLEGED FACTS

APA is a professional society dedicated to the "public health issue of 'mental illness.'" Compl. (ECF No. 12) at ¶¶ 10-11. APA publishes the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* and *Fourth Edition, Transcript Revision* ("*DSM-IV*" and "*DSM-IV-TR*"). *Id.* at ¶¶ 13, 52.

Plaintiff alleges that on February 5, 2011 the St. Louis County Police went to Plaintiff's home after Plaintiff's parents called and said they believed he was suicidal. *Id.* ¶ 15-16. Plaintiff was taken to a hospital and admitted as a psychiatric patient. *Id.* at ¶¶ 17, 20. He was treated there and released two days later. *Id.* at ¶¶ 22-23.

APA's only involvement in this chain of events is that the St. Louis County Police, Mercy Health, their employees, and Dr. Taca allegedly "fundamentally relied" on "APA's characterizations of 'mental illness or 'mental disorder'" in *DSM-IV*, which the APA publishes, in making decisions and taking actions that the complaint alleges "force[d] the Plaintiff into the role of a psychiatric patient and deprive[d] him of his rights under color of law." *Id.* at ¶¶ 13, 24-25. There are no allegations that APA brought Plaintiff to the hospital, treated him as a psychiatric patient, advised any of the other defendants as to Plaintiff, required anyone to use the *DSM*, or that it has given any opinions on whether the *DSM* was used properly in this case. The Complaint is also devoid of any allegations that that APA has ever had any direct involvement or relationship with Plaintiff or any of the Defendants.

BACKGROUND ON THE *DSM*

While APA does not admit the allegations of the Complaint, particularly as they relate to APA, it has invoked Rule 12, which requires the court to judge the legal sufficiency of the complaint while treating all well-pled and plausible allegations as if they were true. Given the

nature of the allegations, and the falsity of Plaintiff's allegations, APA stresses that this brief deals with Plaintiff's inflammatory and erroneous allegations about APA solely because the procedural rules require that they be accepted for purposes of this motion to the extent they are plausible.

Courts may consider documents "specifically mentioned" in the complaint, such as the *DSM* here. *See Moses.com Sec., Inc. v. Comprehensive Software Sys., Inc.*, 406 F.3d 1052, 1063 n.3 (8th Cir. 2005); *see also Illig v. Union Elec. Co.*, 652 F.3d 971, 976 (8th Cir. 2011) ("In addressing a motion to dismiss, the court may consider the pleadings themselves, materials embraced by the pleadings, exhibits attached to the pleadings, and matters of public record."). Thus, the Court may examine *DSM-IV* in connection with this motion. A copy of the introductory section of *DSM-IV* (from its cover to p. xxvii) is attached as Exhibit A.

DSM-IV explains, in detailed introductory sections, that it was created with the involvement of "[m]ore than 1,000 people (and numerous professional organizations)," including 13 Work Groups (each supported by between 50 and 100 advisers), that each reported to a Task Force of 27 members. *DSM-IV* (Ex. A) at xiii-xv. DSM IV does not purport to state facts; rather, "it is a consensus about the classification of mental disorders derived at the time of its initial publication." DSM IV at xxii.

The introductory sections of *DSM-IV* provide numerous prominent and explicit warnings and disclaimers. *DSM-IV* explains that "although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies the precise boundaries for the concept of 'mental disorder,'" which "like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations." *Id.* at xxi. *DSM-IV* discusses in detail the limitations of its "categorical approach to classification." *See id.* at xxii.

DSM-IV explicitly warns that the "diagnostic categories, criteria, and textual descriptions" in the *DSM* require "clinical judgment" and thus "are meant to be employed by individuals with appropriate clinical training and experience in diagnosis," and "not be applied mechanically by untrained individuals" (such as laypersons, including police officers). *Id.* at xxiii. It also warns that there are "significant risks" to using the *DSM* for "forensic purposes," and that "[i]n most circumstances, clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a 'mental disorder,' 'mental disability,' 'mental disease,' or 'mental defect.'" *Id.* It also states that "having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time." *Id.* Further, it notes that "DSM-IV reflects a consensus . . . derived at the time of its initial publication" and "[n]ew knowledge . . . will undoubtedly lead to an increased understanding"; thus, "[t]he text and criteria sets included in the DSM-IV will require reconsideration in light of evolving new information." *Id.* Moreover, *DSM-IV* repeats these warnings in a "Cautionary Statement." *See* id. at xxvii.

Finally, contrary to Plaintiff's allegations, *DSM-IV* does not contain information regarding the treatment (with or without drugs) or the cause of mental disorders. As explained above, *DSM-IV* only provides guidelines for the assessment and diagnosis of mental disorders only. *See also DSM-IV-TR* (Ex. B) (providing similar information, warnings and disclaimers).

ARGUMENT

I. THE CLAIMS AGAINST APA MUST BE DISMISSED FOR LACK OF CONSTITUTIONAL STANDING.

Because the pleaded facts do not even plausibly support the elements required for constitutional standing, the claims against APA must be dismissed for lack of subject-matter jurisdiction under Rule 12(b)(1). To satisfy Article III standing, plaintiff must allege (and

ultimately prove) three elements—(1) an injury in fact; (2) causation; and (3) redressability. *Miller v. Redwood Toxicology Lab., Inc.*, 688 F.3d 928, 933 (8th Cir. 2012) (*quoting Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 102-04 (1998)). However, "[w]hen the injury alleged is the result of actions by some third party, not the defendant, the plaintiff cannot satisfy the causation element of the standing inquiry." *Id.* at 935 (*quoting Katz v. Pershing, LLC*, 672 F.3d 64, 76 (1st Cir. 2012)). "[T]here must be a causal connection between the injury and the conduct complained of—the injury has to be 'fairly . . . trace[able] to the challenged action of the defendant, and not . . . th[e] result [of] the independent action of some third party not before the court.'" *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61(1992) (alterations in original) (*quoting Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 41-42 (1976)).

Here, Plaintiff alleges that he was injured as a result of his alleged "false arrest imprisonment and enforced role as a psychiatric patient." ECF No. 12 at ¶¶ 26, 27; *see also* Counts I-VIII. Yet, he alleges as APA's "allegedly unlawful conduct" its publishing the *DSM-IV*, promoting it, and advocating on behalf of psychiatrists and those suffering from mental disorders—all activities protected by the First Amendment. Apparently, under Plaintiff's causation theory, APA as publisher of diagnostic guidelines for mental disorders should be liable for the actions of Defendants Wilhelm and St. Louis County for allegedly unlawfully arresting him at the beckoning of his parents (ECF No. 12 at ¶¶ 15-19), and for those of Defendants Mercy Health, Winzen and Dr. Taca for allegedly unlawfully imprisoning him and forcing him to be treated as a psychiatric patient (*Id.* at ¶¶ 20-23).

Plaintiff's theory is akin to claiming publishers of highway maps and motel directories should be responsible for kidnappings which use highways and motels; a publisher of chemistry text books should be responsible for a poisoning using chemical combinations discussed in the

textbook; or a publisher of a telephone directory should be responsible for a user's harassing phone calls. Legal theories built on such attenuated claims of causation are not plausible; they are fanciful and unbelievable. As stated in *Springall v. Fredericksburg Hospital and Clinic*, 225 S.W.2d 232, 235 (Tex.Civ.App. 1949), *quoted in Union Pump Co. v. Allbritton*, 898 S.W.2d 773 (Tex. 1995):

> [T]he law does not hold one legally responsible for the remote results of his wrongful acts and therefore a line must be drawn between immediate and remote causes. The doctrine of "proximate cause" is employed to determine and fix this line and "is the result of an effort by the courts to avoid, as far as possible the metaphysical and philosophical niceties in the age-old discussion of causation, and to lay down a rule of general application which will, as nearly as may be done by a general rule, apply a practical test, the test of common experience, to human conduct when determining legal rights and legal liability."

Plaintiff's attenuated causation theory here is quite similar to that of the plaintiff as addressed by the Eighth Circuit in *Miller v. Redwood*. There, the plaintiff, a recovering alcoholic, was arrested for violating probation after a test came back positive for alcohol. *Miller*, 688 F.3d at 932. After a contested probation violation hearing, a court released the plaintiff, finding that the state had failed to meet its burden because the test could have been a false positive caused by the plaintiff's "significant incidental exposure" to alcohol. *Id.* Subsequently, the plaintiff brought suit against the laboratory for negligence, products liability and other claims because "[b]ased solely on the test results, a probation violation was filed against [him] and he was arrested." *Id.* at 932, 935.

The Eighth Circuit *sua sponte* raised standing. *Id.* at 935. In dismissing the case, the court found that there was just "too big of a gap for purposes of Article III" and that "[f]or purposes of Article III, too many factors st[ood] in the way of a direct causal relationship." *Id.* at 935-36. The plaintiff's allegation was "merely a bare hypothesis" and did not "adequately trace his alleged injuries" to the laboratory:

> Indeed, Redwood did not file a probation violation against Miller. It was the State that filed the probation violation and incarcerated Miller. Too, it was the State that chose the particular test, ultimately established and implemented the cut-off levels for the probationers it tested, and interpreted the test results provided by Redwood accordingly. The amended complaint does not and cannot allege a causal connection between Redwood's actions and any presumed injury suffered by Miller sufficient for purposes of Article III. There is no allegation that Miller's alleged injuries are a direct consequence of Redwood's allegedly unlawful conduct.

Id. The Eighth Circuit also noted that "Redwood's literature instructs that it is very important for its clients to obtain clinical correlation in addition to analyzing any test results." *Id.* at 936.

Similarly, APA did not arrest Plaintiff, it did not admit him to a psychiatric facility, it did not make clinical judgment, and it did not treat him as a psychiatric patient. Plaintiff does not allege otherwise. Instead, Plaintiff merely alleges that the other defendants did all these things after somehow relying upon *DSM-IV*—just as the plaintiff in *Miller* alleged that the probation officer and State of Minnesota filed a violation against him and took him into custody based on the laboratory's alcohol test results. *Id.* at 932, 935.[1] Further, as in *Miller*, *DSM-IV* also provides numerous warnings and disclaimers, as described above, including that "diagnostic criteria" in *DSM* "are offered as guidelines" that "reflect a consensus of current formulations," and their "proper use . . . requires specialized clinical training." Ex. A at xxvii ("Cautionary Statement"); *see also* Ex. A at xxvii ("It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category . . . does not imply that the condition meets legal or other nonmedical criteria for what constitutes mental disease, mental disorder, or mental disability.").

[1] Similarly, kidnappers rely on highway maps, poisoners rely on chemistry books, and telephone harassers use telephone books. Indeed, if indirect causation claims such as those made by plaintiff were cognizable, then in today's world it would be plausible to sue Google as a defendant in practically all claims in which the alleged wrongdoer used the Internet for information gathering.

Accordingly, just as the causation asserted in *Miller* was too remote for Article III standing purposes, plaintiff's alleged long chain of causation here cannot meet that standard. For this reason, Plaintiff's complaint must be dismissed under Rule 12(b)(1) for lack of Article III standing.

II. PLAINTIFF'S DIRECT ACTIONS AGAINST THE APA MUST BE DISMISSED UNDER GENERAL TORT PRINCIPLES AND THE FIRST AMENDMENT.

A. Plaintiff's Products Liability Count Must be Dismissed Because the Ideas and Content Within the DSM *Are Not Products.*

Plaintiff purports to hold APA liable under strict products liability law for its publication of the *DSM-IV* and *DSM-IV-TR*. *See* ECF No. 12, Count VIII. This count, however, must be dismissed for failure to state a claim, because expression within a book is not a product under products liability law in Missouri or any other state. To hold otherwise would significantly impair freedom of speech under the First Amendment. As discussed in the comments to the Restatement (Third) of Torts: Products Liability § 19 (1998):

> Although a tangible medium such as a book, itself clearly a product, delivers the information, the plaintiff's grievance in such cases is with the information, not with the tangible medium. Most courts, expressing concern that imposing strict liability for the dissemination of false and defective information ***would significantly impinge on free speech have, appropriately, refused to impose strict products liability in these cases***.

(emphasis added). APA is aware of no case that has found strict products liability applicable to a book such as the *DSM*.[2]

In fact, the court in *Winter v. G.P. Putnam's Sons*, 938 F.2d 1033, 1036 (9th Cir. 1991),

[2] The only counter-examples APA has located involve aeronautical charts, which are graphical depictions of mechanical data and not analogous to the *DSM*. *See Winter v. G.P. Putnam's Sons*, 938 F.2d 1033, 1035-36 (9th Cir. 1991) (discussing *Brocklesby v. United States*, 767 F.2d 1288, 1294-95 (9th Cir. 1985) and other aeronautical chart cases). Courts have uniformly distinguished these cases—to the approval of the Restatement, as explained in the section cited above—to find that books like the *DSM*, such as textbooks, "how-to" books, and others, are not covered under products liability law.

rejected a very similar claim, "declin[ing] to expand products liability law to embrace the ideas and expression in a book." There, the Ninth Circuit dismissed a products liability claim against *The Encyclopedia of Mushrooms* finding it was not a "product" for the purpose of products liability law under the Restatement (Second) of Torts, which both California and Missouri follow. *Id.* at 1035; *Columbia Mut. Ins. v. Epstein*, 239 S.W.3d 667, 671 (Mo. App. E.D. 2007) (applying the Restatement (Second) of Torts § 402A to products liability law in Missouri).

Also analogous to the present case is *Jones v. J.B. Lippincott Co.*, 694 F. Supp. 1216 (D. Md. 1988). There, a nursing student sued the book publisher of the *Textbook for Medical and Surgical Nursing* after she injured herself using a treatment suggested in the book. *Id.* at 1216. The court rejected extending Section 402A "to the dissemination of an idea or knowledge in books or other published materials." *Id.* at 1217. It also suggested that such an extension would "chill expression and publication," and thus be "inconsistent with fundamental free speech principles" as set forth by the Supreme Court in *Gertz v. Robert Welch, Inc.*, 418 U.S. 323 (1974). *See also Herceg v. Hustler Magazine*, Inc., 565 F.Supp. 802, 803-04 (S.D. Tex. 1983) (granting motion to dismiss in case brought after person died imitating "autoerotic asphyxiation" described in magazine article because contents of magazines are not within meaning of Restatement § 402A). Numerous other courts have reached the same conclusion.[3] Unlike these publications, DSM IV does not even rise to the level of providing instructions. Indeed, DSM states "diagnostic criteria in DSM IV are meant to serve as guidelines to be informed by clinical

[3] *See also Walter v. Bauer*, 439 N.Y.S.2d 821, 822-23 (Sup. Ct. 1981) (student injured doing science project described in textbook; court held that the book was not a defective product for purposes of products liability law because the intended use of a book is reading and the plaintiff was not injured by reading), *aff'd in part & rev'd in part on other grounds*, 451 N.Y.S.2d 533 (1982); *Smith v. Linn*, 563 A.2d 123, 126 (1989) (reader of Last Chance Diet book died from diet complications; court held that book is not a product under Restatement § 402A), *aff'd*, 587 A.2d 309 (1991); *see also Watters v. TSR, Inc.*, 904 F.2d 378 (6th Cir. 1990).

judgment and are not meant to be used in a cookbook fashion." DSM IV at xxxii. Accordingly, because the Missouri Supreme Court would not find products liability applicable to the *DSM*, Count VIII must be dismissed with prejudice for failure to state a claim.

B. Plaintiff's Negligence Count For Failure To Warn Must Be Dismissed Because Of The Lack Of Legal Duty To Him.

In order for negligence to be actionable, "a plaintiff must establish that there was a duty and that the breach of that duty was the proximate cause of his injury." *Hoffman v. Union Elec. Co.*, 176 S.W.3d 706, 708 (Mo. banc 2005). "Whether a duty exists is purely a question of law." *Id.* "The judicial determination of the existence of duty rest on sound public policy." *Id.* "In considering whether a duty exists in a particular case, a court must weigh the foreseeability of the injury, the likelihood of the injury, the magnitude of the burden of guarding against it and the consequences of placing that burden on defendant." *Id.*

Courts applying garden variety negligence principles have frequently found that publishers have no duty to verify the accuracy of their published books or provide warnings, and that trade associations owe no legal duty to the public with respect to misuse of their published standards. Further, as described in Section I, with respect to constitutional standing, such claims lack causation. Accordingly, Plaintiff's negligence count must be dismissed with prejudice.

1. As a Publisher or Author, the APA Owes No Legal Duty to Plaintiff.

The Ninth Circuit found in *Winter v. G.P. Putnam's Sons* that the publisher of *The Encyclopedia of Mushrooms* had "no duty to investigate the accuracy of the contents of the books it publishes." 938 F.2d 1033, 1037 (9th Cir. 1991). After reviewing relevant precedent, the Ninth Circuit stated that "the cases uniformly refuse to impose such a duty." *Id.* The court went on to state that "[w]ere we tempted to create this duty, the gentle tug of the First Amendment and the values embodied therein would remind us of the social costs." *Id.*

As another example, the court in *Lewin v. McCreight*, 655 F. Supp. 282, 283-84 (E.D. Mich. 1987), found that the publisher of a "How To" book had no duty to warn of "defective ideas" in the books it publishes, and thus the publisher was not liable to plaintiffs injured in explosion while mixing a mordant according to a book on metalsmithing. The cases are legion finding no duty on behalf of a publisher. *E.g., Brandt v. Weather Channel*, 42 F. Supp. 2d 1344 (S.D. Fla. 1999) (holding no duty owed by weather news channel to a viewer who drowned in an unpredicted weather event and granting motion to dismiss).[4]

The prohibition against liability for negligent publication applies to both authors and publishers. Indeed, author and publisher liability are both aspects of "publisher liability," and the legal standards are the same for both. *Cubby v. Compuserve*, 776 F.Supp. 135, 139 (S.D.N.Y. 1991); *Zeran v. Am. Online, Inc.*, 129 F.3d 327, 331-32 (4th Cir. 1997) (describing both authors and publishers of statements of others as "publishers" subject to same legal standard). Courts in negligent publication cases have recognized that neither publishers nor authors may be liable for negligent publication. For example, in both *Brandt v. Weather Channel, Inc.*, 42 F. Supp. 2d 1344 (S.D. Fla. 1999) and *Gutter v. Dow Jones, Inc.*, 490 N.E.2d 898, 902 (Ohio 1986), the defendants could be characterized as both author and publisher, and the court readily dismissed the negligent publication claims. *See also Roman v. City of New York*, 802, 442 N.Y.S.2d 945,

[4] *See also First Equity Corp. v. Standard & Poor's Corp.*, 869 F.2d 175 (2d Cir. 1989) (affirming motion to dismiss; publisher of financial information not liable under Florida law to subscriber for negligent misrepresentation); *Cardozo v. True*, 342 So.2d 1053, 1056 (Fla. App. 2d Dist. 1977) (publisher of cookbook not liable to purchaser of book for breach of warranty for failure to warn of dangers of poisonous ingredients in recipe); *Gutter v. Dow Jones, Inc.*, 490 N.E.2d 898, 902 (Ohio 1986) (Wall Street Journal not liable for inaccurate description of certain corporate bonds); *Smith v. Linn*, 386 Pa.Super. 392, 396, 563 A.2d 123, 126 (1989) (publisher of diet book not liable for death caused by complications arising from the diet), *aff'd*, 587 A.2d 309 (Pa. 1991).

948 (Sup. Ct. 1981) (Planned Parenthood not liable for misstatement in contraceptive pamphlet).

APA does not owe a legal duty to Plaintiff. To hold otherwise would violate public policy by significantly impinging free speech and chilling the publication of books. *See Hoffman v. Union Elec. Co.*, 176 S.W.3d 706, 708 (Mo. banc 2005) (*en banc*) ("The judicial determination of the existence of duty rest on sound public policy.").

2. Viewed As a Standards-Setting Trade Association, the APA Owes No Legal Duty to Plaintiff.

Plaintiff may claim that APA is a standards-setting organization. Unlike true standards organizations, the *DSM* provides only *guidelines* for the diagnosis of mental disorders, and not detailed, technical standards, intended to be followed in cookbook fashion, that could be met with mathematical precision. The *DSM* represents simply a consensus among over a thousand experts and health care professionals with respect to diagnostic guidelines and classifications.

However, even with respect to standards-setting organizations, courts have routinely rejected the claim that they owe a legal duty of care to the general public. For example, in *Beasock v. Dioguardi Enterprises, Inc.*, 494 N.Y.S.2d 974 (Sup. Ct. 1985), the plaintiff brought a wrongful death suit against the Tire and Rim Association ("TRA") after her husband died "while attempting to inflate a 16-inch truck tire mistakenly mounted on a 16.5-inch rim, using a service station air pump when the tire exploded." *Id.* at 975. Plaintiff alleged that the tire and rim, compliant with TRA published standards, were dangerous, and that her husband's death was caused by compliance with faulty standards that did not prevent or warn against the use of mismatched tires and rims. *Id.* at 976. But TRA neither mandated nor monitored the use of its standards. *Id.* at 979. The court refused to impose upon TRA a "duty to warn," finding that to do so would be "unreasonable." *Id.* The court found that there was no duty between the association and the decedent, although there would be between the manufacturer and the

decedent. *Id.* Numerous other courts have followed *Beasock*, finding no legal duty.[5] Similarly, while hospitals and psychiatrists may owe a duty of care to their patients, APA, which does not exercise control over them, does not owe any such duty as a matter of law and public policy.

C. The First Amendment Bars Product Liability and Negligence Claims Based on Expressive Content Such as that of DSM-IV.

Even apart from the settled tort precedents that hold that one cannot bring product liability and negligence claims based on a book or similar expressive content, it is clear as a matter of constitutional law that the First Amendment would not permit such claims.

1. Liability Here Would Violate Basic Principles of Against Content-Based Restrictions on Speech.

Wherever liability is based on expressive content, the First Amendment comes into play. *United States v. Stevens*, 130 S.Ct. 1577 (2010) (Roberts, C.J.) (describing limited areas in which restrictions upon the content of speech are permitted). The First Amendment does not permit exceptions simply because certain speech is undesirable or harmful from someone's point of view. *Id*. 130 S.Ct .at 1585 ("The First Amendment itself reflects a judgment by the American

[5] *Howard v. Poseidon Pools, Inc.*, 133 Misc.2d 50, (N.Y. Sup. Ct. 1986), *aff'd in relevant part*, 134 A.D.2d 926 (N.Y. Ct. App. 1987) (granting summary judgment to swimming pool trade association on negligence claims, even though association had published minimum safety standards, because it owed no duty to plaintiff or to control the manufacturer); *Meyers v. Donnatacci*, 531 A.2d 398 (N.J. Sup. Ct. 1987) (holding that, by promulgating safety standards for residential in-ground swimming pools, a trade association did not assume a duty to warn consumers of the danger of shallow diving); *Friedman v. F.E. Myers Co.*, 706 F.Supp. 376 (E.D. Pa. 1989) (granting summary judgment to trade association of water pump manufacturers on claims of negligence and concert of action, because association owed no duty to plaintiff); *Bailey v. Edward Hines Lumber Co.*, 719 N.E.2d 178 (Ill. App. 1999) (granting summary judgment to truss-plate trade association on third-party indemnification claim brought by truss manufacturer that had relied on association's recommendations, because association owed no duty to carpenters who relied on recommendations); *Commerce and Industry Ins. Co. v. Grinnell Corp.*, 1999 WL 508357 (E.D. La. July 15, 1999) (granting summary judgment on subrogation claim by insurance company against trade association that published fire safety codes, because association owed no duty to owner or occupant of warehouse that burned down).

people that the benefits of its restrictions on the Government outweigh the costs. Our Constitution forecloses any attempt to revise that judgment simply on the basis that some speech is not worth it.").

In both *Stevens* and *United States v. Alvarez*, 132 S.Ct. 2537 (2011), the Supreme Court has recently emphasized that government-imposed restrictions on content are generally limited to narrow well-recognized categories of unprotected speech, such as obscenity, libel, and incitement to imminent violence. Books describing medical conditions which are designed to aid medical personnel in making diagnoses fit in none of these established limited categories, and hence receive full First Amendment protection. In *Alvarez*, Justice Kennedy noted:

> "[A]s a general matter, the First Amendment means that government has no power to restrict expression because of its message, its ideas, its subject matter, or its content." *Ashcroft* v. *American Civil Liberties Union*, 535 U. S. 564, 573 (2002) (internal quotation marks omitted). As a result, the Constitution "demands that content-based restrictions on speech be presumed invalid . . . and that the Government bear the burden of showing their constitutionality." *Ashcroft* v. *American Civil Liberties Union*, 542 U. S. 656, 660 (2004).

Id. at 2543-44. In *Alvarez*, the Supreme Court held that even false statements about military honors were protected by the First Amendment, and the court emphasized that the purpose of the First Amendment is "to allow more speech, not less" and that constitutional law maintains a "distrust of content-based speech prohibitions." *Id*. at 2545, 2547. Put another way, the First Amendment denies government the "power to restrict expression because of the message, ideas, its subject matter, or its content." *Police Dept. of Chicago v. Mosley*, 408 U. S. 92, 95 (1972).

Expressions of opinion are fully protected by the Constitution, and, in matters of opinion, the First Amendment commands that the government defer to the marketplace of ideas. *Gertz v. Robert Welch, Inc*., 418 U.S. 323, 339 (1974) ("Under the First Amendment there is no such thing as a false idea"); *Bose Corp. v. Consumers Union of United States, Inc.*, 466 U.S. 485, 503-

504 (1984) ("[T]he freedom to speak one's mind is not only an aspect of individual liberty—and thus a good unto itself—but also is essential to the common quest for truth and the vitality of society as a whole."). The "quest for truth" and scientific understanding lies at the heart of the preparation, publication, and use of the *DSM*. The *DSM* explicitly offers only "diagnostic categories, criteria, and textual descriptions" that require "clinical judgment" (DSM IV at xxiii), and which represent only a "consensus about the classification of mental disorders derived at the time of its initial publication" (*id*. at xxii). The *DSM* "admit[s] that no definition adequately specifies the precise boundaries for the concept of 'mental disorder,'" (*id.* at xxi), and specifically notes that "[n]ew knowledge . . . will undoubtedly lead to an increased understanding" (*id*. at xxvii). Thus, the *DSM* clearly offers fully protected opinions, theories, and scientific assertions based on current knowledge, not factual statements that may fall within certain categories of unprotected speech.

Within the realm of constitutionally protected speech under *Stevens* and *Alverez,* any content-based restriction on speech, whether by direct censorship, or by imposition of criminal or tort liability, must meet the "most exacting scrutiny." *Turner Broad. Sys., Inc. v. FCC*, 512 U. S. 622, 642 (1994); *accord Sorrell v. IMS Health, Inc.*, 131 S.Ct. 2653, 2663 (2011) (heightened judicial scrutiny is warranted as to content-based burdens on protected expression). Initially, there must be a "compelling government interest," usually involving issues such as national security or protection of basic civil rights of citizens. *Alvarez*, at 2548. Next, the government's chosen restriction on the speech at issue must be "actually necessary" to achieve its interest, or, put another way, it must achieve that interest in a manner least restrictive on free speech interests. *Alvarez* at 2548. Among other things, the proponent of the regulation must prove that counterspeech would not suffice to achieve its interest. *Id.*

Plaintiff's assertion here of tort liability based on publication of a medical diagnostic manual, sounding in either strict product liability or negligence, clearly cannot overcome the strict scrutiny First Amendment test. No compelling government interest exists to favor the tiny minority of persons, such as plaintiff, who dispute the very existence of mental illness in any form or presentation, over the great majority who desire the benefits attendant to scientific study and references with respect to mental illness. Even if, as plaintiff seems to claim, under the current medical regime some persons are sometimes improperly treated or identified for treatment, imposing liability on medical reference publishers would be a drastic method of addressing that harm, and certainly not the least restrictive alternative. There are literally hundreds of reforms of medical or legal procedures that could address such alleged harms without restricting essential medical research and expression.

Among other things, counterspeech, in the form of alternative texts, treatments, diagnoses, and professionals, are fully available to address any legitimate concerns of plaintiff or persons in his position, and tort liability cannot be imposed on the opinions, theories, guidelines, and diagnostic criteria that APA has contributed to the medical and scientific communities.

2. The Supreme Court Does Not Permit Creative Tort Theories to Evade Protections Against Content-Based Restrictions on Speech.

Liability for negligent publication would also violate the Supreme Court's clear holdings that, even if the speech in issue here were inappropriately viewed as within one of the unprotected categories, tort liability based on content must meet the standards of *New York Times v. Sullivan*, 376 U.S. 254 (1964). *Sullivan* set a strict standard for liability based on content, because the First Amendment is meant to ensure a "uninhibited, robust and wide-open" debate on important issues (*id*. at 270), and to afford free speech rights the "'breathing space' that they 'need . . . to survive'" (*id* at 271-72). The *Sullivan* standard requires clear and

convincing proof of knowing falsity (or its equivalent, reckless disregard of the truth), and of course no such finding can be made where non-factual ideas opinions and scientific theories and analyses are involved. *Id*. at 279-80. Many courts have held that *Sullivan* sets the sole rule for liability based on content and one may not evade *Sullivan's* standards by creatively alleging other torts such as intentional affliction of remote emotional distress, tortious interference with contract, or negligent publication. Indeed, the U.S. Supreme Court, in *Hustler Magazine v. Falwell*, 485 U.S. 46, 50 (1998), noted that "the recognition of the fundamental importance of the free flow of ideas and opinions on matters of public interest and concern" lies at the heart of the First Amendment, and it therefore applied the *Sullivan* standard where a plaintiff tried to creatively use a non-defamation tort to attack content that it claimed to be harmful.

The *Sullivan* standard clearly bars liability here. First, given the theoretical, scientific, nature of the content, which, as the *DSM* introduction notes, is subject to differing opinions and interpretations, no "knowing falsity" can ever be proven. Second, scientific theories lie at the core of important speech which, under the First Amendment, are to be encouraged, not chilled. There would be no breathing space, or free and wide-open debate, on scientific theories if every disagreement about them could be taken into the courtroom and subjected to the crude methods of tort law which are designed for totally different situations and circumstances.

For all of these reasons, plaintiff's tort claims are barred by the First Amendment.

III. PLAINTIFF'S CONSPIRACY COUNT MUST BE DISMISSED AS TO THE APA.

Plaintiff's Count V for conspiracy does not satisfy pleading requirements. *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007) holds that a plaintiff has an obligation to provide more than "labels and conclusions." *Id.* at 553–55. Dismissal under Rule 12(b)(6) is proper when, even assuming the truth of all well-pleaded factual allegations, the plaintiff fails to set forth "enough facts to state a claim to relief that is plausible on its face." *Twombly* at 570; *Ashcroft v.*

Iqbal, 129 S.Ct. 1937, 1949 (2009). "A formulaic recitation of the elements of a cause of action" does not satisfy the general pleading requirements under the Federal Rules of Civil Procedure. *Id.* Plaintiffs must plead enough factual allegations "to raise a right to relief above the speculative level." *Id.* at 1965.

While Count V purports in its title to be asserted against all defendants, in neither mentions or references APA. Paragraphs 39 through 41 simply allege that "[t]wo or more of the defendants conspired" against Plaintiff, leaving it completely unknown whether any, all, or only some of these paragraphs are directed against APA. Further, the count does not state the legal theory on which the claim against APA is being brought. However, because Plaintiff alleges that the Court has jurisdiction pursuant to 42 U.S.C. §§ 1983 and 1985, we will address both statutes here as possible bases for the conspiracy claim.

A. Plaintiff has Failed to Plausibly Allege APA's Involvement in Any Conspiracy.

Reading the entire Complaint as generously as possible with respect to conspiracy-relevant allegations, Plaintiff asserts that the APA has a public mission with respect to mental disorders, that it publishes *DSM-IV*, and other defendants used *DSM* in connection with their alleged misconduct toward plaintiff. But even these factual allegations are not sufficient to allege a role in a conspiracy. Nothing is pled in Count V to support any claim that APA conspired to "manufacture false legal evidence" or that it conspired to "deter the Plaintiff, by intimidation or threat, from becoming a witness in court and/or from testifying freely, fully and truthfully on matters pertinent to this complaint." ECF No. 12 at ¶¶ 40, 41. Further, with respect to paragraph 39, none of the pled facts even *plausibly* support an assertion that the APA conspired "by falsely pathologizing [Plaintiff's] human emotions and reactions, which [it] knew or should have known to be normal," particularly considering that there is no allegation that the APA ever met or even knew of Plaintiff before this suit was filed. *Id.* at ¶ 39.

B. Plaintiff Has Not and Cannot Adequately Plead a Claim Under 42 U.S.C. § 1985.

With respect to any potential claim as to a civil rights conspiracy under 42 U.S.C. § 1985, subsections (1) and (2), as well as subsection (3), second and third clauses, are entirely irrelevant to the pleaded facts. *See* 42 U.S.C. § 1985; *Coleman v.* Garber, 800 F.2d 188, 190 (8th Cir. 1986) (discussing the different portions of § 1985). As to the first clause of subsection (3), Plaintiff has not and cannot plead the required elements:

> In order to prove the existence of a civil rights conspiracy under § 1985(3), the [plaintiff] must prove: (1) that the defendants did "conspire," (2) "for the purpose of depriving, either directly or indirectly, any person or class of persons of equal protection of the laws, or equal privileges and immunities under the laws," (3) that one or more of the conspirators did, or caused to be done, "any act in furtherance of the object of the conspiracy," and (4) that another person was "injured in his person or property or deprived of having and exercising any right or privilege of a citizen of the United States."

Davis v. Jefferson Hosp. Ass'n, 685 F.3d 675, 684 (8th Cir. 2012). Plaintiff has failed to plead these elements as to APA, let alone facts sufficient to plausibly support them.

1. Plaintiff Does Not and Cannot Allege a Conspiracy Based on Class-Based Animus.

The "purpose" element of Section 1985(3) claims requires the plaintiff "provide a *class-based invidiously discriminatory animus*." *Id.* (emphasis added). Otherwise, § 1985 would present "serious constitutional problems by creating a 'general federal tort law.'" *Harrison v. Springdale Water & Sewer Comm'n*, 780 F.2d 1422, 1430 (8th Cir. 1986). A complaint which fails to allege any facts that would tend to show that the alleged conspirators were motivated by such animus fails to state a claim. *Ledwith v. Douglas*, 568 F.2d 117, 119 (8th Cir. 1978).

Plaintiff's complaint alleges at most the story of a man who was involuntarily admitted into a psychiatric institution. Count V lacks any assertion that the plaintiff was discriminated against because of an identifiable class-based invidiously discriminatory animus. Accordingly,

any claim under 42 U.S.C. § 1985 must be dismissed with prejudice for failure to state a claim.[6]

2. Plaintiff Does Not and Cannot Allege With Particularity the Existence of a § 1985 Conspiracy.

Plaintiff also has not and cannot allege the existence of a conspiracy between APA and any other defendant as required. In fact, Plaintiff has not even provided a bare assertion that APA actually entered into a conspiracy, but has simply alleged that "[t]wo or more of the defendants conspired." ECF No. 12, Count V. These allegations as well as those found throughout the rest of the Complaint do not satisfy the standard set forth in *Iqbal* and *Twombly*, nor are there any set of facts that Plaintiff could plead to do so.

The Eighth Circuit has stated that a "conspiracy" under § 1985 is "an agreement between the parties to inflict a wrong against or injury upon another, and an overt act that results in damage." *Gometz v. Culwell*, 850 F.2d 461, 464 (8th Cir. 1988) (internal quotation omitted). It has also held that a plaintiff bringing a claim under § 1985 "must allege with particularity and specifically demonstrate with material facts that the defendants reached an agreement." *Davis v. Jefferson Hosp. Ass'n*, 685 F.3d 675, 685 (8th Cir. 2012) (*quoting City of Omaha Emps. Betterment Ass'n v. City of Omaha*, 883 F.2d 650, 652 (8th Cir. 1989)). To satisfy this burden, plaintiff must "point to at least some facts which would suggest that [the parties] 'reached an understanding' to violate [plaintiff's] rights." *City of Omaha Emps.*, 883 F.2d at 652; *see also Webb v. Goord*, 340 F.3d 105, 110 (2d Cir. 2003) (holding that to establish a § 1985 conspiracy, plaintiff must "provide some factual basis supporting a meeting of the minds"). However, "a

[6] To the extent Plaintiff asserts that he has alleged a claim under the second clause in subsection (2) of § 1985, this too would fail under the same analysis. Like the first clause of § 1985(3), a claim under the second clause of § 1985(2) also requires "some racial, or perhaps otherwise class-based, invidiously discriminatory animus behind the conspirators' action." *Coleman v. Garber*, 800 F.2d 188, 191 (8th Cir. 1986) (citing *Kush v. Rutledge*, 460 U.S. 719, 726 (1983)).

complaint containing only conclusory, vague, or general allegations of conspiracy to deprive a person of constitutional rights cannot withstand a motion to dismiss." *Boddie v. Schnieder*, 105 F.3d 857, 862 (2d Cir. 1997).

Here, Plaintiff has failed to make any factual allegations that APA has entered into a conspiracy. The mere allegation that by publishing *DSM-IV* and engaging in public advocacy (both protected activities under the First Amendment), APA provided "a primary, vital facilitation and encouragement of the [alleged] deprivations" caused by other defendants, does not plead a conspiracy. Nor can the court, consistent with *Twomby's* "plausibility" standard, read Count V to allege that APA, by engaging in protected speech, *i.e.*, publishing the *DSM-IV* and advocating on the public health issue regarding mental disorders, entered into a conspiracy to deprive an unknown person in the future of his constitutional rights.

C. Plaintiff Has Not and Cannot Adequately Plead a Claim Under 42 U.S.C. § 1983.

Reasonably construed, the Complaint does not allege a claim under 42 U.S.C. § 1983. Assuming, *arguendo*, that such a claim is intended, Plaintiff has not and cannot adequately state a claim for relief. "The essential elements of a constitutional claim under § 1983 are (1) that the defendant acted under color of state law, and (2) that the alleged wrongful conduct deprived the plaintiff of a constitutionally protected federal right." *L.L. Nelson Enter., Inc. v. County of St. Louis*, 673 F.3d 799, 805 (8th Cir. 2012). Further, "[l]iability under section 1983 requires a causal link to, and a direct responsibility for, the deprivation of rights." *Mayorga v. Missouri*, 442 F.3d 1128, 1132 (8th Cir. 2006) (*citing Madewell v. Roberts*, 909 F.2d 1203, 1208 (8th Cir. 1990)). That is, to state a claim, the plaintiff "must allege specific facts of personal involvement in, or direct responsibility for, a deprivation of his constitutional rights." *Id.* Because Plaintiff has not pled and cannot satisfy this standard, any claim pursuant to § 1983 must be dismissed with prejudice.

1. Plaintiff Cannot Plead a Causal Link Between the APA and His Alleged Deprivation of Rights.

Plaintiff has not plead, nor can it, the required causal link that the APA was directly involved in or responsible for the alleged violations of his Fourth, Fifth and Fourteenth Amendment rights. *See* ECF No. 12 at ¶ 39; *Mayorga*, 442 F.3d at 1132. Plaintiff simply pleads that the APA published the *DSM-IV* and that it promotes the "public health issue of 'mental illness.'" *See* ECF No. 12 at ¶¶ 11, 13. Yet, there is no causal connection pled between this and any alleged violations of Plaintiff's constitutional rights. The mere fact that APA published and promoted the *DSM-IV*, which was used by one or more of APA's co-defendants, does not come anywhere close to the "personal involvement in, or direct responsibility for" the alleged violations as required under *Mayorga* to adequately plead a § 1983 case. *See also Roberts v. Conley*, No. 2:08-CV-044 ERW, 2009 WL 2170173, at *3, 5-6 (E.D. Mo. July 20, 2009). Accordingly, any claim pursuant to § 1983 must be dismissed with prejudice.

2. Plaintiff Does Not and Cannot Allege State Action.

Because § 1983 only applies to state action, any potential claim under this section by Plaintiff must be dismissed. Where a defendant is a private entity, such as APA, the plaintiff "must establish not only that a private actor caused a deprivation of constitutional rights, but that the private actor willfully participated with state officials and reached a mutual understanding concerning the unlawful objective of a conspiracy." *Crawford v. Van Buren County*, 678 F.3d 666, 670 (8th Cir. 2012) (*quoting Dossett v. First State Bank*, 399 F.3d 940, 951 (8th Cir. 2005)). Thus, "[i]n order to survive a motion to dismiss on his § 1983 claim, [Plaintiff] must allege (1) an agreement between a state actor and a private party; (2) to act in concert to inflict an unconstitutional injury; and (3) an overt act done in furtherance of that goal causing damages." *Ciambriello v. County of Nassau*, 292 F.3d 307, 324-225 (2d Cir. 2002). "Private violation of

constitutional rights or federal statutes by a private actor is not sufficient to state a claim under section 1983." *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 940 (1982).

Because Plaintiff has not alleged that the APA has acted under color of state law, any claim under § 1983 must be dismissed. *See* ECF No. 12 at ¶ 25 (alleging that Defendants Winzen, Wilhelm, Police, Taca, and Mercy acted "under color of law," but not APA). In fact, Plaintiff merely alleges that by publishing *DSM-IV* and engaging in public advocacy (both protected activities under the First Amendment), APA provided "a primary, vital facilitation and encouragement of the [alleged] deprivations" caused by other defendants. *Id.* This fails to plead that APA "willfully participated with state officials and reached a mutual understanding concerning the unlawful objective of a conspiracy." *Crawford*, 678 F.3d at 670.

Further, as discussed above in Section III.A, Plaintiff has not and cannot plead that APA entered into any conspiracy with any co-defendants, let alone state actor co-defendants. Nor can Plaintiff establish the required elements as set forth in *Ciambriello*. *See also Vander Linden v. Wilbanks*, 128 F. Supp. 2d 900, 903 (D. S.C. 2000) (dismissing § 1983 claim with prejudice where publisher defendant simply engaged in traditional publishing activities).

CONCLUSION

For the foregoing reasons, the American Psychiatric Association respectfully requests that the Court dismiss with prejudice all claims against APA in Plaintiff's Amended Complaint.

Respectfully submitted,
THOMPSON COBURN LLP

By */s/ Mark Sableman*

Mark Sableman, 36276MO
Anthony Blum, 60993MO
One US Bank Plaza
St. Louis, Missouri 63101
314-552-6000
FAX 314-552-7000

msableman@thompsoncoburn.com
ablum@thompsoncoburn.com

Attorneys for Defendant American Psychiatric Association

Certificate Of Service

I hereby certify that on May 20, 2013, the foregoing was filed electronically with the Clerk of Court to be served by operation of the Court's electronic filing system upon the following:

S. Randolph Kretchmar
1170 Michigan Avenue
Wilmette, IL 60091
s_randolph@earthlink.net

James C. Thoele
Brinker & Doyen, LLP
34 N. Meramec Ave. 5th Floor
Clayton, MO 63105

Kenneth W. Bean
Sandberg, Phoenix & von Gontard, P.C.
600 Washington Ave. 15th Floor
St. Louis, MO 63101-1313
Direct: 314-446-4265
kbean@sandbergphoenix.com

Michael E. Hughes
St. Louis County Counselor's Office
41 S. Central Avenue
Clayton, MO 63105
mhughes2@stlouisco.com

I further certify that on May 20, 2013, a true and correct copy of the foregoing was served on Defendant Allen Frances, M.D., by mail to:

Dr. Allen Frances, M.D.
1820 Avenida Del Mundo
Coronado, CA 92118
allenfrances@vzw.blackberry.net

/s/ Mark Sableman
Mark Sableman
Attorney for American Psychiatric Association
Thompson Coburn LLP
One US Bank Plaza
St. Louis, MO 63101
(314) 552-6000

Diagnostic and Statistical Manual of Mental Disorders

Fourth Edition

DSM-IV™

American Psychiatric Association

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FOURTH EDITION

DSM-IV™

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FOURTH EDITION

DSM-IV™

PUBLISHED BY THE
AMERICAN PSYCHIATRIC ASSOCIATION
WASHINGTON, DC

Manufactured in the United States of America on acid-free paper

American Psychiatric Association
1400 K Street, N.W., Washington, DC 20005

The correct citation for this book is American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Washington, DC, American Psychiatric Association, 1994.

Library of Congress Cataloging-in-Publication Data
Diagnostic and statistical manual of mental disorders : DSM-IV. — 4th ed.
p. cm.
Prepared by the Task Force on DSM-IV and other committees and work groups of the American Psychiatric Association.
Includes index.
ISBN 0-89042-061-0 (hard : alk. paper). — ISBN 0-89042-062-9 (paper : alk. paper)
1. Mental illness—Classification. 2. Mental illness—Diagnosis.
I. American Psychiatric Association. II. American Psychiatric Association. Task Force on DSM-IV. III. Title: DSM-IV.
[DNLM: 1. Mental Disorders—classification. 2. Mental Disorders—diagnosis. WM 15 D536 1994]
RC455.2.C4D54 1994
616.89'075—dc20
DNLM/DLC
for Library of Congress 94-6304
CIP

British Library Cataloguing in Publication Data
A CIP record is available from the British Library.

First printing 150,000, May 1994

Text Design—Jane H. Davenport
Manufacturing—R. R. Donnelly & Sons Company

To Melvin Sabshin,
a man for all seasons

Contents

- Task Force on DSM-IV ix
- Acknowledgments xiii
- Introduction xv
- Cautionary Statement xxvii
- Use of the Manual 1
- DSM-IV Classification 13
- Multiaxial Assessment 25
- Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence 37
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders . 123
- Mental Disorders Due to a General Medical Condition 165
- Substance-Related Disorders 175
- Schizophrenia and Other Psychotic Disorders 273
- Mood Disorders 317
- Anxiety Disorders 393
- Somatoform Disorders 445
- Factitious Disorders 471
- Dissociative Disorders 477
- Sexual and Gender Identity Disorders 493
- Eating Disorders 539
- Sleep Disorders 551
- Impulse-Control Disorders Not Elsewhere Classified 609
- Adjustment Disorders 623

- Personality Disorders 629
- Other Conditions That May Be a Focus of Clinical Attention 675
- Additional Codes 687
- Appendixes

Appendix A Decision Trees for Differential Diagnosis 689

Appendix B Criteria Sets and Axes Provided for Further Study . . 703

Appendix C Glossary of Technical Terms 763

Appendix D Annotated Listing of Changes in DSM-IV 773

Appendix E Alphabetical Listing of DSM-IV Diagnoses and Codes 793

Appendix F Numerical Listing of DSM-IV Diagnoses and Codes 803

Appendix G ICD-9-CM Codes for Selected General Medical Conditions and Medication-Induced Disorders . . . 813

Appendix H DSM-IV Classification With ICD-10 Codes 829

Appendix I Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes 843

Appendix J DSM-IV Contributors 851

- Index 875

Task Force on DSM-IV

Allen Frances, M.D.
Chairperson

Harold Alan Pincus, M.D.
Vice-Chairperson

Michael B. First, M.D.
Editor, Text and Criteria

Nancy Coover Andreasen, M.D., Ph.D.
David H. Barlow, Ph.D.
Magda Campbell, M.D.
Dennis P. Cantwell, M.D.
Ellen Frank, Ph.D.
Judith H. Gold, M.D.
John Gunderson, M.D.
Robert E. Hales, M.D.
Kenneth S. Kendler, M.D.
David J. Kupfer, M.D.
Michael R. Liebowitz, M.D.
Juan Enrique Mezzich, M.D., Ph.D.
Peter E. Nathan, Ph.D.
Roger Peele, M.D.
Darrel A. Regier, M.D., M.P.H.
A. John Rush, M.D.
Chester W. Schmidt, M.D.
Marc Alan Schuckit, M.D.
David Shaffer, M.D.
Robert L. Spitzer, M.D., *Special Adviser*
Gary J. Tucker, M.D.
B. Timothy Walsh, M.D.
Thomas A. Widiger, Ph.D.,
Research Coordinator
Janet B. W. Williams, D.S.W.
John C. Urbaitis, M.D., *Assembly Liaison*
James J. Hudziak, M.D.,
Resident Fellow (1990–1993)
Junius Gonzales, M.D.,
Resident Fellow (1988–1990)

Ruth Ross, M.A., *Science Editor*
Nancy E. Vettorello, M.U.P., *Administrative Coordinator*
Wendy Wakefield Davis, Ed.M., *Editorial Coordinator*
Cindy D. Jones, *Administrative Assistant*
Nancy Sydnor-Greenberg, M.A., *Administrative Consultant*
Myriam Kline, M.S., *Focused Field Trial Coordinator*
James W. Thompson, M.D., M.P.H., *Videotape Field Trial Coordinator*

Anxiety Disorders Work Group

Michael R. Liebowitz, M.D., *Chairperson*
David H. Barlow, Ph.D., *Vice-Chairperson*
James C. Ballenger, M.D.
Jonathan Davidson, M.D.
Edna Foa, Ph.D.
Abby Fyer, M.D.

Delirium, Dementia, and Amnestic and Other Cognitive Disorders Work Group

Gary J. Tucker, M.D., *Chairperson*
Michael Popkin, M.D., *Vice-Chairperson*
Eric Douglas Caine, M.D.
Marshall Folstein, M.D.
Gary Lloyd Gottlieb, M.D.
Igor Grant, M.D.
Benjamin Liptzin, M.D.

Disorders Usually First Diagnosed During Infancy, Childhood, or Adolescence Work Group

David Shaffer, M.D., *Co-Chairperson*
Magda Campbell, M.D., *Co-Chairperson*
Susan J. Bradley, M.D.
Dennis P. Cantwell, M.D.
Gabrielle A. Carlson, M.D.
Donald Jay Cohen, M.D.
Barry Garfinkel, M.D.
Rachel Klein, Ph.D.
Benjamin Lahey, Ph.D.
Rolf Loeber, Ph.D.
Jeffrey Newcorn, M.D.
Rhea Paul, Ph.D.
Judith H. L. Rapoport, M.D.
Sir Michael Rutter, M.D.
Fred Volkmar, M.D.
John S. Werry, M.D.

Eating Disorders Work Group

B. Timothy Walsh, M.D., *Chairperson*
Paul Garfinkel, M.D.
Katherine A. Halmi, M.D.
James Mitchell, M.D.
G. Terence Wilson, Ph.D.

Mood Disorders Work Group

A. John Rush, M.D., *Chairperson*
Martin B. Keller, M.D., *Vice-Chairperson*
Mark S. Bauer, M.D.
David Dunner, M.D.
Ellen Frank, Ph.D.
Donald F. Klein, M.D.

Multiaxial Issues Work Group

Janet B. W. Williams, D.S.W., *Chairperson*
Howard H. Goldman, M.D., Ph.D., *Vice-Chairperson*
Alan M. Gruenberg, M.D.
Juan Enrique Mezzich, M.D., Ph.D.
Roger Peele, M.D.
Stephen Setterberg, M.D.
Andrew Edward Skodol II, M.D.

Personality Disorders Work Group

John Gunderson, M.D., *Chairperson*
Robert M. A. Hirschfeld, M.D., *Vice-Chairperson*
Roger Blashfield, Ph.D.
Susan Jean Fiester, M.D.
Theodore Millon, Ph.D.
Bruce Pfohl, M.D.
Tracie Shea, Ph.D.
Larry Siever, M.D.
Thomas A. Widiger, Ph.D.

Premenstrual Dysphoric Disorder Work Group

Judith H. Gold, M.D., *Chairperson*
Jean Endicott, Ph.D.
Barbara Parry, M.D.
Sally Severino, M.D.
Nada Logan Stotland, M.D.
Ellen Frank, Ph.D., *Consultant*

Psychiatric Systems Interface Disorders (Adjustment, Dissociative, Factitious, Impulse-Control, and Somatoform Disorders and Psychological Factors Affecting Medical Conditions) Work Group

Robert E. Hales, M.D., *Chairperson*
C. Robert Cloninger, M.D., *Vice-Chairperson*
Jonathan F. Borus, M.D.
Jack Denning Burke, Jr., M.D., M.P.H.
Joe P. Fagan, M.D.
Steven A. King, M.D.
Ronald L. Martin, M.D.
Katharine Anne Phillips, M.D.
David A. Spiegel, M.D.
Alan Stoudemire, M.D.
James J. Strain, M.D.
Michael G. Wise, M.D.

Schizophrenia and Other Psychotic Disorders Work Group

Nancy Coover Andreasen, M.D., Ph.D., *Chairperson*
John M. Kane, M.D., *Vice-Chairperson*
Samuel Keith, M.D.
Kenneth S. Kendler, M.D.
Thomas McGlashan, M.D.

Sexual Disorders Work Group

Chester W. Schmidt, M.D., *Chairperson*
Raul Schiavi, M.D.
Leslie Schover, Ph.D.
Taylor Seagraves, M.D.
Thomas Nathan Wise, M.D.

Sleep Disorders Work Group

David J. Kupfer, M.D., *Chairperson*
Charles F. Reynolds III, M.D., *Vice-Chairperson*
Daniel Buysse, M.D.
Roger Peele, M.D.
Quentin Regestein, M.D.
Michael Sateia, M.D.
Michael Thorpy, M.D.

Substance-Related Disorders Work Group

Marc Alan Schuckit, M.D., *Chairperson*
John E. Helzer, M.D., *Vice-Chairperson*
Linda B. Cottler, Ph.D.
Thomas Crowley, M.D.
Peter E. Nathan, Ph.D.
George E. Woody, M.D.

Committee on Psychiatric Diagnosis and Assessment

Layton McCurdy, M.D., *Chairperson* (1987–1994)
Kenneth Z. Altshuler, M.D. (1987–1992)
Thomas F. Anders, M.D. (1988–1994)
Susan Jane Blumenthal, M.D. (1990–1993)
Leah Joan Dickstein, M.D. (1988–1991)
Lewis J. Judd, M.D. (1988–1994)
Gerald L. Klerman, M.D. (deceased) (1988–1991)
Stuart C. Yudofsky, M.D. (1992–1994)
Jack D. Blaine, M.D., *Consultant* (1987–1992)
Jerry M. Lewis, M.D., *Consultant* (1988–1994)
Daniel J. Luchins, M.D., *Consultant* (1987–1991)
Katharine Anne Phillips, M.D., *Consultant* (1992–1994)
Cynthia Pearl Rose, M.D., *Consultant* (1990–1994)
Louis Alan Moench, M.D., *Assembly Liaison* (1991–1994)
Steven K. Dobscha, M.D., *Resident Fellow* (1990–1992)
Mark Zimmerman, M.D., *Resident Fellow* (1992–1994)

Joint Committee of the Board of Trustees and Assembly of District Branches on Issues Related to DSM-IV

Ronald A. Shellow, M.D., *Chairperson*
Harvey Bluestone, M.D.
Leah Joan Dickstein, M.D.
Arthur John Farley, M.D.
Carol Ann Bernstein, M.D.

Acknowledgments

DSM-IV is a team effort. More than 1,000 people (and numerous professional organizations) have helped us in the preparation of this document. Members of the Task Force on DSM-IV and DSM-IV Staff are listed on p. ix, members of the DSM-IV Work Groups are listed on pp. x–xii, and a list of other participants is included in Appendix J.

The major responsibility for the content of DSM-IV rests with the Task Force on DSM-IV and members of the DSM-IV Work Groups. They have worked (often much harder than they bargained for) with a dedication and good cheer that has been inspirational to us. Bob Spitzer has our special thanks for his untiring efforts and unique perspective. Norman Sartorius, Darrel Regier, Lewis Judd, Fred Goodwin, and Chuck Kaelber were instrumental in facilitating a mutually productive interchange between the American Psychiatric Association and the World Health Organization that has improved both DSM-IV and ICD-10, and increased their compatibility. We are grateful to Robert Israel, Sue Meads, and Amy Blum at the National Center for Health Statistics and Andrea Albaum-Feinstein at the American Health Information Management Association for suggestions on the DSM-IV coding system. Denis Prager, Peter Nathan, and David Kupfer helped us to develop a novel data reanalysis strategy that has been supported with funding from the John D. and Catherine T. MacArthur Foundation.

Many individuals within the American Psychiatric Association deserve recognition. Mel Sabshin's special wisdom and grace made even the most tedious tasks seem worth doing. The American Psychiatric Association Committee on Psychiatric Diagnosis and Assessment (chaired by Layton McCurdy) provided valuable direction and counsel. We would also like to thank the American Psychiatric Association Presidents (Drs. Fink, Pardes, Benedek, Hartmann, English, and McIntyre) and Assembly Speakers (Drs. Cohen, Flamm, Hanin, Pfaehler, and Shellow) who helped with the planning of our work. Carolyn Robinowitz and Jack White, and their respective staffs in the American Psychiatric Association Medical Director's Office and the Business Administration Office, have provided valuable assistance in the organization of the project.

Several other individuals have our special gratitude. Wendy Davis, Nancy Vettorello, and Nancy Sydnor-Greenberg developed and implemented an organizational structure that has kept this complex project from spinning out of control. We have also been blessed with an unusually able administrative staff, which has included Elisabeth Fitzhugh, Willa Hall, Kelly McKinney, Gloria Miele, Helen Stayna, Sarah Tilly, Nina Rosenthal, Susan Mann, Joanne Mas, and, especially, Cindy Jones. Ruth Ross, our tireless Science Writer, has been responsible for improving the clarity of expression and

organization of DSM-IV. Myriam Kline (Research Coordinator for the NIH-funded DSM-IV Focused Field Trials), Jim Thompson (Research Coordinator for the MacArthur Foundation–funded Videotape Field Trial), and Sandy Ferris (Assistant Director for the Office of Research) have made many valuable contributions. We would also like to acknowledge all the other staff persons at the American Psychiatric Association who have helped with this project. Ron McMillen, Claire Reinburg, Pam Harley, and Jane Davenport of American Psychiatric Press have provided expert production assistance.

Allen Frances, M.D.
Chair, Task Force on DSM-IV

Harold Alan Pincus, M.D.
Vice-Chair, Task Force on DSM-IV

Michael B. First, M.D.
Editor, DSM-IV Text and Criteria

Thomas A. Widiger, Ph.D.
Research Coordinator

Introduction

This is the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* or DSM-IV. The utility and credibility of DSM-IV require that it focus on its clinical, research, and educational purposes and be supported by an extensive empirical foundation. Our highest priority has been to provide a helpful guide to clinical practice. We hoped to make DSM-IV practical and useful for clinicians by striving for brevity of criteria sets, clarity of language, and explicit statements of the constructs embodied in the diagnostic criteria. An additional goal was to facilitate research and improve communication among clinicians and researchers. We were also mindful of the use of DSM-IV for improving the collection of clinical information and as an educational tool for teaching psychopathology.

An official nomenclature must be applicable in a wide diversity of contexts. DSM-IV is used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems). It is used by psychiatrists, other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, counselors, and other health and mental health professionals. DSM-IV must be usable across settings—inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care, and with community populations. It is also a necessary tool for collecting and communicating accurate public health statistics. Fortunately, all these many uses are compatible with one another.

DSM-IV was the product of 13 Work Groups (see Appendix J), each of which had primary responsibility for a section of the manual. This organization was designed to increase participation by experts in each of the respective fields. We took a number of precautions to ensure that the Work Group recommendations would reflect the breadth of available evidence and opinion and not just the views of the specific members. After extensive consultations with experts and clinicians in each field, we selected Work Group members who represented a wide range of perspectives and experiences. Work Group members were instructed that they were to participate as consensus scholars and not as advocates of previously held views. Furthermore, we established a formal evidence-based process for the Work Groups to follow.

The Work Groups reported to the Task Force on DSM-IV (see p. ix), which consisted of 27 members, many of whom also chaired a Work Group. Each of the 13 Work Groups was composed of 5 (or more) members whose reviews were critiqued by between 50 and 100 advisers, who were also chosen to represent diverse clinical and research expertise, disciplines, backgrounds, and settings. The involvement of many international experts ensured that DSM-IV had available the widest pool of information and would be applicable across cultures. Conferences and workshops were held to provide

conceptual and methodological guidance for the DSM-IV effort. These included a number of consultations between the developers of DSM-IV and the developers of ICD-10 conducted for the purpose of increasing compatibility between the two systems. Also held were methods conferences that focused on cultural factors in the diagnosis of mental disorder, on geriatric diagnosis, and on psychiatric diagnosis in primary care settings.

To maintain open and extensive lines of communication, the Task Force on DSM-IV established a liaison with many other components within the American Psychiatric Association and with more than 60 organizations and associations interested in the development of DSM-IV (e.g., American Health Information Management Association, American Nurses' Association, American Occupational Therapy Association, American Psychoanalytic Association, American Psychological Association, American Psychological Society, Coalition for the Family, Group for the Advancement of Psychiatry, National Association of Social Workers, National Center for Health Statistics, World Health Organization). We attempted to air issues and empirical evidence early in the process in order to identify potential problems and differences in interpretation. Exchanges of information were also made possible through the distribution of a semiannual newsletter (the *DSM-IV Update*), the publication of a regular column on DSM-IV in *Hospital and Community Psychiatry*, frequent presentations at national and international conferences, and numerous journal articles.

Two years before the publication of DSM-IV, the Task Force published and widely distributed the *DSM-IV Options Book*. This volume presented a comprehensive summary of the alternative proposals that were being considered for inclusion in DSM-IV in order to solicit opinion and additional data for our deliberations. We received extensive correspondence from interested individuals who shared with us additional data and recommendations on the potential impact of the possible changes in DSM-IV on their clinical practice, teaching, research, and administrative work. This breadth of discussion helped us to anticipate problems and to attempt to find the best solution among the various options. One year before the publication of DSM-IV, a near-final draft of the proposed criteria sets was distributed to allow for one last critique.

In arriving at final DSM-IV decisions, the Work Groups and the Task Force reviewed all of the extensive empirical evidence and correspondence that had been gathered. It is our belief that the major innovation of DSM-IV lies not in any of its specific content changes but rather in the systematic and explicit process by which it was constructed and documented. More than any other nomenclature of mental disorders, DSM-IV is grounded in empirical evidence.

Historical Background

The need for a classification of mental disorders has been clear throughout the history of medicine, but there has been little agreement on which disorders should be included and the optimal method for their organization. The many nomenclatures that have been developed during the past two millennia have differed in their relative emphasis on phenomenology, etiology, and course as defining features. Some systems have included only a handful of diagnostic categories; others have 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, we focus 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).

In the United States, the initial impetus 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 illness in the United States was the recording of the frequency of one category—"idiocy/insanity" in the 1840 census. By the 1880 census, seven categories of mental illness were distinguished—mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy. In 1917, the Committee on Statistics of the American Psychiatric Association (at that time called the American Medico-Psychological Association [the name was changed in 1921]), 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.

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). Contemporaneously, the World Health Organization (WHO) published the sixth edition of 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, 9 for psychoneuroses, and 7 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 the *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 that was conducted by the British psychiatrist Stengel. His report can be credited with having inspired many of the recent advances in diagnostic methodology—most especially the need for explicit definitions as a means of promoting reliable clinical diagnoses. However, the next round of diagnostic revision, 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*.

As had been the case for DSM-I and DSM-II, the development of DSM-III was coordinated with the development of the next (ninth) version of ICD, 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 the extensive empirical work then under way 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 delineate categories to facilitate 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).

Experience with 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.

The DSM-IV Revision Process

The third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) represented a major advance in the diagnosis of mental disorders and greatly facilitated empirical research. The development of DSM-IV has benefited from the substantial increase in the research on diagnosis that was generated in part by DSM-III and DSM-III-R. Most diagnoses now have an empirical literature or available data sets that are relevant to decisions regarding the revision of the diagnostic manual. The Task Force on DSM-IV and its Work Groups conducted a three-stage empirical process that included 1) comprehensive and systematic reviews of the published literature, 2) reanalyses of already-collected data sets, and 3) extensive issue-focused field trials.

Literature Reviews

Two methods conferences were sponsored to articulate for all the Work Groups a systematic procedure for finding, extracting, aggregating, and interpreting data in a comprehensive and objective fashion. The initial tasks of each of the DSM-IV Work Groups were to identify the most pertinent issues regarding each diagnosis and to determine the kinds of empirical data relevant to their resolution. A Work Group member or adviser was then assigned the responsibility of conducting a systematic and comprehensive review of the relevant literature that would inform the resolution of the issue and also document the text of DSM-IV. The domains considered in making decisions included clinical utility, reliability, descriptive validity, psychometric performance characteristics of individual criteria, and a number of validating variables.

Each literature review specified 1) the issues or aspects of the text and criteria under consideration and the significance of the issues with respect to DSM-IV; 2) the review method (including the sources for identifying relevant studies, the number of studies considered, the criteria for inclusion and exclusion from the review, and the variables catalogued in each study); 3) the results of the review (including a descriptive summary of the studies with respect to methodology, design, and substantive correlates of the findings, the relevant findings, and the analyses conducted on these findings); and 4) the various options for resolving the issue, the advantages and disadvantages of each option,

recommendations, and suggestions for additional research that would be needed to provide a more conclusive resolution.

The goal of the DSM-IV literature reviews was to provide comprehensive and unbiased information and to ensure that DSM-IV reflects the best available clinical and research literature. For this reason, we used systematic computer searches and critical reviews done by large groups of advisers to ensure that the literature coverage was adequate and that the interpretation of the results was justified. Input was solicited especially from those persons likely to be critical of the conclusions of the review. The literature reviews were revised many times to produce as comprehensive and balanced a result as possible. It must be noted that for some issues addressed by the DSM-IV Work Groups, particularly those that were more conceptual in nature or for which there were insufficient data, a review of the empirical literature had limited utility. Despite these limitations, the reviews were helpful in documenting the rationale and empirical support for decisions made by the DSM-IV Work Groups.

Data Reanalyses

When a review of the literature revealed a lack of evidence (or conflicting evidence) for the resolution of an issue, we often made use of two additional resources—data reanalyses and field trials—to help in making final decisions. Analyses of relevant unpublished data sets were supported by a grant to the American Psychiatric Association from the John D. and Catherine T. MacArthur Foundation. Most of the 40 data reanalyses performed for DSM-IV involved the collaboration of several investigators at different sites. These researchers jointly subjected their data to questions posed by the Work Groups concerning the criteria included in DSM-III-R or criteria that might be included in DSM-IV. Data reanalyses also made it possible for Work Groups to generate several criteria sets that were then tested in the DSM-IV field trials. Although, for the most part, the data sets used in the reanalyses had been collected as part of epidemiological studies or treatment or other clinical studies, they were also highly relevant to the nosological questions facing the DSM-IV Work Groups.

Field Trials

Twelve DSM-IV field trials were sponsored by the National Institute of Mental Health (NIMH) in collaboration with the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The field trials allowed the DSM-IV Work Groups to compare alternative options and to study the possible impact of suggested changes. Field trials compared DSM-III, DSM-III-R, ICD-10, and proposed DSM-IV criteria sets in 5–10 different sites per field trial, with approximately 100 subjects at each site. Diverse sites, with representative groups of subjects from a range of sociocultural and ethnic backgrounds, were selected to ensure generalizability of field-trial results and to test some of the most difficult questions in differential diagnosis. The 12 field trials included more than 70 sites and evaluated more than 6,000 subjects. The field trials collected information on the reliability and performance characteristics of each criteria set as a whole, as well as of the specific items within each criteria set. The field trials also helped to bridge the boundary between clinical research and clinical practice by determining how well suggestions for change that are derived from clinical research findings apply in clinical practice.

Criteria for Change

Although it was impossible to develop absolute and infallible criteria for when changes should be made, there were some principles that guided our efforts. The threshold for making revisions in DSM-IV was set higher than that for DSM-III and DSM-III-R. Decisions had to be substantiated by explicit statements of rationale and by the systematic review of relevant empirical data. To increase the practicality and clinical utility of DSM-IV, the criteria sets were simplified and clarified when this could be justified by empirical data. An attempt was made to strike an optimal balance in DSM-IV with respect to historical tradition (as embodied in DSM-III and DSM-III-R), compatibility with ICD-10, evidence from reviews of the literature, analyses of unpublished data sets, results of field trials, and consensus of the field. Although the amount of evidence required to support changes was set at a high threshold, it necessarily varied across disorders because the empirical support for the decisions made in DSM-III and DSM-III-R also varied across disorders. Of course, common sense was necessary, and major changes to solve minor problems required more evidence than minor changes to solve major problems.

We received suggestions to include numerous new diagnoses in DSM-IV. The proponents argued that the new diagnoses were necessary to improve the coverage of the system by including a group of individuals that were undiagnosable in DSM-III-R or diagnosable only under the Not Otherwise Specified rubric. We decided that, in general, new diagnoses should be included in the system only after research has established that they should be included rather than being included to stimulate that research. However, diagnoses already included in ICD-10 were given somewhat more consideration than those that were being proposed fresh for DSM-IV. The increased marginal utility, clarity, and coverage provided by each newly proposed diagnosis had to be balanced against the cumulative cumbersomeness imposed on the whole system, the paucity of empirical documentation, and the possible misdiagnosis or misuse that might result. No classification of mental disorders can have a sufficient number of specific categories to encompass every conceivable clinical presentation. The Not Otherwise Specified categories are provided to cover the not infrequent presentations that are at the boundary of specific categorical definitions.

The DSM-IV Sourcebook

Documentation has been the essential foundation of the DSM-IV process. The *DSM-IV Sourcebook,* published in five volumes, is intended to provide a comprehensive and convenient reference record of the clinical and research support for the various decisions reached by the Work Groups and the Task Force. The first three volumes of the *Sourcebook* contain condensed versions of the 150 DSM-IV literature reviews. The fourth volume contains reports of the data reanalyses, and the fifth volume contains reports of the field trials and a final executive summary of the rationale for the decisions made by each Work Group. In addition, many papers were stimulated by the efforts toward empirical documentation in DSM-IV, and these have been published in peer-reviewed journals.

Relation to ICD-10

The tenth revision of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10), developed by WHO, was published in 1992, but will probably

not come into official use in the United States until the late 1990s. Those preparing ICD-10 and DSM-IV have worked closely to coordinate their efforts, resulting in much mutual influence. ICD-10 consists of an official coding system and other related clinical and research documents and instruments. The codes and terms provided in DSM-IV are fully compatible with both ICD-9-CM and ICD-10 (see Appendix H). The clinical and research drafts of ICD-10 were thoroughly reviewed by the DSM-IV Work Groups and suggested important topics for DSM-IV literature reviews and data reanalyses. Draft versions of the ICD-10 Diagnostic Criteria for Research were included as alternatives to be compared with DSM-III, DSM-III-R, and suggested DSM-IV criteria sets in the DSM-IV field trials. The many consultations between the developers of DSM-IV and ICD-10 (which were facilitated by NIMH, NIDA, and NIAAA) were enormously useful in increasing the congruence and reducing meaningless differences in wording between the two systems.

Definition of *Mental Disorder*

Although this volume is titled the *Diagnostic and Statistical Manual of Mental Disorders,* the term *mental disorder* unfortunately implies a distinction between "mental" disorders and "physical" disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much "physical" in "mental" disorders and much "mental" in "physical" disorders. The problem raised by the term "mental" disorders has been much clearer than its solution, and, unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate substitute.

Moreover, although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of "mental disorder." The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. All medical conditions are defined on various levels of abstraction—for example, structural pathology (e.g., ulcerative colitis), symptom presentation (e.g., migraine), deviance from a physiological norm (e.g., hypertension), and etiology (e.g., pneumococcal pneumonia). Mental disorders have also been defined by a variety of concepts (e.g., distress, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndromal pattern, etiology, and statistical deviation). Each is a useful indicator for a mental disorder, but none is equivalent to the concept, and different situations call for different definitions.

Despite these caveats, the definition of *mental disorder* that was included in DSM-III and DSM-III-R is presented here because it is as useful as any other available definition and has helped to guide decisions regarding which conditions on the boundary between normality and pathology should be included in DSM-IV. In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in

the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.

A common misconception is that a classification of mental disorders classifies people, when actually what are being classified are disorders that people have. For this reason, the text of DSM-IV (as did the text of DSM-III-R) avoids the use of such expressions as "a schizophrenic" or "an alcoholic" and instead uses the more accurate, but admittedly more cumbersome, "an individual with Schizophrenia" or "an individual with Alcohol Dependence."

Issues in the Use of DSM-IV

Limitations of the Categorical Approach

DSM-IV is a categorical classification that divides mental disorders into types based on criteria sets with defining features. This naming of categories is the traditional method of organizing and transmitting information in everyday life and has been the fundamental approach used in all systems of medical diagnosis. A categorical approach to classification works best when all members of a diagnostic class are homogeneous, when there are clear boundaries between classes, and when the different classes are mutually exclusive. Nonetheless, the limitations of the categorical classification system must be recognized.

In DSM-IV, there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder. There is also no assumption that all individuals described as having the same mental disorder are alike in all important ways. The clinician using DSM-IV should therefore consider that individuals sharing a diagnosis are likely to be heterogeneous even in regard to the defining features of the diagnosis and that boundary cases will be difficult to diagnose in any but a probabilistic fashion. This outlook allows greater flexibility in the use of the system, encourages more specific attention to boundary cases, and emphasizes the need to capture additional clinical information that goes beyond diagnosis. In recognition of the heterogeneity of clinical presentations, DSM-IV often includes polythetic criteria sets, in which the individual need only present with a subset of items from a longer list (e.g., the diagnosis of Borderline Personality Disorder requires only five out of nine items).

It was suggested that the DSM-IV Classification be organized following a dimensional model rather than the categorical model used in DSM-III-R. A dimensional system classifies clinical presentations based on quantification of attributes rather than the assignment to categories and works best in describing phenomena that are distributed continuously and that do not have clear boundaries. Although dimensional systems increase reliability and communicate more clinical information (because they report clinical attributes that might be subthreshold in a categorical system), they also have serious limitations and thus far have been less useful than categorical systems in clinical practice and in stimulating research. Numerical dimensional descriptions are much less familiar and vivid than are the categorical names for mental disorders. Moreover, there is as yet no agreement on the choice of the optimal dimensions to be used for classification purposes. Nonetheless, it is possible that the increasing research on, and familiarity with, dimensional systems may eventually result in their greater acceptance both as a method of conveying clinical information and as a research tool.

Use of Clinical Judgment

DSM-IV is a classification of mental disorders that was developed for use in clinical, educational, and research settings. The diagnostic categories, criteria, and textual descriptions are meant to be employed by individuals with appropriate clinical training and experience in diagnosis. It is important that DSM-IV not be applied mechanically by untrained individuals. The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion. For example, the exercise of clinical judgment may justify giving a certain diagnosis to an individual even though the clinical presentation falls just short of meeting the full criteria for the diagnosis as long as the symptoms that are present are persistent and severe. On the other hand, lack of familiarity with DSM-IV or excessively flexible and idiosyncratic application of DSM-IV criteria or conventions substantially reduces its utility as a common language for communication.

Use of DSM-IV in Forensic Settings

When the DSM-IV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a "mental disorder," "mental disability," "mental disease," or "mental defect." In determining whether an individual meets a specified legal standard (e.g., for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis. This might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability.

Nonclinical decision makers should also be cautioned that a diagnosis does not carry any necessary implications regarding the causes of the individual's mental disorder or its associated impairments. Inclusion of a disorder in the Classification (as in medicine generally) does not require that there be knowledge about its etiology. Moreover, the fact that an individual's presentation meets the criteria for a DSM-IV diagnosis does not carry any necessary implication regarding the individual's degree of control over the behaviors that may be associated with the disorder. Even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time.

It must be noted that DSM-IV reflects a consensus about the classification and diagnosis of mental disorders derived at the time of its initial publication. New knowledge generated by research or clinical experience will undoubtedly lead to an increased understanding of the disorders included in DSM-IV, to the identification of new disorders, and to the removal of some disorders in future classifications. The text and criteria sets included in DSM-IV will require reconsideration in light of evolving new information.

The use of DSM-IV in forensic settings should be informed by an awareness of the risks and limitations discussed above. When used appropriately, diagnoses and

diagnostic information can assist decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination. By providing a compendium based on a review of the pertinent clinical and research literature, DSM-IV may facilitate the legal decision makers' understanding of the relevant characteristics of mental disorders. The literature related to diagnoses also serves as a check on ungrounded speculation about mental disorders and about the functioning of a particular individual. Finally, diagnostic information regarding longitudinal course may improve decision making when the legal issue concerns an individual's mental functioning at a past or future point in time.

Ethnic and Cultural Considerations

Special efforts have been made in the preparation of DSM-IV to incorporate an awareness that the manual is used in culturally diverse populations in the United States and internationally. Clinicians are called on to evaluate individuals from numerous different ethnic groups and cultural backgrounds (including many who are recent immigrants). Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM-IV Classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture. For example, certain religious practices or beliefs (e.g., hearing or seeing a deceased relative during bereavement) may be misdiagnosed as manifestations of a Psychotic Disorder. Applying Personality Disorder criteria across cultural settings may be especially difficult because of the wide cultural variation in concepts of self, styles of communication, and coping mechanisms.

DSM-IV includes three types of information specifically related to cultural considerations: 1) a discussion in the text of cultural variations in the clinical presentations of those disorders that have been included in the DSM-IV Classification; 2) a description of culture-bound syndromes that have not been included in the DSM-IV Classification (these are included in Appendix I); and 3) an outline for cultural formulation designed to assist the clinician in systematically evaluating and reporting the impact of the individual's cultural context (also in Appendix I).

The wide international acceptance of DSM suggests that this classification is useful in describing mental disorders as they are experienced by individuals throughout the world. Nonetheless, evidence also suggests that the symptoms and course of a number of DSM-IV disorders are influenced by cultural and ethnic factors. To facilitate its application to individuals from diverse cultural and ethnic settings, DSM-IV includes a new section in the text to cover culture-related features. This section describes the ways in which varied cultural backgrounds affect the content and form of the symptom presentation (e.g., depressive disorders characterized by a preponderance of somatic symptoms rather than sadness in certain cultures), preferred idioms for describing distress, and information on prevalence when it is available.

The second type of cultural information provided pertains to "culture-bound syndromes" that have been described in just one, or a few, of the world's societies. DSM-IV provides two ways of increasing the recognition of culture-bound syndromes:

1) some (e.g., *amok, ataque de nervios*) are included as separate examples in Not Otherwise Specified categories; and 2) an appendix of culture-bound syndromes (Appendix I) has been introduced in DSM-IV that includes the name for the condition, the cultures in which it was first described, and a brief description of the psychopathology.

The provision of a culture-specific section in the DSM-IV text, the inclusion of a glossary of culture-bound syndromes, and the provision of an outline for cultural formulation are designed to enhance the cross-cultural applicability of DSM-IV. It is hoped that these new features will increase sensitivity to variations in how mental disorders may be expressed in different cultures and will reduce the possible effect of unintended bias stemming from the clinician's own cultural background.

Use of DSM-IV in Treatment Planning

Making a DSM-IV diagnosis is only the first step in a comprehensive evaluation. To formulate an adequate treatment plan, the clinician will invariably require considerable additional information about the person being evaluated beyond that required to make a DSM-IV diagnosis.

Distinction Between Mental Disorder *and* General Medical Condition

The terms *mental disorder* and *general medical condition* are used throughout this manual. The term *mental disorder* is explained above. The term *general medical condition* is used merely as a convenient shorthand to refer to conditions and disorders that are listed outside the "Mental and Behavioural Disorders" chapter of ICD. It should be recognized that these are merely terms of convenience and should not be taken to imply that there is any fundamental distinction between mental disorders and general medical conditions, that mental disorders are unrelated to physical or biological factors or processes, or that general medical conditions are unrelated to behavioral or psychosocial factors or processes.

Organization of the Manual

The manual begins with instructions concerning the use of the manual (p. 1), followed by the DSM-IV Classification (pp. 13–24), which provides a systematic listing of the official codes and categories. Next is a description of the DSM-IV multiaxial system for diagnosis (pp. 25–35). This is followed by the diagnostic criteria for each of the DSM-IV disorders accompanied by descriptive text (pp. 37–687). Finally, DSM-IV includes 10 appendixes.

Cautionary Statement

The specified diagnostic criteria for each mental disorder are offered as guidelines for making diagnoses, because it has been demonstrated that the use of such criteria enhances agreement among clinicians and investigators. The proper use of these criteria requires specialized clinical training that provides both a body of knowledge and clinical skills.

These diagnostic criteria and the DSM-IV Classification of mental disorders reflect a consensus of current formulations of evolving knowledge in our field. They do not encompass, however, all the conditions for which people may be treated or that may be appropriate topics for research efforts.

The purpose of DSM-IV is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders. It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category such as Pathological Gambling or Pedophilia does not imply that the condition meets legal or other nonmedical criteria for what constitutes mental disease, mental disorder, or mental disability. The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency.

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FOURTH EDITION

TEXT REVISION

DSM-IV-TR™

AMERICAN PSYCHIATRIC ASSOCIATION

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FOURTH EDITION

TEXT REVISION

DSM-IV-TR™

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FOURTH EDITION

TEXT REVISION

DSM-IV-TR™

Published by the
American Psychiatric Association
Washington, DC

Manufactured in the United States of America on acid-free paper.

American Psychiatric Association
1400 K Street, N.W., Washington, DC 20005
www.psych.org

The correct citation for this book is American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

Library of Congress Cataloging-in-Publication Data
Diagnostic and statistical manual of mental disorders : DSM-IV.—4th ed., text revision.
p. ; cm.
Prepared by the Task Force on DSM-IV and other committees and work groups of the American Psychiatric Association.
Includes index.
ISBN 0-89042-024-6 (casebound : alk. paper)—ISBN 0-89042-025-4 (pbk. : alk. paper)
1. Mental illness—Classification—Handbooks, manuals, etc. 2. Mental illness—Diagnosis—Handbooks, manuals, etc. I. Title: DSM-IV. II. American Psychiatric Association. III. America: Psychiatric Association. Task Force on DSM-IV.
[DNLM: 1. Mental Disorders—classification. 2. Mental Disorders—diagnosis.
WM 15 D536 2000]
RC455.2.C4 D536 2000
616.89'075—dc21

00-024852

British Library Cataloguing in Publication Data
A CIP record is available from the British Library.

Text Design—Anne Barnes
Manufacturing—R. R. Donnelley & Sons Company

To Melvin Sabshin,
a man for all seasons

Contents

Task Force on DSM-IV xi
Work Groups for the DSM-IV-TR Text Revision xv
Acknowledgments for DSM-IV-TR xix
Acknowledgments for DSM-IV Text Revision xxi
Introduction xxiii
Cautionary Statement xxxvii
Use of the Manual 1
DSM-IV-TR Classification 13
Multiaxial Assessment 27
Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence 39
Delirium, Dementia, and Amnestic and Other Cognitive Disorders 135
Mental Disorders Due to a General Medical Condition 181
Substance-Related Disorders 191
Schizophrenia and Other Psychotic Disorders 297
Mood Disorders 345
Anxiety Disorders 429
Somatoform Disorders 485
Factitious Disorders 513
Dissociative Disorders 519
Sexual and Gender Identity Disorders 535

Eating Disorders 583
Sleep Disorders 597
Impulse-Control Disorders Not Elsewhere Classified 663
Adjustment Disorders 679
Personality Disorders 685
Other Conditions That May Be a Focus of Clinical Attention 731
Additional Codes 743

Appendix A
Decision Trees for Differential Diagnosis 745

Appendix B
Criteria Sets and Axes Provided for Further Study 759

Appendix C
Glossary of Technical Terms 819

Appendix D
Highlights of Changes in DSM-IV Text Revision 829

Appendix E
Alphabetical Listing of DSM-IV-TR Diagnoses and Codes 845

Appendix F
Numerical Listing of DSM-IV-TR Diagnoses and Codes 857

Appendix G
ICD-9-CM Codes for Selected General Medical Conditions and Medication-Induced Disorders 867

Appendix H
DSM-IV Classification
(With ICD-10 Codes) 883

Appendix I
Outline for Cultural Formulation and
Glossary of Culture-Bound Syndromes 897

Appendix J
DSM-IV Contributors 905

Appendix K
DSM-IV Text Revision Advisers. 929

Index 933

TASK FORCE ON DSM-IV

ALLEN FRANCES, M.D.
Chairperson

HAROLD ALAN PINCUS, M.D.
Vice-Chairperson

MICHAEL B. FIRST, M.D.
Editor, Text and Criteria

Nancy Coover Andreasen, M.D., Ph.D.
David H. Barlow, Ph.D.
Magda Campbell, M.D.
Dennis P. Cantwell, M.D.
Ellen Frank, Ph.D.
Judith H. Gold, M.D.
John Gunderson, M.D.
Robert E. Hales, M.D.
Kenneth S. Kendler, M.D.
David J. Kupfer, M.D.
Michael R. Liebowitz, M.D.
Juan Enrique Mezzich, M.D., Ph.D.
Peter E. Nathan, Ph.D.
Roger Peele, M.D.
Darrel A. Regier, M.D., M.P.H.
A. John Rush, M.D.
Chester W. Schmidt, M.D.
Marc Alan Schuckit, M.D.
David Shaffer, M.D.
Robert L. Spitzer, M.D.
Special Adviser
Gary J. Tucker, M.D.
B. Timothy Walsh, M.D.
Thomas A. Widiger, Ph.D.
Research Coordinator
Janet B. W. Williams, D.S.W.
John C. Urbaitis, M.D.
Assembly Liaison
James J. Hudziak, M.D.
Resident Fellow (1990–1993)
Junius Gonzales, M.D.
Resident Fellow (1988–1990)

Ruth Ross, M.A.
Science Editor
Nancy E. Vettorello, M.U.P.
Administrative Coordinator
Wendy Wakefield Davis, Ed.M.
Editorial Coordinator
Cindy D. Jones
Administrative Assistant
Nancy Sydnor-Greenberg, M.A.
Administrative Consultant
Myriam Kline, M.S.
Focused Field-Trial Coordinator
James W. Thompson, M.D., M.P.H.
Videotape Field-Trial Coordinator

The DSM-IV Text Revision Work Groups are listed on pp. xv–xvii.

Anxiety Disorders Work Group

Michael R. Liebowitz, M.D.
Chairperson
David H. Barlow, Ph.D.
Vice-Chairperson
James C. Ballenger, M.D.
Jonathan Davidson, M.D.
Edna Foa, Ph.D.
Abby Fyer, M.D.

Delirium, Dementia, and Amnestic and Other Cognitive Disorders Work Group

Gary J. Tucker, M.D.
Chairperson
Michael Popkin, M.D.
Vice-Chairperson
Eric Douglas Caine, M.D.
Marshall Folstein, M.D.
Gary Lloyd Gottlieb, M.D.
Igor Grant, M.D.
Benjamin Liptzin, M.D.

Disorders Usually First Diagnosed During Infancy, Childhood, or Adolescence Work Group

David Shaffer, M.D.
Co-Chairperson
Magda Campbell, M.D.
Co-Chairperson
Susan J. Bradley, M.D.
Dennis P. Cantwell, M.D.
Gabrielle A. Carlson, M.D.
Donald Jay Cohen, M.D.
Barry Garfinkel, M.D.
Rachel Klein, Ph.D.
Benjamin Lahey, Ph.D.
Rolf Loeber, Ph.D.
Jeffrey Newcorn, M.D.
Rhea Paul, Ph.D.
Judith H. L. Rapoport, M.D.
Sir Michael Rutter, M.D.
Fred Volkmar, M.D.
John S. Werry, M.D.

Eating Disorders Work Group

B. Timothy Walsh, M.D.
Chairperson
Paul Garfinkel, M.D.
Katherine A. Halmi, M.D.
James Mitchell, M.D.
G. Terence Wilson, Ph.D.

Mood Disorders Work Group

A. John Rush, M.D.
Chairperson
Martin B. Keller, M.D.
Vice-Chairperson
Mark S. Bauer, M.D.
David Dunner, M.D.
Ellen Frank, Ph.D.
Donald F. Klein, M.D.

Multiaxial Issues Work Group

Janet B. W. Williams, D.S.W.
Chairperson
Howard H. Goldman, M.D., Ph.D.
Vice-Chairperson
Alan M. Gruenberg, M.D.
Juan Enrique Mezzich, M.D., Ph.D.
Roger Peele, M.D.
Stephen Setterberg, M.D.
Andrew Edward Skodol II, M.D.

Personality Disorders Work Group

John Gunderson, M.D.
Chairperson
Robert M. A. Hirschfeld, M.D.
Vice-Chairperson
Roger Blashfield, Ph.D.
Susan Jean Fiester, M.D.
Theodore Millon, Ph.D.
Bruce Pfohl, M.D.
Tracie Shea, Ph.D.
Larry Siever, M.D.
Thomas A. Widiger, Ph.D.

Premenstrual Dysphoric Disorder Work Group

Judith H. Gold, M.D.
Chairperson
Jean Endicott, Ph.D.
Barbara Parry, M.D.
Sally Severino, M.D.
Nada Logan Stotland, M.D.
Ellen Frank, Ph.D.
Consultant

Psychiatric Systems Interface Disorders (Adjustment, Dissociative, Factitious, Impulse-Control, and Somatoform Disorders and Psychological Factors Affecting Medical Conditions) Work Group

Robert E. Hales, M.D.
Chairperson
C. Robert Cloninger, M.D.
Vice-Chairperson
Jonathan F. Borus, M.D.
Jack Denning Burke, Jr., M.D., M.P.H.
Joe P. Fagan, M.D.
Steven A. King, M.D.
Ronald L. Martin, M.D.
Katharine Anne Phillips, M.D.
David A. Spiegel, M.D.
Alan Stoudemire, M.D.
James J. Strain, M.D.
Michael G. Wise, M.D.

Schizophrenia and Other Psychotic Disorders Work Group

Nancy Coover Andreasen, M.D., Ph.D.
Chairperson
John M. Kane, M.D.
Vice-Chairperson
Samuel Keith, M.D.
Kenneth S. Kendler, M.D.
Thomas McGlashan, M.D.

Sexual Disorders Work Group

Chester W. Schmidt, M.D.
Chairperson
Raul Schiavi, M.D.
Leslie Schover, Ph.D.
Taylor Seagraves, M.D.
Thomas Nathan Wise, M.D.

Sleep Disorders Work Group

David J. Kupfer, M.D.
Chairperson
Charles F. Reynolds III, M.D.
Vice-Chairperson
Daniel Buysse, M.D.
Roger Peele, M.D.
Quentin Regestein, M.D.
Michael Sateia, M.D.
Michael Thorpy, M.D.

Substance-Related Disorders Work Group

Marc Alan Schuckit, M.D.
Chairperson
John E. Helzer, M.D.
Vice-Chairperson
Linda B. Cottler, Ph.D.
Thomas Crowley, M.D.
Peter E. Nathan, Ph.D.
George E. Woody, M.D.

Committee on Psychiatric Diagnosis and Assessment

Layton McCurdy, M.D.
Chairperson (1987–1994)
Kenneth Z. Altshuler, M.D. (1987–1992)
Thomas F. Anders, M.D. (1988–1994)
Susan Jane Blumenthal, M.D. (1990–1993)
Leah Joan Dickstein, M.D. (1988–1991)
Lewis J. Judd, M.D. (1988–1994)
Gerald L. Klerman, M.D. (deceased) (1988–1991)
Stuart C. Yudofsky, M.D. (1992–1994)
Jack D. Blaine, M.D.
Consultant (1987–1992)
Jerry M. Lewis, M.D.
Consultant (1988–1994)
Daniel J. Luchins, M.D.
Consultant (1987–1991)
Katharine Anne Phillips, M.D.
Consultant (1992–1994)
Cynthia Pearl Rose, M.D.
Consultant (1990–1994)
Louis Alan Moench, M.D.
Assembly Liaison (1991–1994)
Steven K. Dobscha, M.D.
Resident Fellow (1990–1992)
Mark Zimmerman, M.D.
Resident Fellow (1992–1994)

Joint Committee of the Board of Trustees and Assembly of District Branches on Issues Related to DSM-IV

Ronald A. Shellow, M.D.
Chairperson
Harvey Bluestone, M.D.
Leah Joan Dickstein, M.D.
Arthur John Farley, M.D.
Carol Ann Bernstein, M.D.

WORK GROUPS FOR THE DSM-IV TEXT REVISION

MICHAEL B. FIRST, M.D.
Co-Chairperson and Editor

HAROLD ALAN PINCUS, M.D.
Co-Chairperson

Laurie E. McQueen, M.S.S.W.
DSM Project Manager

Yoshie Satake, B.A.
DSM Program Coordinator

Anxiety Disorders Text Revision Work Group

Murray B. Stein, M.D.
Chairperson
Jonathan Abramowitz, Ph.D.
Gordon Asmundson, Ph.D.
Jean C. Beckham, Ph.D.
Timothy Brown, Ph.D., Psy.D.
Michelle Craske, Ph.D.
Edna Foa, Ph.D.
Thomas Mellman, M.D.
Ron Norton, Ph.D.
Franklin Schneier, M.D.
Richard Zinbarg, Ph.D.

Delirium, Dementia, and Amnestic and Other Cognitive Disorders and Mental Disorders Due to a General Medical Condition Text Revision Work Group

Eric Douglas Caine, M.D.
Jesse Fann, M.D., M.P.H.

Disorders Usually First Diagnosed During Infancy, Childhood, or Adolescence Text Revision Work Group

David Shaffer, M.D.
Chairperson
Donald J. Cohen, M.D.
Stephen Hinshaw, Ph.D.
Rachel G. Klein, Ph.D.
Ami Klin, Ph.D.
Daniel Pine, M.D.
Mark A. Riddle, M.D.
Fred R. Volkmar, M.D.
Charles Zeanah, M.D.

Eating Disorders Text Revision Work Group

Katharine L. Loeb, Ph.D.
B. Timothy Walsh, M.D.

Medication-Induced Movement Disorders Text Revision Work Group

Gerard Addonizio, M.D.
Lenard Adler, M.D.
Burton Angrist, M.D.
Daniel Casey, M.D.
Alan Gelenberg, M.D.
James Jefferson, M.D.
Dilip Jeste, M.D.
Peter Weiden, M.D.

Mood Disorders Text Revision Work Group

Mark S. Bauer, M.D.
Patricia Suppes, M.D., Ph.D.
Michael E. Thase, M.D.

Multiaxial Text Revision Work Group

Alan M. Gruenberg, M.D.

Personality Disorders Text Revision Work Group

Bruce Pfohl, M.D.
Thomas A. Widiger, Ph.D.

Premenstrual Dysphoric Disorder Text Revision Work Group

Sally Severino, M.D.

Psychiatric System Interface Disorders (Adjustment, Dissociative, Factitious, Impulse-Control, and Somatoform Disorders and Psychological Factors Affecting Medical Conditions) Text Revision Work Group

Mitchell Cohen, M.D.
Marc Feldman, M.D.
Eric Hollander, M.D.
Steven A. King, M.D.
James Levenson, M.D.
Ronald L. Martin, M.D. (deceased)
Jeffrey Newcorn, M.D.
Russell Noyes, Jr., M.D.
Katharine Anne Phillips. M.D.
Eyal Shemesh, M.D.
David A. Spiegel, M.D.
James J. Strain, M.D.
Sean H. Yutzy, M.D.

Schizophrenia and Other Psychotic Disorders Text Revision Work Group

Michael Flaum, M.D.
Chairperson
Xavier Amador, Ph.D.

Sexual and Gender Identity Disorders Text Revision Work Group

Chester W. Schmidt, M.D.
R. Taylor Segraves, M.D.
Thomas Nathan Wise, M.D.
Kenneth J. Zucker, Ph.D.

Sleep Disorders Text Revision Work Group

Daniel Buysse, M.D.
Peter Nowell, M.D.

Substance-Related Disorders Text Revision Work Group

Marc Alan Schuckit, M.D.

American Psychiatric Association
Committee on Psychiatric Diagnosis and Assessment

David J. Kupfer, M.D.
Chair

James Leckman, M.D.
Member

Katharine Anne Phillips, M.D.
Member

A. John Rush, M.D.
Member

Daniel Winstead, M.D.
Member

Bonnie Zima, M.D., Ph.D.
Member

Barbara Kennedy, M.D., Ph.D.
Consultant

Janet B. W. Williams, D.S.W.
Consultant

Louis Alan Moench, M.D.
Assembly Liaison

Jack Barchas, M.D.
Corresponding Member

Herbert W. Harris, M.D., Ph.D.
Corresponding Member

Charles Kaelber, M.D.
Corresponding Member

Jorge A. Costa e Silva, M.D.
Corresponding Member

T. Bedirhan Ustun, M.D.
Corresponding Member

Yeshuschandra Dhaibar, M.D.
APA/Glaxo-Wellcome Fellow

Acknowledgments for DSM-IV

DSM-IV was a team effort. More than 1,000 people (and numerous professional organizations) have helped us in the preparation of this document. Members of the Task Force on DSM-IV and DSM-IV Staff are listed on p. xi, members of the DSM-IV Work Groups are listed on pp. xii–xiv, and a list of other participants is included in Appendix J.

The major responsibility for the content of DSM-IV rests with the Task Force on DSM-IV and members of the DSM-IV Work Groups. They have worked (often much harder than they bargained for) with a dedication and good cheer that has been inspirational to us. Bob Spitzer has our special thanks for his untiring efforts and unique perspective. Norman Sartorius, Darrel Regier, Lewis Judd, Fred Goodwin, and Chuck Kaelber were instrumental in facilitating a mutually productive interchange between the American Psychiatric Association and the World Health Organization that has improved both DSM-IV and ICD-10, and increased their compatibility. We are grateful to Robert Israel, Sue Meads, and Amy Blum at the National Center for Health Statistics and Andrea Albaum-Feinstein at the American Health Information Management Association for suggestions on the DSM-IV coding system. Denis Prager, Peter Nathan, and David Kupfer helped us to develop a novel data reanalysis strategy that has been supported with funding from the John D. and Catherine T. MacArthur Foundation.

Many individuals within the American Psychiatric Association deserve recognition. Mel Sabshin's special wisdom and grace made even the most tedious tasks seem worth doing. The American Psychiatric Association Committee on Psychiatric Diagnosis and Assessment (chaired by Layton McCurdy) provided valuable direction and counsel. We would also like to thank the American Psychiatric Association Presidents (Drs. Fink, Pardes, Benedek, Hartmann, English, and McIntyre) and Assembly Speakers (Drs. Cohen, Flamm, Hanin, Pfaehler, and Shellow) who helped with the planning of our work. Carolyn Robinowitz and Jack White, and their respective staffs in the American Psychiatric Association Medical Director's Office and the Business Administration Office, have provided valuable assistance in the organization of the project.

Several other individuals have our special gratitude. Wendy Davis, Nancy Vettorello, and Nancy Sydnor-Greenberg developed and implemented an organizational structure that has kept this complex project from spinning out of control. We have also been blessed with an unusually able administrative staff, which has included Elisabeth Fitzhugh, Willa Hall, Kelly McKinney, Gloria Miele, Helen Stayna, Sarah Tilly, Nina Rosenthal, Susan Mann, Joanne Mas, and, especially, Cindy Jones. Ruth Ross, our tireless Science Editor, has been responsible for improving the clarity of expression and organization of DSM-IV. Myriam Kline (Research Coordinator for the NIH-funded DSM-IV Focused Field Trials), Jim Thompson (Research Coordinator for

the MacArthur Foundation–funded Videotape Field Trial), and Sandy Ferris (Assistant Director for the Office of Research) have made many valuable contributions. We would also like to acknowledge all the other staff persons at the American Psychiatric Association who have helped with this project. Ron McMillen, Claire Reinburg, Pam Harley, and Jane Davenport of American Psychiatric Press have provided expert production assistance.

Allen Frances, M.D.
Chairperson, Task Force on DSM-IV

Harold Alan Pincus, M.D.
Vice-Chairperson, Task Force on DSM-IV

Michael B. First, M.D.
Editor, DSM-IV Text and Criteria

Thomas A. Widiger, Ph.D.
Research Coordinator

Acknowledgments for DSM-IV Text Revision

The effort to revise the DSM-IV text was also a team effort. We are especially indebted to the tireless efforts of the DSM-IV Text Revision Work Groups (listed on pp. xv–xvii), who did the lion's share of the work in the preparation of this revision. We would also like to acknowledge the contribution of the various advisers to the Work Groups (see Appendix K, p. 929), who provided their perspective on whether the proposed changes were justified. Finally, we would like to thank the American Psychiatric Association's Committee on Psychiatric Diagnosis and Assessment (listed on p. xvii), who provided helpful guidance and oversight during the process as well as approval of the final document. Special gratitude goes to committee members Katharine A. Phillips and Janet B. W. Williams, for their meticulously careful review of the text revision. Of course, none of this could have happened without the invaluable organizational and administrative assistance provided by the DSM-IV staff, Laurie McQueen and Yoshie Satake, and production assistance provided by Anne Barnes, Pam Harley, Greg Kuny, Claire Reinburg, and Ron McMillen at American Psychiatric Press.

Michael B. First, M.D.
Co-Chairperson and Editor

Harold Alan Pincus, M.D.
Co-Chairperson

Introduction

This is the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, or DSM-IV. The utility and credibility of DSM-IV require that it focus on its clinical, research, and educational purposes and be supported by an extensive empirical foundation. Our highest priority has been to provide a helpful guide to clinical practice. We hoped to make DSM-IV practical and useful for clinicians by striving for brevity of criteria sets, clarity of language, and explicit statements of the constructs embodied in the diagnostic criteria. An additional goal was to facilitate research and improve communication among clinicians and researchers. We were also mindful of the use of DSM-IV for improving the collection of clinical information and as an educational tool for teaching psychopathology.

An official nomenclature must be applicable in a wide diversity of contexts. DSM-IV is used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems). It is used by psychiatrists, other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, counselors, and other health and mental health professionals. DSM-IV must be usable across settings—inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care, and with community populations. It is also a necessary tool for collecting and communicating accurate public health statistics. Fortunately, all these many uses are compatible with one another.

DSM-IV was the product of 13 Work Groups (see Appendix J), each of which had primary responsibility for a section of the manual. This organization was designed to increase participation by experts in each of the respective fields. We took a number of precautions to ensure that the Work Group recommendations would reflect the breadth of available evidence and opinion and not just the views of the specific members. After extensive consultations with experts and clinicians in each field, we selected Work Group members who represented a wide range of perspectives and experiences. Work Group members were instructed that they were to participate as consensus scholars and not as advocates of previously held views. Furthermore, we established a formal evidence-based process for the Work Groups to follow.

The Work Groups reported to the Task Force on DSM-IV (see p. xi), which consisted of 27 members, many of whom also chaired a Work Group. Each of the 13 Work Groups was composed of 5 (or more) members whose reviews were critiqued by between 50 and 100 advisers, who were also chosen to represent diverse clinical and research expertise, disciplines, backgrounds, and settings. The involvement of many international experts ensured that DSM-IV had available the widest pool of information and would be applicable across cultures. Conferences and workshops were held to provide conceptual and methodological guidance for the DSM-IV effort. These

included a number of consultations between the developers of DSM-IV and the developers of ICD-10 conducted for the purpose of increasing compatibility betw the two systems. Also held were methods conferences that focused on cultural fact in the diagnosis of mental disorder, on geriatric diagnosis, and on psychiatric diagnosis in primary care settings.

To maintain open and extensive lines of communication, the Task Force on DSM-IV established a liaison with many other components within the American Psychiatric Association and with more than 60 organizations and associations interested in the development of DSM-IV (e.g., American Health Information Management Association, American Nurses' Association, American Occupational Therapy Association, American Psychoanalytic Association, American Psychological Association, American Psychological Society, Coalition for the Family, Group for the Advancement of Psychiatry, National Association of Social Workers, National Center for Health Statistics, World Health Organization). We attempted to air issues and empirical evidence early in the process in order to identify potential problems and differences in interpretation. Exchanges of information were also made possible through the distribution of a semiannual newsletter (the *DSM-IV Update*), the publication of a regular column on DSM-IV in *Hospital and Community Psychiatry*, frequent presentations at national and international conferences, and numerous journal articles.

Two years before the publication of DSM-IV, the Task Force published and widely distributed the *DSM-IV Options Book*. This volume presented a comprehensive summary of the alternative proposals that were being considered for inclusion in DSM-IV in order to solicit opinion and additional data for our deliberations. We received extensive correspondence from interested individuals who shared with us additional data and recommendations on the potential impact of the possible changes in DSM on their clinical practice, teaching, research, and administrative work. This bread discussion helped us to anticipate problems and to attempt to find the best solution among the various options. One year before the publication of DSM-IV, a near-final draft of the proposed criteria sets was distributed to allow for one last critique.

In arriving at final DSM-IV decisions, the Work Groups and the Task Force reviewed all of the extensive empirical evidence and correspondence that had been gathered. It is our belief that the major innovation of DSM-IV lies not in any of its specific content changes but rather in the systematic and explicit process by which it was constructed and documented. More than any other nomenclature of mental disorders, DSM-IV is grounded in empirical evidence.

Historical Background

The need for a classification of mental disorders has been clear throughout the history of medicine, but there has been little agreement on which disorders should be included and the optimal method for their organization. The many nomenclatures that have been developed during the past two millennia have differed in their relative emphasis on phenomenology, etiology, and course as defining features. Some systems have included only a handful of diagnostic categories; others have 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, we focus 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).

In the United States, the initial impetus 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 illness in the United States was the recording of the frequency of one category—"idiocy/insanity" in the 1840 census. By the 1880 census, seven categories of mental illness were distinguished—mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy. In 1917, the Committee on Statistics of the American Psychiatric Association (at that time called the American Medico-Psychological Association [the name was changed in 1921]), 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.

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). Contemporaneously, the World Health Organization (WHO) published the sixth edition of 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, 9 for psychoneuroses, and 7 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 the *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 that was conducted by the British psychiatrist Stengel. His report can be credited with having inspired many of the recent advances in diagnostic methodology—most especially the need for explicit definitions as a means of promoting reliable clinical diagnoses. However, the next round of diagnostic revision, 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*.

As had been the case for DSM-I and DSM-II, the development of DSM-III was co-

ordinated with the development of the next (ninth) version of ICD, which was published in 1975 and implemented in 1978. Work began on DSM-III in 1974, 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 the extensive empirical work then under way 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 delineate categories to facilitate 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).

Experience with 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.

The DSM-IV Revision Process

The third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) represented a major advance in the diagnosis of mental disorders and greatly facilitated empirical research. The development of DSM-IV has benefited from the substantial increase in the research on diagnosis that was generated in part by DSM-III and DSM-III-R. Most diagnoses now have an empirical literature or available data sets that are relevant to decisions regarding the revision of the diagnostic manual. The Task Force on DSM-IV and its Work Groups conducted a three-stage empirical process that included 1) comprehensive and systematic reviews of the published literature, 2) reanalyses of already-collected data sets, and 3) extensive issue-focused field trials.

Literature Reviews

Two methods conferences were sponsored to articulate for all the Work Groups a systematic procedure for finding, extracting, aggregating, and interpreting data in a comprehensive and objective fashion. The initial tasks of each of the DSM-IV Work Groups were to identify the most pertinent issues regarding each diagnosis and to determine the kinds of empirical data relevant to their resolution. A Work Group member or adviser was then assigned the responsibility of conducting a systematic and comprehensive review of the relevant literature that would inform the resolution of the issue and also document the text of DSM-IV. The domains considered in making decisions included clinical utility, reliability, descriptive validity, psychometric performance characteristics of individual criteria, and a number of validating variables.

Each literature review specified 1) the issues or aspects of the text and criteria under consideration and the significance of the issues with respect to DSM-IV; 2) the review method (including the sources for identifying relevant studies, the number of

studies considered, the criteria for inclusion and exclusion from the review, and the variables catalogued in each study); 3) the results of the review (including a descriptive summary of the studies with respect to methodology, design, and substantive correlates of the findings, the relevant findings, and the analyses conducted on these findings); and 4) the various options for resolving the issue, the advantages and disadvantages of each option, recommendations, and suggestions for additional research that would be needed to provide a more conclusive resolution.

The goal of the DSM-IV literature reviews was to provide comprehensive and unbiased information and to ensure that DSM-IV reflects the best available clinical and research literature. For this reason, we used systematic computer searches and critical reviews done by large groups of advisers to ensure that the literature coverage was adequate and that the interpretation of the results was justified. Input was solicited especially from those persons likely to be critical of the conclusions of the review. The literature reviews were revised many times to produce as comprehensive and balanced a result as possible. It must be noted that for some issues addressed by the DSM-IV Work Groups, particularly those that were more conceptual in nature or for which there were insufficient data, a review of the empirical literature had limited utility. Despite these limitations, the reviews were helpful in documenting the rationale and empirical support for decisions made by the DSM-IV Work Groups.

Data Reanalyses

When a review of the literature revealed a lack of evidence (or conflicting evidence) for the resolution of an issue, we often made use of two additional resources—data reanalyses and field trials—to help in making final decisions. Analyses of relevant unpublished data sets were supported by a grant to the American Psychiatric Association from the John D. and Catherine T. MacArthur Foundation. Most of the 40 data reanalyses performed for DSM-IV involved the collaboration of several investigators at different sites. These researchers jointly subjected their data to questions posed by the Work Groups concerning the criteria included in DSM-III-R or criteria that might be included in DSM-IV. Data reanalyses also made it possible for Work Groups to generate several criteria sets that were then tested in the DSM-IV field trials. Although, for the most part, the data sets used in the reanalyses had been collected as part of epidemiological studies or treatment or other clinical studies, they were also highly relevant to the nosological questions facing the DSM-IV Work Groups.

Field Trials

Twelve DSM-IV field trials were sponsored by the National Institute of Mental Health (NIMH) in collaboration with the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The field trials allowed the DSM-IV Work Groups to compare alternative options and to study the possible impact of suggested changes. Field trials compared DSM-III, DSM-III-R, ICD-10, and proposed DSM-IV criteria sets in 5–10 different sites per field trial, with approximately 100 subjects at each site. Diverse sites, with representative groups of subjects from a range of sociocultural and ethnic backgrounds, were selected to ensure generalizability of field-trial results and to test some of the most difficult ques-

tions in differential diagnosis. The 12 field trials included more than 70 sites and evaluated more than 6,000 subjects. The field trials collected information on th ability and performance characteristics of each criteria set as a whole, as well as c specific items within each criteria set. The field trials also helped to bridge the boundary between clinical research and clinical practice by determining how well suggestions for change that are derived from clinical research findings apply in clinical practice.

Criteria for Change

Although it was impossible to develop absolute and infallible criteria for when changes should be made, there were some principles that guided our efforts. The threshold for making revisions in DSM-IV was set higher than that for DSM-III and DSM-III-R. Decisions had to be substantiated by explicit statements of rationale and by the systematic review of relevant empirical data. To increase the practicality and clinical utility of DSM-IV, the criteria sets were simplified and clarified when this could be justified by empirical data. An attempt was made to strike an optimal balance in DSM-IV with respect to historical tradition (as embodied in DSM-III and DSM-III-R), compatibility with ICD-10, evidence from reviews of the literature, analyses of unpublished data sets, results of field trials, and consensus of the field. Although the amount of evidence required to support changes was set at a high threshold, it necessarily varied across disorders because the empirical support for the decisions made in DSM-III and DSM-III-R also varied across disorders. Of course, common sense was necessary, and major changes to solve minor problems required more evidence than minor changes to solve major problems.

We received suggestions to include numerous new diagnoses in DSM-IV. T ponents argued that the new diagnoses were necessary to improve the coverag system by including a group of individuals that were undiagnosable in DSM-III-R or diagnosable only under the Not Otherwise Specified rubric. We decided that, in general, new diagnoses should be included in the system only after research has established that they should be included rather than being included to stimulate that research. However, diagnoses already included in ICD-10 were given somewhat more consideration than those that were being proposed fresh for DSM-IV. The increased marginal utility, clarity, and coverage provided by each newly proposed diagnosis had to be balanced against the cumulative cumbersomeness imposed on the whole system, the paucity of empirical documentation, and the possible misdiagnosis or misuse that might result. No classification of mental disorders can have a sufficient number of specific categories to encompass every conceivable clinical presentation. The Not Otherwise Specified categories are provided to cover the not infrequent presentations that are at the boundary of specific categorical definitions.

The *DSM-IV Sourcebook*

Documentation has been the essential foundation of the DSM-IV process. The *DSM-IV Sourcebook*, published in four volumes, is intended to provide a comprehensive and convenient reference record of the clinical and research support for the various decisions reached by the Work Groups and the Task Force. The first three volumes of the *Sourcebook* contain condensed versions of the 150 DSM-IV literature reviews. Th

fourth volume contains reports of the data reanalyses, reports of the field trials, and a final executive summary of the rationale for the decisions made by each Work Group. In addition, many papers were stimulated by the efforts toward empirical documentation in DSM-IV, and these have been published in peer-reviewed journals.

Relation to ICD-10

The tenth revision of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10), developed by WHO, was published in 1992. A clinical modification of ICD-10 (ICD-10-CM) is expected to be implemented in the United States in 2004. Those preparing ICD-10 and DSM-IV have worked closely to coordinate their efforts, resulting in much mutual influence. ICD-10 consists of an official coding system and other related clinical and research documents and instruments. The codes and terms provided in DSM-IV are fully compatible with both ICD-9-CM and ICD-10 (see Appendix H). The clinical and research drafts of ICD-10 were thoroughly reviewed by the DSM-IV Work Groups and suggested important topics for DSM-IV literature reviews and data reanalyses. Draft versions of the ICD-10 Diagnostic Criteria for Research were included as alternatives to be compared with DSM-III, DSM-III-R, and suggested DSM-IV criteria sets in the DSM-IV field trials. The many consultations between the developers of DSM-IV and ICD-10 (which were facilitated by NIMH, NIDA, and NIAAA) were enormously useful in increasing the congruence and reducing meaningless differences in wording between the two systems.

The DSM-IV Text Revision

One of the most important uses of DSM-IV has been as an educational tool. This is especially true of the descriptive text that accompanies the criteria sets for DSM-IV disorders. Given that the interval between DSM-IV and DSM-V is being extended relative to the intervals between earlier editions (from 7 years between DSM-III and DSM-III-R and between DSM-III-R and DSM-IV, to at least 12 years), the information in the text (which was prepared on the basis of literature dating up to 1992) runs the risk of becoming increasingly out-of-pace with the large volume of research published each year. In order to bridge the span between DSM-IV and DSM-V, a revision of the DSM-IV text was undertaken. The goals of this text revision were severalfold: 1) to correct any factual errors that were identified in the DSM-IV text; 2) to review the DSM-IV text to ensure that all of the information is still up-to-date; 3) to make changes to the DSM-IV text to reflect new information available since the DSM-IV literature reviews were completed in 1992; 4) to make improvements that will enhance the educational value of DSM-IV; and 5) to update those ICD-9-CM codes that were changed since the DSM-IV 1996 Coding Update. As with the original DSM-IV, all changes proposed for the text had to be supported by empirical data. Furthermore, all proposed changes were limited to the text sections (e.g., Associated Features and Disorders, Prevalence). No substantive changes in the criteria sets were considered, nor were any proposals entertained for new disorders, new subtypes, or changes in the status of the DSM-IV appendix categories.

The text revision process began in 1997 with the appointment of DSM-IV Text Revision Work Groups, corresponding to the original DSM-IV Work Group structure.

The chairs of the original DSM-IV Work Groups were consulted first regarding the composition of these Text Revision Work Groups. Each Text Revision Work G was given primary responsibility for updating a section of the DSM-IV text. Th tailed reviewing the text carefully to identify errors or omissions and then conducting a systematic, comprehensive literature review that focused on relevant material that has been published since 1992. Text Revision Work Group members then drafted proposed changes, which were accompanied by written justifications for the changes along with relevant references. During a series of conference calls, the proposed changes, justifications, and references were presented by a Text Revision Work Group member to other members of the Text Revision Work Group, who provided input regarding whether the changes were justified on the basis of the supporting documentation. Once drafts of the proposed changes were finalized by the Text Revision Work Groups, the changes were more widely disseminated to a group of section-specific advisers (consisting of the original DSM-IV Work Group members supplemented by additional consultants) for further comment and review. These advisers were also given the opportunity to suggest additional changes if they could provide sufficient convincing evidence justifying inclusion in the text. After consideration of the adviser comments, final drafts of proposed changes were produced and submitted for final review and approval by the American Psychiatric Association's Committee on Psychiatric Diagnosis and Assessment.

Most of the proposed literature-based changes were in the Associated Features and Disorders (which includes Associated Laboratory Findings); Specific Culture, Age, and Gender Features; Prevalence; Course; and Familial Pattern sections of the text. For a number of disorders, the Differential Diagnosis section also was expanded to provide more comprehensive differentials. Appendix D (see p. 829) provi n overview of the changes included in this text revision.

Definition of *Mental Disorder*

Although this volume is titled the *Diagnostic and Statistical Manual of Mental Disorders*, the term *mental disorder* unfortunately implies a distinction between "mental" disorders and "physical" disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much "physical" in "mental" disorders and much "mental" in "physical" disorders. The problem raised by the term "mental" disorders has been much clearer than its solution, and, unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate substitute.

Moreover, although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of "mental disorder." The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. All medical conditions are defined on various levels of abstraction—for example, structural pathology (e.g., ulcerative colitis), symptom presentation (e.g., migraine), deviance from a physiological norm (e.g., hypertension), and etiology (e.g., pneumococcal pneumonia). Mental disorders have also been defined by a variety of concepts (e.g., distress, dysfunction, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndromal pattern, etiology, and statistical deviation). Each

is a useful indicator for a mental disorder, but none is equivalent to the concept, and different situations call for different definitions.

Despite these caveats, the definition of *mental disorder* that was included in DSM-III and DSM-III-R is presented here because it is as useful as any other available definition and has helped to guide decisions regarding which conditions on the boundary between normality and pathology should be included in DSM-IV. In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.

A common misconception is that a classification of mental disorders classifies people, when actually what are being classified are disorders that people have. For this reason, the text of DSM-IV (as did the text of DSM-III-R) avoids the use of such expressions as "a schizophrenic" or "an alcoholic" and instead uses the more accurate, but admittedly more cumbersome, "an individual with Schizophrenia" or "an individual with Alcohol Dependence."

Issues in the Use of DSM-IV

Limitations of the Categorical Approach

DSM-IV is a categorical classification that divides mental disorders into types based on criteria sets with defining features. This naming of categories is the traditional method of organizing and transmitting information in everyday life and has been the fundamental approach used in all systems of medical diagnosis. A categorical approach to classification works best when all members of a diagnostic class are homogeneous, when there are clear boundaries between classes, and when the different classes are mutually exclusive. Nonetheless, the limitations of the categorical classification system must be recognized.

In DSM-IV, there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder. There is also no assumption that all individuals described as having the same mental disorder are alike in all important ways. The clinician using DSM-IV should therefore consider that individuals sharing a diagnosis are likely to be heterogeneous even in regard to the defining features of the diagnosis and that boundary cases will be difficult to diagnose in any but a probabilistic fashion. This outlook allows greater flexibility in the use of the system, encourages more specific attention to boundary cases, and emphasizes the need to capture additional

clinical information that goes beyond diagnosis. In recognition of the heterogeneity of clinical presentations, DSM-IV often includes polythetic criteria sets, in which individual need only present with a subset of items from a longer list (e.g., the diagnosis of Borderline Personality Disorder requires only five out of nine items).

It was suggested that the DSM-IV Classification be organized following a dimensional model rather than the categorical model used in DSM-III-R. A dimensional system classifies clinical presentations based on quantification of attributes rather than the assignment to categories and works best in describing phenomena that are distributed continuously and that do not have clear boundaries. Although dimensional systems increase reliability and communicate more clinical information (because they report clinical attributes that might be subthreshold in a categorical system), they also have serious limitations and thus far have been less useful than categorical systems in clinical practice and in stimulating research. Numerical dimensional descriptions are much less familiar and vivid than are the categorical names for mental disorders. Moreover, there is as yet no agreement on the choice of the optimal dimensions to be used for classification purposes. Nonetheless, it is possible that the increasing research on, and familiarity with, dimensional systems may eventually result in their greater acceptance both as a method of conveying clinical information and as a research tool.

Use of Clinical Judgment

DSM-IV is a classification of mental disorders that was developed for use in clinical, educational, and research settings. The diagnostic categories, criteria, and textual descriptions are meant to be employed by individuals with appropriate clinical train and experience in diagnosis. It is important that DSM-IV not be applied mechani by untrained individuals. The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion. For example, the exercise of clinical judgment may justify giving a certain diagnosis to an individual even though the clinical presentation falls just short of meeting the full criteria for the diagnosis as long as the symptoms that are present are persistent and severe. On the other hand, lack of familiarity with DSM-IV or excessively flexible and idiosyncratic application of DSM-IV criteria or conventions substantially reduces its utility as a common language for communication.

In addition to the need for clinical training and judgment, the method of data collection is also important. The valid application of the diagnostic criteria included in this manual necessitates an evaluation that directly accesses the information contained in the criteria sets (e.g., whether a syndrome has persisted for a minimum period of time). Assessments that rely solely on psychological testing not covering the criteria content (e.g., projective testing) cannot be validly used as the primary source of diagnostic information.

Use of DSM-IV in Forensic Settings

When the DSM-IV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be mis-

used or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a "mental disorder," "mental disability," "mental disease," or "mental defect." In determining whether an individual meets a specified legal standard (e.g., for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis. This might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability.

Nonclinical decision makers should also be cautioned that a diagnosis does not carry any necessary implications regarding the causes of the individual's mental disorder or its associated impairments. Inclusion of a disorder in the Classification (as in medicine generally) does not require that there be knowledge about its etiology. Moreover, the fact that an individual's presentation meets the criteria for a DSM-IV diagnosis does not carry any necessary implication regarding the individual's degree of control over the behaviors that may be associated with the disorder. Even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time.

It must be noted that DSM-IV reflects a consensus about the classification and diagnosis of mental disorders derived at the time of its initial publication. New knowledge generated by research or clinical experience will undoubtedly lead to an increased understanding of the disorders included in DSM-IV, to the identification of new disorders, and to the removal of some disorders in future classifications. The text and criteria sets included in DSM-IV will require reconsideration in light of evolving new information.

The use of DSM-IV in forensic settings should be informed by an awareness of the risks and limitations discussed above. When used appropriately, diagnoses and diagnostic information can assist decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination. By providing a compendium based on a review of the pertinent clinical and research literature, DSM-IV may facilitate the legal decision makers' understanding of the relevant characteristics of mental disorders. The literature related to diagnoses also serves as a check on ungrounded speculation about mental disorders and about the functioning of a particular individual. Finally, diagnostic information regarding longitudinal course may improve decision making when the legal issue concerns an individual's mental functioning at a past or future point in time.

Ethnic and Cultural Considerations

Special efforts have been made in the preparation of DSM-IV to incorporate an awareness that the manual is used in culturally diverse populations in the United States and

clinical information that goes beyond diagnosis. In recognition of the heterogeneity of clinical presentations, DSM-IV often includes polythetic criteria sets, in whi individual need only present with a subset of items from a longer list (e.g., the nosis of Borderline Personality Disorder requires only five out of nine items).

It was suggested that the DSM-IV Classification be organized following a dimensional model rather than the categorical model used in DSM-III-R. A dimensional system classifies clinical presentations based on quantification of attributes rather than the assignment to categories and works best in describing phenomena that are distributed continuously and that do not have clear boundaries. Although dimensional systems increase reliability and communicate more clinical information (because they report clinical attributes that might be subthreshold in a categorical system), they also have serious limitations and thus far have been less useful than categorical systems in clinical practice and in stimulating research. Numerical dimensional descriptions are much less familiar and vivid than are the categorical names for mental disorders. Moreover, there is as yet no agreement on the choice of the optimal dimensions to be used for classification purposes. Nonetheless, it is possible that the increasing research on, and familiarity with, dimensional systems may eventually result in their greater acceptance both as a method of conveying clinical information and as a research tool.

Use of Clinical Judgment

DSM-IV is a classification of mental disorders that was developed for use in clinical, educational, and research settings. The diagnostic categories, criteria, and textual descriptions are meant to be employed by individuals with appropriate clinical tr[illegible]ng and experience in diagnosis. It is important that DSM-IV not be applied mech[illegible]y by untrained individuals. The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion. For example, the exercise of clinical judgment may justify giving a certain diagnosis to an individual even though the clinical presentation falls just short of meeting the full criteria for the diagnosis as long as the symptoms that are present are persistent and severe. On the other hand, lack of familiarity with DSM-IV or excessively flexible and idiosyncratic application of DSM-IV criteria or conventions substantially reduces its utility as a common language for communication.

In addition to the need for clinical training and judgment, the method of data collection is also important. The valid application of the diagnostic criteria included in this manual necessitates an evaluation that directly accesses the information contained in the criteria sets (e.g., whether a syndrome has persisted for a minimum period of time). Assessments that rely solely on psychological testing not covering the criteria content (e.g., projective testing) cannot be validly used as the primary source of diagnostic information.

Use of DSM-IV in Forensic Settings

When the DSM-IV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be mis-

able additional information about the person being evaluated beyond that required to make a DSM-IV diagnosis.

Distinction Between *Mental Disorder* and *General Medical Condition*

The terms *mental disorder* and *general medical condition* are used throughout this manual. The term *mental disorder* is explained above. The term *general medical condition* is used merely as a convenient shorthand to refer to conditions and disorders that are listed outside the "Mental and Behavioural Disorders" chapter of ICD. It should be recognized that these are merely terms of convenience and should not be taken to imply that there is any fundamental distinction between mental disorders and general medical conditions, that mental disorders are unrelated to physical or biological factors or processes, or that general medical conditions are unrelated to behavioral or psychosocial factors or processes.

Organization of the Manual

The manual begins with instructions concerning the use of the manual (p. 1), followed by the DSM-IV-TR Classification (pp. 13–26), which provides a systematic listing of the official codes and categories. Next is a description of the DSM-IV Multiaxial System for assessment (pp. 27–37). This is followed by the diagnostic criteria for each of the DSM-IV disorders accompanied by descriptive text (pp. 39–743). Finally, DSM-IV includes 11 appendixes.

Cautionary Statement

The specified diagnostic criteria for each mental disorder are offered as guidelines for making diagnoses, because it has been demonstrated that the use of such criteria enhances agreement among clinicians and investigators. The proper use of these criteria requires specialized clinical training that provides both a body of knowledge and clinical skills.

These diagnostic criteria and the DSM-IV Classification of mental disorders reflect a consensus of current formulations of evolving knowledge in our field. They do not encompass, however, all the conditions for which people may be treated or that may be appropriate topics for research efforts.

The purpose of DSM-IV is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders. It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category such as Pathological Gambling or Pedophilia does not imply that the condition meets legal or other non-medical criteria for what constitutes mental disease, mental disorder, or mental disability. The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency.