Neurosis, Psychodynamics, and *DSM-III*

A History of the Controversy

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• **The adoption of *DSM-III* by the American Psychiatric Association has been viewed as representing a major advance for psychiatry and as an indication of the emergence of a broad professional consensus on diagnostic issues. The process of drafting the new manual was not, however, free of conflict. This article presents a narrative account of the controversies over the role of psychodynamic formulations in *DSM-III* and the more focused, though sharply contested, symbolic dispute over the inclusion of *neurosis* in the nomenclature. It traces the evolution of these disputes and focuses on the interplay of scientific and political considerations as psychiatrists committed to differing professional and therapeutic paradigms confronted each other for more than two years as the profession sought to develop a new manual that would improve the level of reliability of psychiatric diagnosis.**

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The adoption of *DSM-III* by the American Psychiatric Association (APA) has been viewed as marking a signal achievement for psychiatry. Not only did the new diagnostic manual represent an advance toward the fulfillment of the scientific aspirations of the profession, but it indicated an emergent professional consensus over procedures that would eliminate the disarray that has characterized psychiatric diagnosis. The achievement seemed all the more remarkable given the presence within the profession of a diversity of therapeutic tendencies, theoretical orientations, and even epistemological perspectives regarding the nature of valid clinical data.

The preparation of *DSM-III* between 1974 and 1979 was not, however, free of conflict. In most instances, the disputes that surfaced over diagnostic criteria and classifications were relatively circumscribed, involving small groups of subspecialists who were often able to quickly resolve their disagreements through appeals to available empirical studies bearing on the disputed matters. Of a different sort, however, were the controversies over the role of psychodynamic formulations in *DSM-III* and the more focused, although sharply contested, symbolic dispute over the inclusion of *neurosis* in the nomenclature. They emerged early during the drafting of *DSM-III* and persisted until the last stages of the process. They engaged the intelligence, energy, passion, advocacy, and negotiating skills of those concerned with the direction and future of psychiatry as a whole.

This broad struggle reflected a deep and important division within American psychiatry. On the one side were those committed to the position that the profession's advance required a classification system that was atheoretical with regard to what they believed were unproved etiological assumptions, and who therefore pressed for a criteria-based classification that would be reliable and could provide the basis for testable hypotheses. Opposing them were those who argued that decades of experience with the clinically complex issues involved in psychotherapeutic work with patients had established the validity of the psychodynamic perspective. Psychoanalysts who had, until recently, provided the dominant professional scientific paradigm of psychiatry were confronted by those who challenged the scientific value and clinical utility of their etiologically rooted approach to diagnosis.

In the course of the dispute, issues of epistemological importance were given salience, forcing a confrontation over the appropriate methods for making clinical inferences and judgments and for subjecting such data to verification. The importance of maintaining the linguistic conventions of the profession also emerged as a critical matter. Because the controversy centered on what would and would not appear in a text, much of the encounter took on a terminological form and was concerned with what might appear to be an almost farcical attention to words. However, the form of the clash should not obscure its ultimate importance. It was, at base, a struggle over both the image and intellectual commitments of a profession seeking to fashion a paradigm for its discourse and work, a struggle over the relative status and authority of those working within distinct traditions. Thus, even though the new diagnostic manual was not conceived as an official textbook of psychiatry that would address definitively the broad etiological and

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therapeutic issues facing the profession, the preparation of *DSM-III* placed into relief issues far beyond the more circumscribed matters directly related to the development of a classificatory scheme.

Because competing perspectives on the scientific requirements for advancing the practice of psychiatric diagnosis were involved and because important intraprofessional interests were at stake, traditional scientific forms of communication yielded to a process of political encounter. Persuasion through the use of evidence was intermingled with negotiation, dispassionate exchange often gave way to the rhetoric of confrontation, and appeals to reason were often overshadowed by appeals for votes and power. This article presents a narrative account of the conflict that arose from the theoretical dispute over psychodynamics and use of the term *neurosis* in *DSM-III*.

The role of Robert Spitzer as both a central figure in this controversy and as a second author of this article requires some comment. Initially, the first author intended to prepare this monograph on his own, relying on Spitzer as a key informant and critic. But because so much of the material was derived from the latter's records and because so much of the detail of the narrative was derived from his own oral history, it was decided that only a coauthorship would make public the special nature of his contribution and would make clear his responsibility for the information provided. Thus, although warned that Spitzer's name on this report would generate a controversy of its own, we believed that candor demanded its presence. Any other approach would have denied readers an opportunity to judge this narrative fairly. In presenting this account, we hope to have opened the way for others to study an important aspect of the recent history of psychiatry and the process through which that history was made.

To achieve accuracy in this presentation, we subjected personal recollections to critical evaluation and correction through the analysis of archival material. The records, memoranda, and letters of the members of the APA Task Force on Nomenclature (responsible for drafting *DSM-III*) were reviewed. So, too, were the minutes of the various decision-making bodies of the APA, including the Assembly of District Branches and board of trustees. Unfortunately, only limited cooperation on the part of the American Psychoanalytic Association and the Baltimore-District of Columbia Society for Psychoanalysis made an examination of all relevant archival material from these sources impossible. Interviews with many of the major participants in this dispute and an examination, when made available, of their private correspondence provided additional sources of data. These interviews were especially important in gaining information regarding the efforts of those who viewed the Task Force position as posing a threat to their theoretical commitments. Among those who were interviewed were the following: Howard Berk, Robert Campbell, Paul Fink, Allen Frances, John Frosch, William Frosch, Leo Madow, William Offenkrantz, Roger Peele, Lawrence Rockland, Melvin Sabshin, John Talbott, Janet Williams, and Miltiades Zaphiropoulos.

A draft of this report was sent to each major participant in the controversy, asking for corrections of detail and for judgments about the fairness of our analysis. Each response was carefully considered in the final revisions of this article. Despite these efforts, we acknowledge that this is only one version of the controversy over psychodynamics and use of the term *neurosis* in *DSM-III*.[1] Like all narratives, it required selection among the universe of raw data, and hence may reflect the authors' biases. The files on which we depended are available for inspection and should provide a source of evidence for researchers seeking to prepare alternate interpretations or further in-depth analyses.

DSM-III AND THE PSYCHODYNAMIC PERSPECTIVE

In 1974, the board of trustees of the APA adopted a resolution calling for a revision of *DSM-II*. Because Robert Spitzer had assisted in the development of *DSM-II*, was engaged in diagnostic research, had urged an early start of the drafting of the new manual, and had achieved national prominence in the debate over the status of homosexuality in *DSM-II*, he was chosen to head the task force charged with preparing *DSM-III*.

Given the opportunity to bring together those he believed most expert on nosological issues, Spitzer, a researcher at the New York State Psychiatric Institute with training in psychoanalysis, selected a group of psychiatrists and consultant psychologists committed primarily to diagnostic research and not to clinical practice. With its intellectual roots in St Louis instead of Vienna, and with its intellectual inspiration derived from Kraepelin, not Freud,[2] the task force was viewed from the outset as unsympathetic to the interests of those whose theory and practice derived from the psychoanalytic tradition.

Committed to the rigorous application of the principles of testability and scientific verification, the task force set as its goal the development of an empirically based manual that would raise the low level of reliability of psychiatric diagnosis[3] through the use of explicit and carefully defined criteria. The *DSM-II* and other classifications were severely flawed by their failure to provide formal criteria for determining the boundaries of their diagnoses.[4] In the absence of such criteria, clinicians had been forced to rely on more global descriptions of disorders that frequently entailed etiological assumptions.

The task force believed that the large body of etiological evidence put forth by those committed to a psychodynamic perspective could not serve as the basis for defining the diagnostic classes in *DSM-III*. Baldly asserting that psychiatry simply did not yet know with certainty the causes of many of the maladies it attempted to treat and study, the task force determined that when neither etiology nor underlying process was known, "classification should be based on shared phenomenological characteristics."[5] Such an approach, it was asserted, would allow clinicians and researchers with different theoretical perspectives on the etiology of mental disorders to use the same diagnostic system reliably. With this outlook and a commitment to descriptive research, the task force was destined to create a diagnostic manual that would mark a radical departure for American psychiatry. For those who had come to believe that psychodynamic tradition provided the foundation for contemporary psychiatry, this departure was to represent a disturbing challenge.

The most striking consequence of this perspective was the early decision by the task force to eliminate *neurosis* as a diagnostic class. Indeed, despite its venerable history, its role in *DSM-II*, and its importance in the contemporary psychiatric discourse of those committed to, as well as those who rejected, the psychodynamic orientation, the inclusion of *neurosis* was never seriously considered. When a draft of the new *DSM-III* nomenclature appeared in the spring of 1976, the accompanying progress report simply stated that the traditional neurotic subtypes had been distributed under other rubrics. "There is no group of conditions which together comprise the 'neuroses.'"[6]

For the task force, and most of American psychiatry, *neurosis* was an etiological rather than a descriptive concept. It assumed, as *DSM-II* noted, an underlying process of intrapsychic conflict resulting in symptom formation that served unconsciously to control anxiety.[7] However, there was no empirical basis for assuming the universal presence of such conflict in those disorders that had traditionally been termed *neurotic*. There was, for example, no justification for asserting that intrapsychic conflict was always present in what had been denominated "neurotic depression."[8] Furthermore, since intrapsychic conflict was present in both those with and those without psychiatric disorders, it could not possibly serve as the basis for discrete class formation, the very purpose of a diagnostic manual.[9] Finally, the task force held that the term *neurosis* has lost even its earlier specificity as contemporary psychoanalytic theory had shifted its focus of interest from the "symptom neuroses" to the "character neuroses (personality disorders)."

Opposition to the new nomenclature, the theoretical approach of the task force, and the implications of both for those schooled in the psychodynamic tradition, was slow to take form. When it did, it stressed both procedural and substantive issues. Critics found it disconcerting that a task force, seemingly so remote from the world of clinical psychiatry, was in a position to refashion the language and conceptual framework of the profession. They found it troubling that what they believed to be the idiosyncratic commitments of the task force had led it to seek a radical revision of psychiatry's official diagnostic manual.

Among the early and vocal antagonists of the first *DSM-III* drafts and of the task force was Howard Berk, a practitioner in Queens, NY. In January 1976, he spoke out against what he perceived as a dangerous course.

> There is reason to claim that language, including the nomenclatures in various arts and sciences, is the framework of and guide to thinking of the users of that language, that a mature language provides treasures of logic, knowledge and wisdom to the user. Living languages do change . . . . However, change can be destructive, as is vulgarization and wide and peremptory extirpation of large parts of the living language of a people, of a science, of an art . . . . It is not reactionary or regressive to protect one's thinking and language against loosely conceived and untried changes.[11]

Berk's "antagonism toward those who would deprive psychiatry of *neurosis*, thus rendering obsolete "psychiatric textbooks and literature on a massive scale," was further provoked by what he took to be their arrogance and utter disdain for those who were troubled by the implications of these changes.

In January 1976, Spitzer learned also that John Schimel planned to publish an editorial in the *Journal of the American Academy of Psychoanalysis* that would attack *DSM-III* as a "Retreat From a Psychiatry of People."[12] The *DSM-II* "was a trial," but *DSM-III* would "prove to be even more of a handicap to intensive therapy of patients." Unlike many practitioners who were to oppose *DSM-III* because of the deletion of *neurosis*, Schimel was distressed by what he took to be the proposed rejection of the unconscious and of psychodynamics. Underscoring what he viewed as the epistemological threat of *DSM-III*, he charged that the only reality recognized by the new manual was that which was "scientific, behaviorist and measurable." Only concerted moves by those opposed to this trend could "maintain psychiatry as a humane, open, and socially progressive force."[13]

Ultimately, concern about *DSM-III* was reflected in the APA Assembly of District Branches. A proposal of the Pennsylvania Psychiatric Society, "that the assembly, as the most representative body of American psychiatry, have an input in *DSM-III*," quickly gained the support of the psychiatric societies constituting area 3 of the association (Delaware, Maryland, New Jersey, Pennsylvania, and Washington, DC).[14] At the May 1976 annual meeting of the APA, that proposal, with the endorsement of Robert Spitzer, was passed by the assembly, and a liaison committee was established.[15] Because he had moved to the fore as an early commentator on *DSM-III*, Howard Berk was selected as chair of that committee.

With this new platform, Berk sought to mobilize pressure against the manual. In one sharply worded attack, addressed to all who had attended the St Louis Conference to Critically Examine *DSM-III* at Mid-Stream in June 1976, he reiterated his earlier opposition to the proposed change in terminology.[16] "The proposed nomenclature displays a generous measure of linguistic and conceptual sterility. *DSM-III* gets rid of the castles of neurosis and replaces it with a diagnostic Levittown." The task force had embarked on its course because of its "narrow, strictured, one-sided approach." Psychiatry would suffer if a "rigid exclusionism were allowed to paralyze the creative and intuitive activity of that large part of psychiatry that lies outside the conceptual pale of the task force."

Remarkably, despite the existence of such dissatisfaction, neither the American Psychoanalytic Association nor the American Academy of Psychoanalysis moved to create institutional mechanisms for the expression of concern about *DSM-III* until the latter part of 1976. And then the establishment of special committees to provide a formal psychoanalytic contribution to *DSM-III* came at the behest of the task force itself.

As the American Psychoanalytic Association's committee, under the leadership of Leo Madow, began to review *DSM-III*, what concerned it most was not the absence of *neurosis* as a diagnostic class. Indeed, Spitzer was told by Madow and his colleagues that they recognized that the use of *neurosis* in *DSM-II* bore little relationship to the contemporary psychoanalytic understanding of the concept. Furthermore, the *DSM-III* classifications, "bad as they were," were not the primary issues. The source of concern was rather the "superficial" descriptive material accompanying most of the categories.[17] The task force claimed that its posture was "atheoretical." Madow's group saw it as antianalytic, since it brought into question the central etiological assumptions of the psychoanalytic perspective. Underscoring the epistemological dimension of the controversy, Madow asserted, "The general impression was that only those items were included [in the descriptions of the disorders] that could be proven statistically, which was—we felt—in a not so subtle way, an antianalytic stance."[18]

When Madow presented his first report to the executive council of the American Psychoanalytic Association at the end of April 1977, he urged its leadership to underwrite the cost of hiring an analyst to recast the material in *DSM-III* based on a contemporary psychoanalytic perspective. Only such an effort would meet Spitzer's challenge that those who objected to the task force descriptions should attempt to provide better ones.

In the discussion that followed this report,[19] some members of the executive council asserted that Spitzer could be reasoned with if efforts were made to present relevant scientific arguments. Others, however, were less sanguine. Spitzer was characterized as having "a huge amount of power with very little limit-setting." Otto Kernberg por-

trayed a critical situation for psychoanalysis. Describing his participation in the St Louis conference, he recalled a sense of "helplessness." Spitzer, despite his apparent flexibility, had "extremely strong negative feelings about psychoanalysis," and, Kernberg asserted, had surrounded himself with associates who were even more hostile to psychoanalysis. Although it was possible to dismiss the entire effort as "a joke," such a course would be irresponsible. The *DSM-III* text was a disaster. "It is a straitjacket and a powerful weapon in the hands of people whose ideas are very clear, very publicly known, and the guns are pointed at us." Believing that the Assembly of District Branches could stop *DSM-III*, others urged a major protest. Howard Berk, who was under attack within the assembly, had to be supported. "This is a power issue," said one council member.

The executive council sidestepped Madow's request for funds to rewrite sections of *DSM-III*. However, it did place the American Psychoanalytic Association on record as seeking an increased analytic contribution to the new manual, as well as a slowing of the pace at which it was being pressed toward final approval.

The organization of psychoanalytic pressure against *DSM-III* was not limited however, to the activity of either the American Psychoanalytic Association or the Academy of Psychoanalysis. Indeed, their more cautious efforts were surpassed by those of analysts affiliated with local institutes and societies. Most important in this respect was the work of the Baltimore-District of Columbia Society for Psychoanalysis. At the request of Roger Peele, assistant superintendent of St Elizabeth's Hospital and representative of the Washington Psychiatric Society to the assembly, the Baltimore-DC group established a committee to evaluate *DSM-III*.[20] Its critical evaluation and its influence on the Washington Psychiatric Society were to prove vitally important during the last phase of struggle over *DSM-III* in 1979.

Concerned about the impact of psychoanalytic disaffection and about repeated criticisms of the ideologically narrow composition of the task force, Spitzer moved, in mid-1977, to broaden the membership of his committee.[21] He added two analysts to the task force—John Frosch and William Frosch. John Frosch, a senior figure, with an interest in the epistemological and conceptual problems of diagnosis, was a perfect choice from Spitzer's perspective. Although committed to psychoanalysis, he had made clear his belief that psychiatry had suffered in the past from its failure to distinguish between etiological, dynamic, and descriptive levels of analysis.[22] William Frosch, his nephew, had already demonstrated his capacity to work within the Task Force perspective by contributing to its work on substance abuse disorders. Sympathetic to what he believed were the needs of the research community, he accepted the descriptive, criteria-based approach to diagnosis.[23]

Having assumed the responsibility for representing a psychoanalytic perspective within the task force, the Frosches were in an unenviable position. Those who saw *DSM-III* as radically flawed could view their roles only with suspicion. Although John Frosch had repeatedly made clear his commitment to the psychoanalytic viewpoint, both he and William were viewed as unwittingly facilitating Spitzer's antipsychoanalytic moves. Within the task force itself, their heterodoxy was not always a welcome addition. And they themselves believed that, at times, their suggestions met with an unreasonable animus.[23,24]

Despite these circumstances, quite early in his tenure, John Frosch did attempt to reverse the task force decision that had aroused the ire of many dynamically oriented psychiatrists. He urged Spitzer to reconsider the decision to delete *neurosis*.[25] Although unhappy about the decision to eschew all etiological and dynamic considerations in *DSM-III*, he believed that even an exclusively descriptive manual could make use of the term. He therefore requested that an effort be made to define descriptive "frames of reference" for neurosis before abandoning the term. Although nothing came of this proposal, a more fully developed argument for the descriptive use of the concept made a successful reappearance 1½ years later.

Frosch's suggestion went no further, in part because the question of neurosis was not the primary issue for those actively seeking to change *DSM-III*. Although the Louisiana Psychiatric Society issued a call to "support neurosis,"[26] and although individual critics continued to underscore the clinical and symbolic importance of the deletion of the term,[27] others minimized its importance. Indeed, in the fall of 1977, Miltiades Zaphiropoulos of the American Academy of Psychoanalysis Committee on DSM-III applauded its removal.[28] The term *neurosis* "has become a bad habit with more pretend than actual communicative value." Zaphiropoulos went even further, virtually conceding on the broader issue of psychodynamics in *DSM-III*. "Generally speaking, it has become evident, once again, that all of psychiatry is not psychoanalysis and that all psychoanalysis is not one and the same thing. As psychoanalytic practitioners, we can probably learn to live with *DSM-III*."[28]

Others were not so ready to yield. Madow's committee continued to press its case by seeking the inclusion of psychodynamic data in the descriptions of the disorders. Central to that effort was the submission to the Task Force of a psychoanalytically informed revision of the *DSM-III* text on the anxiety disorders. Despite the importance with which it viewed this task, the committee did not turn to an analyst of national prominence. Rather it was Lawrence Rockland, a member of Madow's group, who prepared the new material that included changes in the descriptions of the disorders as well as psychodynamically based etiological formulations. Only the inclusion of such material, Rockland argued, would permit *DSM-III* to serve adequately and responsibly its function as the "minitextbook of psychiatry" it was bound to become.[29]

The response to these revisions provides clear evidence of how differently each side viewed the conceptual demands of diagnosis. The task force accepted some of Rockland's descriptive changes, but found without merit his dynamic and etiological recommendations, eg, that obsessive compulsive disorder represented a "regression to anal conflicts." These proposals were characterized as "simplistic and parochial," as derived from a "set of inferences that have been documented only by anecdotal material."[30] Even John Frosch was not enthusiastic. More important, he used this occasion to warn against the political pressures he sensed to be at play. Believing that diagnostic matters ought to be settled scientifically, he urged resistance to gestures designed to "propitiate . . . the American Psychoanalytic Association or any other group."[31]

Having rebuffed this major effort by Madow's committee, Spitzer attempted to find some mechanism for accommodating the concerns of his psychoanalytic opponents. One suggestion would have included a recognition of competing etiological formulations in the descriptions of each disorder.[32] On another occasion, adopting a suggestion of William Frosch, he proposed a special axis for coping mechanisms. In each instance his efforts at what he termed "diplomatic

nosology" were held in check by members of the task force less given to negotiated settlements in diagnostic matters.

One effort at meeting the objections of critics who believed that *DSM-III* would serve as a stilted minitextbook of psychiatry did go beyond the preliminary stage. Repeatedly, psychodynamic opponents of *DSM-III* had charged that its proposed diagnoses could not meet the needs of those who required a fuller picture in planning clinical interventions, since "psychiatric diagnoses made only on the basis of signs and symptoms, without a positive psychodynamically informed, coherent understanding of why the patient has developed the symptom at this time is second-rate diagnosis."[33]

Spitzer's new proposal, christened "Project Flower" after the apparently latitudinarian Maoist aphorism "Let a thousand flowers bloom, let a hundred schools of thought contend," suggested the publication of a companion volume to *DSM-III*.[34] Proponents of the major therapeutic orientations would prepare chapters noting the ways in which *DSM-III* might be used in treatment planning, indicating which data, in addition to the formal diagnosis, might be necessary for clinical intervention. Although ostensibly designed to meet the needs of groups as diverse as the Association for the Advancement of Behavior Therapy, the Society for Biological Psychiatry, the American Psychoanalytic Association, and the American Academy of Psychoanalysis, its primary purpose was to bring to closure the dispute over the inclusion of psychodynamics in *DSM-III*.

Without compromising the atheoretical orientation of *DSM-III*, Project Flower would permit "the recognition by the APA of these various viewpoints, not the endorsement of any of them."[34] For some critics, this was an intelligent, if not completely satisfactory, solution to what appeared an insoluble conflict. For others, it was simply one more clever device to mask the crucial fact that *DSM-III* rejected the centrality of psychodynamics. "It is unreasonable . . . to treat equally the carefully reproduced work of thousands of psychoanalysts and psychodynamic clinicians and the relatively recent learning theorists or esoteric fantasies about the etiology of psychopathology."[33]

In an effort to diffuse the sometimes acrimonious controversy between the task force and its psychoanalytic opponents, Lester Grinspoon, chair of the APA Council on Research and Development, to which Spitzer's group was accountable, convened a special meeting on Sept 8, 1978. At that session, neither side gave ground as well-worn arguments were reiterated.[35] During the meeting, Spitzer and his supporters defended their work and argued that a sample survey of those engaged in the *DSM-III* field trials indicated that even among those who identified themselves as psychodynamically oriented, the new approach to diagnosis had met with widespread approval. Those who challenged the task force focused on the inadequacy of a diagnostic system that ignored psychodynamics, and on the limitations of observational techniques that did not employ the interpretative skills of dynamically informed clinicians. The issue of neurosis was barely mentioned.

Any hopes that this special meeting could smooth the disagreements proved groundless. A deep divide existed, and neither face-to-face encounters nor verbal formulations seemed likely to bridge it.

While intraprofessional energies were focused on the role of psychodynamics in *DSM-III*, the media seized on the deletion of *neurosis*. Their accounts invariably portrayed psychiatric deliberations as peculiar, almost irresponsible. "Farewell to Neuroses: Mental Health Dictionary Drops Name," wrote the *Detroit Free Press*. In the *Boston Globe*,[36] the tale was recounted in an ironic story entitled "Putting an End to Neurosis." Even the medical press could not resist the opportunity to make psychiatrists seem a bit silly. "No More Neuroses—Psychiatry Has Retired Them," was the headline in *Medical World News*.[37] "Neuroses Banned" was the way in which *Hospital Doctor*[38] told its readers of the events that had come to pass.

But if these events were the occasion of some mirth for those outside the profession, to those who had attempted to modify the course adopted by the Task Force, it appeared that by the end of 1978, little more could be done. John Frosch, discouraged by the contentious stance of some of Spitzer's colleagues, had resigned from the task force. Leo Madow, who viewed his own efforts as having been too little and too late, was ready to end his committee's work.

Disappointment characterized Madow's final report to the American Psychoanalytic Association.[39] His committee had failed to move the Task Force. Neither the Council on Research and Development nor the APA Executive Committee had been sympathetic to psychoanalytic concerns. Efforts to enlist the support of the American Association of the Chairmen of Departments of Psychiatry had also proved fruitless. More important, in his view, was the unwillingness of the American Psychoanalytic Association itself to confront forcefully the challenge of *DSM-III*. Twice, requests for funds to underwrite the preparation of psychoanalytically informed material for the new manual had been rejected. Madow noted, with some dismay, the collaboration of several psychoanalysts in the drafting of descriptive material on the personality disorders. They had been "taken in by a scientism that presents itself as science." Finally, Madow's committee urged the association to reject Project Flower, since collaboration in that effort could only provide a justification for the "neo-Kraepelinian" approach of *DSM-III*, undercutting the need for fundamental change. In the discussion following the submission of this report, the council of the American Psychoanalytic Association adopted a cautious posture. It rejected Madow's oppositional gesture on Project Flower and endorsed the writing of a chapter on psychoanalytic treatment for the proposed volume.[40]

DSM-III AND THE STRUGGLE OVER *NEUROSIS*

With this decision, the most potentially serious challenge to *DSM-III* by psychoanalysts and psychodynamically oriented psychiatrists had apparently ended. Within a month, however, a new locus of opposition surfaced, more focused in its criticism, more dramatic in its posture, and more threatening in its tone. Late in January 1979, only four months before the Assembly of District Branches was scheduled to vote on *DSM-III*, Robert Spitzer received a letter of protest from Boyd Burris, president of the Baltimore-District of Columbia Society for Psychoanalysis.[41] While earlier challenges to Spitzer had expressed a diffuse dissatisfaction with the nondynamic thrust of the descriptions of the various disorders, the Baltimore-DC group seized on the more discreet discontent of those opposed to the loss of *neurosis*. While accepting the need for a descriptive organization of disorders for which etiologies were uncertain, Burris and his group held that this was not the case with the neuroses. Rejecting the task force claims, Burris stated that "the contributions of psychoanalysis to the psychodynamic conceptualization of the neurotic disorders allows specific etiologic considerations to be formulated" for these conditions. And so, the group proposed a revised nomenclature that involved a return to the terminology of *DSM-II*.

Burris made it obvious to Spitzer that his was not simply one more effort by politically timid psychoanalysts. Not only did his group represent 124 members of the APA, but copies of his challenge were being sent to the Maryland and Washington Psychiatric Societies, the representatives of Baltimore and Washington to the Assembly of District Branches, the medical director of the APA, and the president of the American Psychoanalytic Association. Burris knew the importance of mobilizing a broad constituency. He wanted Spitzer to know it, too.

To Spitzer and a number of his colleagues, the surprising revival of the demand to reintroduce *neurosis* could not be explained solely by its theoretical importance for psychoanalysis. They saw more mundane concerns at work, as well. Psychoanalytic practitioners, they believed, feared that a change in psychiatric nomenclature might result in a challenge by third-party reimbursement sources seeking to limit payment to patients receiving long-term therapy. It was no coincidence, in their view, that this new source of opposition arose in Washington, DC, where federal employees received generous coverage for psychotherapeutic treatment.

While Spitzer was attempting to thwart Burris' challenge to the deletion of *neurosis*, new and unexpected sources of dissent emerged. In early March, a number of adherents of the descriptive orientation of *DSM-III* began to argue, as had John Frosch more than a year before, that the elimination of *neurosis* was a mistake. Most important in this regard was the recommendation of Lyman Wynne, himself a member of the task force. Wynne[42] suggested that the neurotic disorders could be defined descriptively by the presence of distressing symptoms that were relatively enduring and that had no effect on reality perception, orientation, or judgment. With this proposal, there was no need to incorporate psychoanalytically derived assumptions about etiology or psychodynamics.

On March 10, 1979, delegates to the area 3 council (Delaware, Maryland, New Jersey, Pennsylvania, and Washington, DC) voted unanimously to oppose the deletion of *neurosis*.[43] Failure to reintroduce the concept would necessitate a vote against the approval of *DSM-III* itself at the spring meeting of the Assembly of District Branches. Two days later, Roger Peele, representative to the assembly from the Washington Psychiatric Society, wrote to Spitzer of a "groundswell of sentiment to preserve [the term] neurosis." Putting forth what was to become known as the "Peele Proposal," he offered his own classification as well as a descriptive justification for "neurotic disorders."[44]

Peele believed that, despite its historical linkage to psychoanalytic theory and practice, the term *neurotic* did not require an assumption of intrapsychic conflict. Incorporating a descriptively defined *neurosis* in the nomenclature would avoid an unnecessary rupture with the past, would be consonant with the terminology of International Classification of Diseases (ninth revision) (ICD-9), and would not require that American psychiatry diverge from the international psychiatric community. Political realism also dictated such a move. Peele warned that failure to accommodate those who opposed the deletion of *neurosis* would result in a major clash in the assembly, might produce a struggle between the assembly and the board of trustees, and could eventuate in a divisive referendum of America's psychiatrists. Committed to both the advances embodied in *DSM-III* and the professional integrity of American psychiatry, Peele urged a pragmatic course on Spitzer.

With Peele pressing for a statesmanlike approach, Spitzer was presented with almost daily evidence of erosion of the anti-*neurosis* position. Psychiatrists in New York who were sympathetic to *DSM-III* informed him that their representatives in the Assembly of District Branches would support the position of area 3. The Washington Psychiatric Society voted to take a similar stance.[20] And Boyd Burris sent a letter to the leadership of the American Psychoanalytic Association, as well as to all affiliated analytic societies, urging them to pressure district branch representatives to join the groundswell depicted by Peele. "The issue," he wrote, "is one of votes."[45]

Spitzer no longer could ignore the existence of a broad coalition of forces committed to the reintroduction of *neurosis*. Nor could he isolate the proponents of such a change, portraying them as the rear guard of American psychiatry. The task, then, as he saw it, was to preserve the structure of the *DSM-III* classification and its descriptive orientation while yielding some ground to those committed to the classification *neurosis*.

On March 27, Spitzer offered such a compromise. Capitalizing on the recently concluded agreement between Egypt and Israel, he termed it a "neurotic peace treaty."[46] There were three elements in this proposal: (1) The introduction to *DSM-III* would spell out, in a fairly extended discussion, the distinction between neurotic disorders, descriptively defined, and the neurotic process, so important in the etiological formulations of dynamic psychiatrists; (2) although no disorder would be denominated neurotic, and although *neurosis* would not serve the function of delimiting a class of disorders, a prefatory note at the head of the classification would state the following: "The neurotic disorders include the following: anxiety disorders of childhood and adolescence; some affective disorders; somatoform and dissociative disorders and some psychosexual dysfunctions"; (3) the *DSM-III* glossary would cross-reference the terms *symptom neurosis* and *neurotic disorders* as well as *character neurosis* and *personality disorders*.

Although Spitzer attempted to convince the task force that his proposed resolution of the impasse over *neurosis* was neither a capitulation to political pressure nor a regression in the face of a threatened referendum, such was not the view of several members of the task force, the most vocal of whom was Donald Klein.[47] He accused Spitzer of usurping the authority of the task force by offering his "peace treaty" without first consulting the rest of the committee. More important, he found the substance of the proposal unacceptable. The very vagueness regarding which of the affective and somatoform disorders were to be considered neurotic was a reflection of a more serious problem: Spitzer had sought to reach a compromise with those attempting to preserve a psychoanalytic influence on the nomenclature. For Klein, "the political pressure to reinstate the term 'neurosis' into *DSM-III* did not come from those who felt that its deletion represented the loss of a useful descriptive term." Rather, "they wish the term reinserted because they wish a covert affirmation of their psychogenic hypotheses. This is all too painfully obvious." Klein held that in avoiding the true meaning of the clash, Spitzer had engaged in an obfuscatory maneuver, one "unworthy of scientists who are attempting to advance our field via classification and reliable definition." It was not for the task force to engage in such political maneuvers, even if the APA might ultimately choose to do so.

The peace treaty did not meet with an enthusiastic response by those whom Spitzer had attempted to win over, and now his authority was challenged by those who constituted his own base of authority. In justifying both his

precipitate effort at negotiation undertaken without the prior approval of the task force and the content of his proposal, he tried to convince the task force that Klein had misread the situation and had failed to appreciate the extraordinary pressure of time and the possibility of a truly serious defeat at the hands of those who had no commitment to the structure of *DSM-III*.[48] "With no alternative [to the Peele proposal], the likely scenario would be an assembly and board of trustees vote to direct the task force to introduce neurotic disorders as a *diagnostic class* into *DSM-III*." Despite his very pessimistic initial assessment of the appeal of Klein's position within the task force, Spitzer was ultimately able to convince a substantial majority of its members of the merits of his approach.

With his political base intact, Spitzer confronted those pressing to reintroduce *neurosis* as a diagnostic class at a meeting held on April 7. The issues at stake were crucial, the specter of a referendum was ever present, exchanges were sometimes barbed.[49] Hector Jaso, who had replaced Howard Berk as chair of the assembly's liaison committee, made it clear to Boyd Burris that his group wanted the neurotic disorders included in the nomenclature without the etiological implications of the psychoanalytic perspective. Although Roger Peele was committed to a descriptive use of the neurotic disorders, his insistence that the term serve a classificatory function put him at odds with Spitzer. Despite the importance of the issues, much of the meeting was taken up with disputes over the placement of words, the use of modifiers, the capitalization of entries. In the context of negotiations among adversaries who were attempting to reach a terminological compromise, each adjustment, each attempt at fine tuning, carried with it symbolic importance to those engaged in a process that was at once political and scientific.

By the end of the day, a compromise emerged that seemed to satisfy many of the participants. Most important was an agreement to move the statement about the scope of the neurotic disorders from the head of the classification into the midst of the nomenclature preceding the affective disorders. Without yielding to the demand that *neurosis* serve a classificatory role, this shift gave the term the appearance of serving a delimiting function.

However, that resolution of the controversy failed utterly to satisfy Burris, or even his more moderate allies in the Washington Psychiatric Society. Indeed, the April 7 compromise served only to sharpen the lines of conflict. Jaso's willingness to support Spitzer disclosed the complicity of those who had been thought to represent America's psychiatrists. In a letter to Jules Masserman, president of the APA, Burris wrote that if the elected representatives and officials of the APA failed to meet this challenge, "The majority of the . . . rank and file [will] exercise its democratic rights to have a diagnostic nomenclature of maximum usefulness. Unfortunately for us all, *DSM-III* in its present version would seem to have all the earmarks for causing an upheaval in American psychiatry which would not soon be put down."[50]

Concerned about the prospect of a battle that could only harm American psychiatry, but capitalizing on the existence of a serious challenge to *DSM-III*, Roger Peele continued to seek modifications that might bring both sides together.[20] In a letter to Burris and his colleagues, he urged "that we build upon the gains of the [April] 7th [meeting] rather than attack [them]."[51] Two elements were central to his new effort at conciliation: (1) Clinicians were to be given the option of indicating that a particular disorder was neurotic, through both a special coding device and a label. Thus, for example, "Generalized Anxiety Disorder, 300.02," could, if the clinician so determined, be listed as "Generalized Anxiety Disorder (Neurotic) 300.02N." (2) In a departure from this more general approach to the neurotic disorders, the proposed *DSM-III* listing "Chronic Depressive Disorder, 300.12," was to be replaced by "Neurotic Depression, 300.40," the *DSM-II* name and code number.

Peele's proposal, with some slight modifications, became the official position of the Washington Psychiatric Society. On April 25, the society addressed a letter to all representatives and deputy representatives to the Assembly of District Branches urging support for its position at the May 12 session.[52] Emphasizing both the importance of the proposed changes and their circumscribed nature, the appeal stated, "These proposals are being made to increase the acceptability of *DSM-III* in American psychiatry without violating [its] basic structure . . . that has already been carefully and thoughtfully developed."

Despite the appearance of a strong oppositional force, some of those who were actively committed to the reintroduction of *neurosis* were concerned privately about the true strength of their movement. On the surface, it appeared that the Washington Psychiatric Society had been able to weld an impressive coalition, but Roger Peele saw the danger of a last moment breach that would permit the "anti-*neurosis*" forces to triumph. In a letter to Boyd Burris he wrote, "I'm not too concerned at this point with Spitzer's position. He does want a consensus and may go along with much of what we come up with. Our bigger task is getting the many pro-neurosis forces to unite . . . not achieving this is the major reason we are likely to lose."[53]

Spitzer, however, was also worried. Following consultation among several task force members, he introduced a new compromise and negotiating strategy on April 30.[54] *Chronic depressive disorder* was to be rechristened *dysthymic disorder*, drawing on an obsolete term for chronic mild despondency. Through the minor adjustment of reintroducing the code number 300.40, those who so desired could use the term *neurotic depression* by opting for the term employed in the clinical modification of ICD-9. Furthermore, although unhappy about the prospect, Spitzer accepted the inclusion of *neurotic depression* in parentheses after *dysthymic disorder*. Finally, the new compromise even acquiesced to the Washington Psychiatric Society's recommendation of the "N" coding of disorders that clinicians believed to be neurotic. With the backing of his task force, Spitzer offered these compromises to assembly delegates as well as to the board of trustees of the APA.

It was not, however, simply the threat being led by the Washington Psychiatric Society that convinced the task force to compromise at the end of April. Equally important was the realization that considerable opposition to *DSM-III* existed within the board of trustees.[55] At its meeting on April 21 and 22, the board had come close to a vote of no confidence in *DSM-III*, its dissatisfaction held in check by the bureaucratic momentum behind the new manual. Strikingly, the issue that provided the occasion for this assault was not *neurosis*, but the introduction to *DSM-III*.

In an effort to allay the fears of psychodynamic practitioners, the board of trustees had, in December 1978, requested that Spitzer include special material in the *DSM-III* introduction indicating how the diagnostic manual could be used by those with a dynamic orientation.[56] The Joint American Psychoanalytic Association—American Academy of Psychoanalysis Committee on *DSM-III*, at that time preparing a chapter for Project Flower, had taken the board's December action as an invitation to write textual

material for Spitzer.[57] Encouraged by Melvin Sabshin, the APA's medical director, the committee prepared an extended statement.[58] Spitzer responded that the inclusion of such material within *DSM-III* would be both "extremely embarrassing and extremely divisive. Its inclusion in *DSM-III* could only be viewed as an official endorsement of one school of thought."[59]

By April 1979, it had become clear to William Offenkrantz, chair of the joint psychoanalytic committee, that the task force would use at most a brief paraphrase of his group's text, and so he appealed directly to the board.[58] At its April session, the board listened sympathetically to the Offenkrantz complaint—some members out of theoretical sympathy, some out of weariness with the controversies surrounding the task force's work, some out of a desire to end the divisive threats to the APA.[60] When the depths of dissatisfaction became clear, the board realized that it was confronted with a serious crisis, at once political, institutional, and theoretical. To meet this challenge, a special committee under the leadership of Keith Brodie was appointed. With the assembly scheduled to convene on May 12, the committee had to move swiftly to prevent an embarrassing end to the years of effort at forging a diagnostic manual.

In comments sent to Brodie, a number of board members made clear their profound dissatisfaction with *DSM-III*, some because they were committed to the perspective of the pro-*neurosis* forces,[61] others because of their concern about the politically divisive impact of adopting *DSM-III* without the concept *neurosis*.[62] Included among those expressing serious doubts were Jules Masserman, president of the association.[63] While there was some strong support for Spitzer, most notably from Judd Marmor,[64] with whom he had been in sharp conflict over the concept of ego-dystonic homosexuality,[65] it was clear that a compromise solution was a matter of some urgency.

It was John Talbott, a member of Brodie's committee, who attempted to eliminate the lingering controversy by proposing a modification and an extension of Spitzer's April 30 proposal to include *neurotic depression* in parentheses after "Dysthymic Disorder."[66] Phobic, anxiety, obsessive-compulsive, hysterical, and depersonalization neurosis were to appear in the new nomenclature as parenthetical terms following the appropriate *DSM-III* entries. An explanatory note would indicate that the *neuroses* were being included to facilitate identification with the terms used in *DSM-II*.[67] With this proposal, Brodie was able to elicit from Spitzer approval for a compromise designed to placate an opposition that was still threatening assembly rejection of *DSM-III* and a referendum if that proved necessary.[68] Boyd Burris and his colleagues welcomed the "Talbott Plan" as "taking a bold step towards reaching a compromise in *DSM-III*," although they raised strong objection to the proposed text identifying the *neuroses* solely as *DSM-II* terms.[69]

Despite the enormous activity surrounding the issue of *neurosis* in the period following the April 7 meeting, despite the compromises arrived at, Roger Peele believed that a last-minute failure was still possible. Committed to a *DSM-III* that would be "acceptable" as well as "reliable," he believed that the one remaining barrier was Spitzer's insistence that *dysthymic disorder* be the preferred *DSM-III* term for neurotic depression. Only "neurotic depression (dysthymic disorder)," he held, would preclude failure.

The assembly's liaison committee met on May 10, two days before the assembly was to convene, and upheld by a vote of 10 to 1 Peele's insistence on a modified Talbott Plan that would include "300.40 Neurotic Depression (Dysthymic Disorder)." For Spitzer, that change was unacceptable. Determined to have the assembly override its own committee's recommendations, he and his close collaborator on *DSM-III*, Janet Williams, met with the caucus of each area's representatives to the assembly. Using arguments well rehearsed during three years of debate, they sought to elicit support. In two of the seven caucuses, the liaison committee's position had clearly prevailed. In at least two others, the Talbott Plan had apparently been successful. This degree of uncertainty made it impossible to predict the outcome of the assembly's vote. The picture was no less ambiguous for Roger Peele, who had engaged so forcefully in a political strategy of the middle ground. Speaking for those engaged in office practice, "the grass roots," "the rank and file," he pressed individual delegates with his appeal for a universally acceptable manual.[20]

When at last the assembly met, Hector Jaso presented the liaison committee's recommendation that *DSM-III*, as submitted by the task force, be approved with one amendment. *Neurotic depression*, not *dysthymic disorder*, was to be the preferred term. Roger Peele defended this position, stressing the importance of the term *neurotic depression* for psychiatry, and charging that the task force was "phobic" about the word "neurosis."[20] In response, Spitzer defended the spirit of compromise that had characterized the task force's work, suggesting that opposition to its recommendation could be explained only in terms of emotional and political motivations. When in the course of the brief debate, Spitzer asserted that the parenthetically included *neurotic depression* could be used in making diagnoses, support for the liaison committee's position weakened. At that point, Peele realized that his cause was lost. By what observers believe was a 2 to 1 margin, the assembly approved by voice vote the Talbott Plan's parenthetical inclusion of the *neuroses*, making no exception for *dysthymic disorder*. A second motion, to approve *DSM-III* in its entirety, was then offered and was approved by an overwhelming majority. Spitzer's expression of gratitude from the podium was greeted with a standing ovation. At least momentarily, the deep divisions within the assembly's ranks appeared to have been closed.

Despite the assembly's approval, those who had struggled to preserve the status of *neurosis* did not end their efforts. Since the council on research and development, the reference committee, and the board of trustees had not yet acted on *DSM-III*, the proponents of *neurosis* could still press for modifications that might more closely reflect their perspective. Taking Spitzer at his word, that either the new *DSM-III* terms or the parenthetically included *neuroses* might be used in making diagnoses, they argued that the parentheses be deleted and that the word *or* separate the two terms. Only such a move could assure that the *neuroses* would be viewed in a "nonpejorative" light, as equivalents to the newly coined terms.[70]

Although the reference committee, at its meeting on June 8 and 9, rejected this proposal,[71] it was brought to the board of trustees two weeks later. There, as part of a final gesture at compromise, Spitzer proposed that the word *or* be included *within* the parentheses, thus producing the final form of the *DSM-III* listing, eg:

> Anxiety Disorder (or Anxiety Neurosis)
> Dysthymic Disorder (or Neurotic Depression)

With that, it was possible for the board to provide its final approval of *DSM-III*.

In the end, many of those who had challenged the task

force's attempt to exclude reference to *neurosis* believed that they had achieved a modicum of victory.[72] For others, but especially academic psychoanalysts, the preeminent concern never had been *neuroses.* "Ultimately, the important issue for dynamic psychiatry is not the presence or absence of the word *neurosis,*" wrote Arnold Cooper, president of the American Psychoanalytic Association, and Allen Frances, his colleague at Cornell University. More important for them was the "general realization by psychiatrists of all orientations that unconscious psychological conflict is ubiquitous in human behavior, makes at least a partial contribution to all psychiatric disorders, and is centrally involved in some."[73] Even such critics signaled general, if somewhat grudging, respect for the final draft of *DSM-III.* Cooper and Robert Michels, writing in the *American Journal of Psychiatry,* termed *DSM-III* "eminently usable" and a "major achievement" despite what they implied were its implicit biological biases.[74] An editorial in the *Journal of the American Academy of Psychoanalysis* noted: "In *DSM-III,* a concerted attempt has been made to build an expedient multiaxial, phenomenologically weighted diagnostic system that psychoanalysts may find useful since the coding designates coexisting personality disorders, psychosocial stresses, and an estimate of adaptive functioning."[75]

Others remained critical. A December 1979 report, prepared by the Joint American Psychoanalytic Association-American Academy of Psychoanalysis Committee on *DSM-III,* underscored the existence of remaining dissatisfaction.[76] Unlike those who believed that psychodynamic formulations were less rigorous than those used in *DSM-III,* the joint committee asserted that "a century of experience with the psychodynamic point of view had given inferences about the unconscious, intrapsychic conflict and defense mechanisms, a status close to those derived from direct observation." Indeed, these inferences, confirmed by "vast amounts of clinical data," were "essential" if psychiatric observations were to be "meaningful and coherent." By deciding to banish all psychodynamic inference to the degree possible, *DSM-III* had deprived psychiatry of a powerful integrating and organizing tool. In the end, the task force, representing but one point of view, had burdened the profession as a whole with an "unnecessary and ideologically mistaken handicap."

With the publication of *DSM-III,* the occasion for a pointed clash among the diverse tendencies that make up contemporary American psychiatry was ended. But the presence within the profession of disparate orientations provides the roots of lingering dissatisfaction with the diagnostic manual. Indeed, the interest in *DSM-IV* on the part of those who had just ended their dispute over *DSM-III,* indicates the temporary nature of the current lull.

CONCLUSIONS

For many psychiatrists, the controversy over *neurosis* and psychodynamics in *DSM-III* was a source of considerable embarrassment. The entire process of achieving a settlement seemed more appropriate to the encounter of political rivals than to the orderly pursuit of scientific knowledge. On each side of the controversy, it was held that important scientific truths were at stake, and yet the situation had demanded, of those who found themselves in opposition, the adoption of strategic postures and the employment of the techniques of politics. Of course, these postures and techniques took on a special character required by the professional nature of the controversy and were often mediated by the language of psychiatric discourse. Thus, in addition to the efforts at persuasion, the reliance on negotiation, the use of polemics, and the threats of a referendum, there were the more traditional appeals to reason and empirical evidence. Scientific politics is not a mere replica of more ordinary politics, but it is politics nevertheless.

The political dimension of the dispute over *neurosis* and psychodynamics in *DSM-III* does not mark psychiatry as unique among scientific disciplines, however.[77] For many years, philosophers concerned with the explication of the logic of scientific inquiry portrayed an image of scientific progress that disregarded the extent to which social and professional interests came into play in the resolution of controversies.[78] Recent empirical research into the history and sociology of science has shown how far from the truth of scientific work and practice that perspective had led us. Scientific activity and controversy are now understood to be affected in important ways by intraprofessional interests, as well as by broad historical and social trends.[79] When there has been disagreement over epistemological matters, over what will count as evidence, and over what will be taken as appropriate standards of verification, scientific controversies have not unusually taken an especially acrimonious turn.[80] In the debate between the "externalists"[81] (those who stress social, political, and historical forces) and the "internalists"[82] (those who stress the role of reason and evidence), it has been found that neither extreme is fully adequate to the task of comprehending scientific controversies.[83]

In the clash among psychiatrists who confronted each other over psychodynamics and *neurosis* in *DSM-III,* important disagreements involving professional paradigms[84] were at stake. Not only was there lack of agreement over the ways in which psychological data were to be apprehended and subject to verification, important intraprofessional interests were at stake as well. That this dispute took on a political form and that it was at times passionately fought should therefore come as no surprise.

To assure the accuracy of this study, we asked a number of those directly involved in this controversy to review our manuscript. Their careful reading and suggestions made an important contribution to our final draft. In this regard, we wish to acknowledge the efforts of Howard Berk, Allen Frances, John Frosch, William Frosch, Donald Klein, Roger Peele, John Talbott, Leo Madow, and Lawrence Rockland. In addition, we wish to thank the anonymous reviewers for *Archives of General Psychiatry* for their helpful criticism that made a major contribution to the revisions of this report.

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